Mental Health Act

A focus on restrictive intervention reduction programmes in inpatient mental health services

December 2017

Introduction

In 2015, the Mental Health Act Code of Practice set an expectation for mental health services to commit to reducing restrictive interventions. These interventions include the use of restraint, seclusion and rapid tranquilisation, but also wider practices, for example imposing blanket bans that restrict a person's liberty and other rights, such as stopping them from accessing outdoor space.

Our report on the *State of care in mental health services 2014 to 2017* highlighted concerns that care for some patients is overly restrictive.

CQC aims to improve quality of care by identifying excellence and sharing positive solutions from and with mental health providers. To do this, we identified five NHS mental health trusts where we have seen effective approaches to reduce restrictive practice. We asked them to tell us what they were doing to reduce the use of restrictive interventions and what was working well for staff and the people who use their services.

The examples show that there is no one-size-fits-all strategy to reduce the need for restrictive practices. But they all share characteristics of good practice and show that a positive and therapeutic culture across the whole organisation can reduce the need for restrictive interventions. Training for staff is also crucial to understand the causes of violence and aggression, and quality improvement techniques and evidence-based approaches such as Safewards can help support staff to change their practice. We have seen that successful trusts involve the whole multidisciplinary team in considering and developing approaches for wards or for individual patients. They also meaningfully involve people who use services in making improvements, to help them to develop successful approaches to manage their own distress, and to improve the ward environment.

To show how the five examples relate to the Code of Practice, we have reproduced the appropriate standard from the Code alongside each one. We encourage all providers to learn from these examples of good practice, and consider whether they can adapt them and improve their own restrictive intervention reduction programmes to improve the quality of care.

We have featured examples from the following trusts:

- Improved leadership and governance – North West Boroughs Healthcare NHS Foundation Trust
- A programme to reduce restrictive interventions – Mersey Care NHS Foundation Trust
- Supporting positive behaviour – Tees, Esk and Wear Valleys NHS Foundation Trust
- Providing person-centred care – Cambridgeshire and Peterborough NHS Foundation Trust
- Embedding a positive and therapeutic culture – East London NHS Foundation Trust.

Example 1: Improved leadership and governance

> *26.5 Providers should have governance arrangements in place that enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions. When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner. All mental health providers therefore should have in place a regularly reviewed and updated restrictive intervention reduction programme.*
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> Mental Health Act, Code of Practice (2015)

All well-led services must have good governance arrangements to monitor, report, analyse and respond to issues and to improve the quality and safety of care for the people who use their services. For restrictive interventions, this includes leadership teams looking across the available data for their clinical areas, identifying where there are more frequent episodes of restraint or violent incidents, and working with clinical teams to find a solution. This may include working with other clinical teams in the same service, or working with other similar services to compare approaches, and share data and learning.

North West Boroughs Healthcare NHS Foundation Trust

North West Boroughs Healthcare NHS Foundation Trust provides mental health services and learning disability services across the north west of England. It serves a population of 938,000 across the Boroughs of Halton, Knowsley, St Helens, Warrington and Wigan. It also provides community health services in the Borough of Knowsley. We inspected the trust in July 2016, and rated it as good overall in November 2016.

ReSTRAIN YOURSELF

In 2014, the Advancing Quality Alliance (AQuA), a quality improvement organisation based in the north west of England, was successful in its bid for funding from the Health Foundation to run a two-year restraint reduction project led by the University of Central Lancashire. The ReSTRAIN YOURSELF project tested the 'Six core Strategies' (an evidence-based approach to reducing restraint originally from the USA). The majority of mental health trusts in the north west of England participated in the project and then shared the learning.

North West Boroughs Healthcare NHS Foundation Trust signed up for the project in response to the significantly high levels of restraint in England identified in Mind's report *Mental Health crisis care: physical restraint in crisis*.

Data collection and review

The trust started by setting up a review of its data through its Prevention and Management of Violence and Aggression (PMVA) group. The trust found there had been 225 instances of prone restraint in 2013/14. The data review had the added benefit of leading to improvements in the reporting process to better separate the types of restraint being used.

The project used a controlled study with both an active and a control ward. Staff on the active ward received training on ReSTRAIN YOURSELF, supported by a philosophy of trauma-informed care. Champions in the team were identified and trained in quality improvement methods to make sure that the testing of all ideas followed a 'plan-do-study-act' (PDSA) approach underpinned by clear aims and measures.

The trust collected data from the study over a six-month baseline phase, a five-month implementation phase and a 12-month adoption phase. Staff recorded each incident of violence or restraint on 'safety crosses' and the organisation's central incident reporting and risk management database. Descriptive statistics were used to assess the number and proportion of violent incidents and incidents of physical restraint over the study period.

There was a 23% reduction in the number of violent incidents and of incidents of physical restraint on the active ward over the 12-month adoption phase, compared with the baseline phase. The number of standing restraints increased for the control ward but decreased on the active ward over the study period. Both wards reported a very low number of supine (lying face-up) and prone (lying face-down) restraints during this period.

Sharing learning

Following the project in 2016, the trust signed up to the AQuA restraint reduction programme, along with other trusts in the region, with a focus on sharing learning across the organisations. The programme consisted of training in reducing restraint, quality improvement methodology and monthly action learning sessions. The restraint reduction package, based on the Six Core Strategies, had been developed by AQuA into a web-based toolkit that all teams used as a reference to support implementation.

The challenge was to sustain the learning beyond the programme and extend it across the trust. During 2016, the trust had no clear governance around least restrictive practice. However, after reviewing the work of the previous PMVA group, the trust set up a new 'least restrictive practice group', with membership including ward managers across the trust. The group meets monthly to look at what the latest data is saying and to respond accordingly. The group's terms of reference include building quality improvement capability across inpatient teams.

To ensure sustainability, the trust appointed a project lead who, as part of the patient safety leader's programme, will support the implementation of reducing restraint approaches across the organisation.

The trust's restraint reduction package has been developed over time and includes:

- Unwritten rules – an opportunity for the team to look at the existing rules that govern the behaviour of staff and patients in the wards, determine which rules work and do not work for staff and for patients, and agree a process of removing, tweaking or confirming rules. This has helped staff to challenge some of the restrictive rules that only benefit staff.
- Community meetings – patients have the space to talk about the mood of the ward by using weather symbols (sunny, cloudy and stormy). This has enabled patients to begin to talk to staff about violence and aggression, and how staff respond to it, in a managed and safe way.
- Sensory rooms – some of the wards have developed sensory rooms and furnished them with a range of equipment such as lights, music and heavy blankets. This has created a safe and comfortable space for patients to use when feeling distressed.

- My Safety Plan – a self-management plan that supports patients in identifying their triggers, early warning signs and calming strategies.
- Debrief – staff often found it difficult to carry out a formal debrief because of the challenges of managing immediate reactions of patients and staff, the lack of available staff because of shift patterns, and issues with finding an appropriate physical space. The trust has found that carrying out patient debriefs helps to then have staff debriefs. The patient debriefs have been very powerful in reminding all staff of the impact of violence, aggression and restraint on the individual. This has led to improved relationships with patients.

Impacts and improvement

The trust has applied quality improvement methodology to help to implement the project and to gauge its success. This consists of:

- A clear aim of a 40% reduction in restraint within a fixed period.
- A driver diagram outlining how the aim can be achieved (plan on a page).
- A range of secondary drivers that all teams aimed to complete using a PDSA approach.
- Regular data collection, including the use of statistical process charts that are visible to all teams to monitor trends. This includes training staff in measurement and variation.
- A range of data including the number and type of incidents of restraint, violent incidents, staff and patient injuries, transfer to psychiatric intensive care units, and use of 'as required' medication. This range of data enables balancing measures to be developed to make sure that when restraint rates are falling, it is not due to an increase in the number of patients being placed in seclusion or an increase in the use of medication to manage behaviour.
- A baseline assessment that is completed by all ward managers, which focuses on a manager's confidence that their team is implementing all aspects of the restraint programme.
- The monitoring of all PDSA work across the inpatient units by the least restrictive practice.

The trust has seen a reduction of between 20% and 40% in the use of restraint in wards that have implemented restraint reduction approaches. The trust also saw the number of uses of prone restraint reduce from 225 in 2013/14 to 126 in 2015/16, and work is continuing to bring this down further.

The trust recognises that it is a long process, which is mainly about changing the culture. It is currently looking at a new policy framework on least restrictive practice with the expectation that all inpatient services work this way. The policy will incorporate all restrictive practice procedures, such as seclusion, escorting, and observations. Alongside this work, the training department has been amending the training in PMVA and conflict resolution to better reflect a least restrictive approach.

The new governance arrangements at the trust will support a process of embedding restraint reduction across all services.

For more information about North West Boroughs Healthcare NHS Foundation Trust, email communications@nwbh.nhs.uk.

Example 2: A programme to reduce restrictive interventions

26.6 Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should demonstrate organisational commitment to restrictive intervention reduction at a senior level, how the use of data relating to restrictive interventions will inform service developments, continuing professional development for staff, how models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways, how service users are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

Mental Health Act, Code of Practice (2015)

The Code is clear that if there is no reduction programme, this should be challenged by patients, carers, regulators and commissioners. The details of each programme will be unique to the type of service and patient group, but all should have a clear emphasis on improving patient experience and should support patients and staff to be engaged in the programme.

Mersey Care NHS Foundation Trust

Mersey Care NHS Foundation Trust provides specialist inpatient and community mental health, learning disability and substance misuse services for adults in Liverpool, Sefton and Kirkby. It provides specialist high secure and learning disability and autism secure beds to a much wider population encompassing north west England, parts of central England, and Wales. The trust currently employs more than 5,000 staff and provides some services to almost 11 million people. We inspected the trust in March 2017, and rated it as good overall in June 2017.

No Force First

'No Force First' is an innovative approach to reducing restraint, originally developed by Recovery Innovations, a substance misuse treatment centre based in the USA. In 2013, Mersey Care piloted this model with positive results in reducing the use of restraint on wards, as well as reducing staff sickness.

Following this success, it was rolled out across the whole trust. The trust now has a strong culture of collaborative empowerment where staff and people who use services work together to reduce conflict and promote safety and recovery. The trust has deliberately set itself an ambitious goal of eliminating the use of restrictive interventions.

It aims to achieve this goal in the following ways:

- Promoting the 'whole systems approach' that has been developed to prevent crisis and conflict on the wards. Staff and people who use the service work collaboratively to make the wards safer and more recovery focused. This approach supports personalised care so that patients and staff can use their strengths to promote compassion towards others.
- Developing a cooperative culture, rather than a restrictive culture, to reduce incidents of aggression, self-harm and physical intervention.
- Developing a deeper understanding of the people the trust supports in order to see their experiences in a trauma-informed, empathetic manner, and working together to build resilience.
- Including the experiences of people who use services, and engaging in co-production work.
- Engaging in partnership working and positive communication to encourage future improvements, while maintaining safety for staff and people who use services.
- Ensuring that practice meets the most up-to-date national guidance and continues to be progressive.
- Using data and evidence-based approaches to see if they help improve clinical outcomes and quality of care on the wards.

The trust set No Force First as one of its strategic priorities to ensure the full support and commitment of its board. This helped to sustain progress and increased the importance of this new approach at every level of the organisation.

The trust also co-produced a guide to reducing restrictive practice that is used on all inpatient wards to support implementation and sustainability. The guide covers the philosophy of the model, the six key interventions (generated from the experience of pilot wards) and a toolkit of extra strategies that teams can use to reduce conflict and improve care on the wards.

The trust also co-produced ward engagement sessions with staff and the people that use services. These sessions set out the negative impact of physical intervention on people and are used to help engage and inspire people to make changes and innovations to improve services. It also delivers a Recovery College peer tutoring course to enable experts by experience to co-deliver personal safety service training to all staff.

As well as implementing the Reducing Restrictive Practice policy and strategy, the trust also delivered the No Force First video as part of the personal safety training curriculum. The video moves away from the traditional focus on restrictive interventions and instead focuses on a preventative approach. The trust is now delivering training around preventative strategies to avoid conflict, and on how to support staff and people who use services to address their needs in positive ways.

The trust also delivered values-based recruitment training across the trust. This training encourages people who use services and those who care for them to help deliver the training. It places an emphasis on the principles of least restriction. The training is a crucial factor in maintaining the success of No Force First as it makes sure the future workforce can learn about, and feel aligned with, the values of the trust.

Now that No Force First is a full part of the approach to reduce restrictive practices, the trust has a number of ways to make sure that teams remain engaged in the improvement work. It feeds back analysis of incident data and recognises and celebrates the areas with positive results, as well as identifying areas that need extra support.

Quality improvement approaches

The trust carries out quality improvement using PDSA cycles (simple, measurable changes to ward practices, service and activities). These cycles develop small but critical changes to practice that then help to reduce conflict through collaboration between ward teams and the people using services. This method of testing out new ideas over short periods creates a more dynamic approach to change. For example, one ward worked on a new model for more positive, recovery-focused nursing handovers. The ward rapidly implemented training in this area, which generated positive results. Other teams were then able to adopt the approach and share the learning.

Mersey Care has also used design thinking approaches to address both aggression and self-harm. Design thinking uses human needs to re-frame and solve complex problems with a hands-on, iterative approach. The trust has used it to generate and refine creative solutions around clinical engagement and to address the specific challenges teams face. The trust is evaluating the outcomes of this programme in partnership with Liverpool University.

Culture

The trust found that the process of changing culture can be challenging and there are difficulties in moving from the pilot phase to implementing change across an organisation.

It is addressing these challenges in a number of ways. For example, it is integrating new processes into standard clinical practice and supporting cultural champions in using the new approach. Some staff were initially concerned that the new ways of working might make clinical practice unsafe. However, the outcomes demonstrate that this is not the case. Expanding and enhancing the role of experts by experience is also helping to address some of the initial anxiety about the shift in culture.

The trust is now establishing a culture of continuous improvement, developing new tools and training, and providing regular updates to improve practice and keep staff engaged. It also shares stories of the human cost of restrictive practices from people's experiences to encourage frontline staff to connect emotionally.

The No Force First model can be effective across a range of services, for example wards for elderly people and high secure wards. Mersey Care's H.O.P.E.(S) programme in high secure services at Ashworth Hospital is based on the principles of No Force First and supports people back into the ward community from long-term segregation. It can also be used to support other approaches. For example, the trust's learning disability division used it in conjunction with the Safewards approach (a model that uses a range of ideas and techniques to keep people safe on the wards) and achieved positive outcomes.

No Force First has been adopted nationally in both high secure health settings and in a number of segregation units in prisons.

H.O.P.E.(S) MODEL

The HOPE(S) clinical model is a recovery-based approach to working with patients in segregation, developed from research and clinical practice:

- **H**arnessing the engagement of the patient and clinical teams through key attachments and partnerships.
- Providing **O**pportunities for positive behaviours, meaningful and physical activities.
- Identifying **P**rotective and preventative risk and clinical management strategies.
- **E**nhancement of the environment and experience of the person through structured, progressive and graded plans.
- Throughout engaging in these tasks, the **(S)**ystem needs to be managed and developed to provide support throughout all stages of the approach.

Positive outcomes and looking to the future

In the first two years of the pilot, the trust recorded around a 60% reduction in the use of physical intervention in the wards that participated. The approach was then implemented across all wards and, between April 2016 and August 2017, there was a 37% reduction in the use of restraint. Alongside this, the number of assaults on staff has decreased (by 46%) in secure and local divisions.

As a fewer number of staff are now involved in physical interventions, and are therefore less exposed to assault, the trust has seen financial savings as a result of less sickness-related absence. For example, last year in the secure division of the trust, savings equated to nearly £250,000. The approach has resulted in an improved experience for people using the services of the trust, and the benefits of a safer environment for everyone.

Looking to the future, Mersey Care is focusing on delivering a more compassionate approach to supporting its staff. Members of staff are encouraged to openly share learning from events that do not go as planned, and develop creative solutions. The focus is not around blaming individuals but instead looking at the system and how that contributed to the event and could be improved, asking the question, ‘what in our system contributed to this event?’

For more information about Mersey Care NHS Foundation Trust, email communications@merseycare.nhs.uk.

Example 3: Supporting positive behaviour

> *26.15 Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such a care or treatment plan is referred to as a positive behaviour support plan. These individualised care plans, should be available and kept up to date.*
>
> Mental Health Act, Code of Practice (2015)

The 2015 Code introduced standards about the use of positive behaviour support plans. The plans should include strategies to reduce the likelihood of behavioural disturbances, how staff should respond to early signs of challenging behaviour, and should give clear instructions on how to minimise a patient's distress and risk of harm.

The approach to positive behaviour support may be a feature of a restrictive interventions reduction programme. Staff should monitor the use and effectiveness of the individualised plans to help inform reviews and future developments in programmes, and seek feedback from patients and carers on their experience of the service wherever possible.

Tees, Esk and Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health and learning disability services to the people of County Durham and Darlington, Teesside, Hambleton and Richmondshire, Scarborough Whitby and Rydale, Harrogate and Craven, and the Vale of York. The trust serves a population of 1.6 million people and employs more than 6,500 staff. We inspected the trust in January 2017, and rated it as good overall in May 2017.

Using Positive Behaviour Support as a component of a Positive and Safe plan

The trust's approach to reducing the use of restrictive intervention was first developed in 2014, following the publication of Mind's report *Mental health crisis care: physical restraint in crisis*. As part of the approach, the trust set out priorities that included long-term commitments to reduce the use of restrictive interventions across services, and to improve the quality of life for people using its services.

The approach to reducing the use of force includes a Positive and Safe plan and is based on six core strategies. These areas continue to evolve as the trust learns from experiences and has a better understanding of the national agenda for reducing the use of restrictive interventions. The approach is supported by a dedicated team of staff, with the support of a designated lead at board level.

Open and transparent reporting

The trust has recognised the importance of an open and transparent reporting culture, which was central to the plan. The Positive and Safe team reviews episodes of challenging behaviour daily, with formal reviews completed quarterly.

The trust has also developed its reporting systems and continues to train the workforce to record instances of restraint effectively. It is now considering how this information could be made more readily available in clinical areas, including by developing an electronic dashboard that would allow staff to use the data to inform their clinical practice.

The trust introduced Safewards interventions across all inpatient areas. Safewards is a recognised evidence-based model to help reduce the use of restrictive practices. All clinical areas were supported to adopt the Safewards model. There are Safewards champions for each ward, who provide practical support and help with implementation, training and coaching.

There are also regular events across directorates to share learning and best practice and to celebrate achievements. The Positive and Safe plan also considers how the principles of Safewards can be applied to crisis support teams and wider community services.

Positive behaviour support plans

Alongside the Safewards approach, the trust was keen to develop the use of Positive Behaviour Support plans across services. These collaborative plans involved the person using the service, and the wider multidisciplinary team. The focus was on preventing episodes of aggression from happening by understanding the person's behaviour. This approach has been embedded in the trust's policy.

Ongoing training

The trust regularly holds masterclasses to make sure that staff have the appropriate knowledge and understanding of how to develop positive behaviour support plans. Support and coaching is also available for all nurses across the trust, and there are plans to make video resources available. The trust monitors quality through an annual Positive and Safe audit.

One important element of the plan is providing training in Prevention and Management of Violence and Aggression. The trust's training curriculum has been revised to reflect the guidance in *A Positive and Proactive Workforce,* with a greater focus on positive and proactive approaches and non-restrictive approaches rather than physical interventions. The trust introduced theory-based modules that focus on preventative approaches, for example, interaction, de-escalation, Positive Behaviour Support and debriefing. Staff are encouraged to complete the theory-based modules before learning any physical skills in how to prevent challenging behaviours occurring. The modules are delivered jointly with experts by experience.

Learning from incidents

In addition to the training programme, the trust's Positive and Safe team continue to review incidents involving challenging behaviour. The purpose of this is to identify opportunities for further learning to help staff to reduce their use of restrictive practices. A recent example, identified as part of this ongoing review, was an initiative to teach nurses to administer rapid tranquilisation using alternative parts of the body (deltoid and ventrogluteal sites). This means that prone (lying face down) restraint is not required and a less restrictive hold can be used. While clinical staff always aimed to avoid prone restraint, this simple change has supported a number of wards to reduce its use further.

When episodes of challenging behaviour do occur, the Positive and Safe team are committed to learning lessons from them. They analyse why an incident has happened, investigate what can be done to prevent it happening again, and also consider how to offer support to all those who were involved.

The trust has developed two 'Rapid Reflection' tools for staff and patients to use following an incident. They are designed to be simple and quick to complete in a busy ward environment. Following a successful pilot earlier this year, the tools are now being embedded across the trust.

Positive outcomes and looking to the future

The trust has developed a robust clinical framework that considers the use of restrictive interventions, and how incidents can be prevented or minimised. As a result, the trust has seen a big reduction in the use of restrictive interventions in some areas, with some services identifying a 20% decrease in total incidents and a 70% reduction in prone restraints in some wards.

The Positive and Safe plan is still at an early stage and Tees, Esk and Wear Valleys recognises that some of the culture change will take time to embed across services. The trust is keen to develop its plan further by looking at how technology may help reduce the use of restrictive interventions. It is also considering the physical environment of wards and how they could be adapted to further reduce the use of restrictive interventions and therefore improve the quality of life for people using the services.

For more information about Tees, Esk and Wear Valleys NHS Foundation Trust, email tewv.communications@nhs.net.

Example 4: Providing person-centred care

> *26.8 People suffering from a mental disorder should, on admission to hospital, be assessed for immediate and potential risks of behavioural disturbance. Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.*
>
> Mental Health Act, Code of Practice (2015)

Involving patients, carers and families in reducing restrictive interventions at an individual level or across the service is critical to ensuring that programmes are effective. We will always expect to see person-centred care and the involvement of people who use services in a provider's strategies.

Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust provides integrated community and mental health, learning disability and social care services to a population of 891,000, and employs over 3,400 staff in more than 50 locations. We inspected the trust in May 2015, and rated it as good overall in October 2015.

In 2013, the trust initiated PROMISE (Proactive Management of Integrated Services and Environments) to help reduce the use of restraint. The project focused on understanding the scale of the problem and decreasing the use of force through person-centred care. The aim was to create an evidence-based framework that would support staff and people using services to reduce the use of restraint. The trust carried out quantitative and qualitative research, and embedded innovations to influence practice across the organisation. The research was funded by East of England Collaboration for Leadership in Applied Health Research and Care. PROMISE is a co-produced initiative, which was co-founded by a patient and a professional. People with lived experience of physical restraint were actively involved in shaping the qualitative research and a patient advisory group provided a steer to the project.

Looking at the data

Initially, the trust placed an emphasis on incident reporting and evaluating data and information about the service. The trust carried out a detailed audit of physical interventions and rapid tranquilisation.

The trust also established a Positive and Proactive Care (PPC) steering group to look at the physical intervention data.

Alongside this, the trust made changes to the incident reporting and risk management database (Datix software) to make sure it could capture sufficient data about the restrictive interventions. The Prevention and Management of Violence and Aggression (PMVA) team supported staff to complete Datix training, and published a 'top tips' guide on the Datix system. The trust also recognised a need for clinically informed Datix training and asked the PMVA team to help support staff with training on Datix software.

These changes informed improvements in practice and enabled the trust to report more clearly on performance.

For example, data reports are routinely produced for scrutiny at the PPC steering group. The reports include breakdowns of a range of physical interventions and include numbers, locations and descriptions of incidents of prone restraint and seclusion. The reports also detail whether staff and people using services have been de-briefed.

Listening to staff and people who use services

The PROMISE team wanted to gain a better understanding of the key issues in physical restraint by listening to the experiences of staff and people who use services. The team carried out one-to-one semi-structured interviews with 13 people who use services and 22 staff who had direct experience or had witnessed restraint.

The interviews also captured suggestions from patients and staff for how to reduce restraint in mental health wards and their views on proactively managing the ward environment. The suggestions were grouped under four key themes: improving communication and relationships between staff and people who use services; making staff-related changes (such as having more staff (particularly more skilled and experienced staff); improving ward environments and spaces; and having more activities and distraction for patients on the wards.

Empowering frontline staff

Staff were empowered at all levels to think creatively about new proactive care initiatives that could be introduced and ways to eliminate reliance on force. Engaging staff in this way helped to avoid defensiveness and led to more positive conversations about how healthcare can be improved.

The trust asked staff to think of even the smallest thing that could be changed at each point in the day to make a positive impact, and to help patients manage their distress. Questions, based on the model of appreciative enquiry, included:

- What are we doing well that we should continue and build on?
- What should we stop doing?
- What should we start doing or do differently?

Sharing good practice

The PROMISE team carried out a mapping exercise to capture all of the innovation and good practice across services from staff at all levels. It identified and shared more than 200 ideas and new initiatives.

Ward managers then shared this innovative practice. They presented it at events, sharing the stories and celebrating the work of staff. This helped to ensure that new initiatives were owned by frontline staff and not enforced from above.

The trust recognised that even small changes can start to shift the culture. For example, it was better to wake a person with a cup of tea in bed rather than giving them a nudge and telling them to get their medication. This can make a great difference to patient experience and the way someone starts their day. These changes to practice are reflected in the high overall satisfaction scores for the adult inpatient wards.

Changing culture – the ‘no’ audit

Staff who worked on a three-week treatment unit at the trust came up with the idea of the ‘no’ audit. Staff said that when they had to say ‘no’ to patients, this could sometimes be distressing. However, each occasion provided an opportunity to reflect. The trust encourages staff to think further about their response and whether they had listened carefully and if they could have compromised with the person using the service. If staff felt they had to say ‘no’, the trust encouraged them to think about whether they said it in the nicest possible way and offered an explanation.

This has led to a culture of ‘say yes first’ at the trust, which helps patients to understand what needs to happen for a member of staff to say ‘yes’.

The ‘reflect’ acronym helps staff to remember what they need to consider when answering a patient’s request:

R – Reframe: What would it have taken to say yes?
E – Easy: Was ‘no’ the easy option?
F – Feeling: What would it have felt like?
L – Listen: Did we listen?
E – Explain: Did we explain?
C – Creative: Were we creative enough?
T – Time: Did we take the time?

An example of this is having pets on the wards. Many people want to see their dog, but pets are not routinely allowed because of infection control procedures. However, animals can be very therapeutic and have a calming effect. After considering the risks, staff decided that the benefits of allowing pets on wards far outweighed the risks, as long as the other patients did not mind.

On another ward, the trust made changes to the way people collect their medicine, to make it a more dignified experience. The ward manager recognised how disruptive it was to dispense medicine over a hatch, and saw that this was a potential cause of friction because it was giving the message: ‘on one side stood those with power, and on the other, stood those without power who were queueing in an institutionalised line’. The trust replaced the stable door, brought chairs in to the clinic room, and now invites patients to the clinic room individually to take their medication in privacy.

Impact

Integrating fundamental aspects of PROMISE into day-to-day activities has made a huge contribution to reducing the use of physical restraint at the trust. This reduction has been sustained over a period of nearly three years, and any regular use is usually only associated with a particularly unwell patient.

For more information about Cambridgeshire and Peterborough NHS Foundation Trust, email communications@cpft.nhs.uk.

Example 5: Embedding a positive and therapeutic culture

> *26.4 Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. This culture should aim at preventing behavioural disturbances, early recognition, and de-escalation.*
>
> Mental Health Act, Code of Practice (2015)

The Code highlights the importance of embedding a positive and therapeutic culture. This includes ensuring that staff have the ability to work with multidisciplinary teams to identify individualised person-centred support, have access to training opportunities that help to discuss, share and learn from other colleagues and clinicians, and feel supported to deliver evidence-based high-quality care to the people who use the services.

East London NHS Foundation Trust

East London NHS Foundation Trust provides services to a population of 820,000 in East London and 630,000 in Bedfordshire and Luton. It also provides psychological therapies in Richmond and children and young people's speech and language therapy in Barnet. The trust has a mother and baby unit at the Homerton Hospital, which receives referrals from across south east England. The trust employs around 5,000 permanent staff in more than 100 community and inpatient sites. We inspected the trust in June 2016, and rated it as outstanding overall in September 2016.

Reducing violence

Violence is the biggest cause of reported safety incidents at East London NHS Foundation Trust. The trust formed the Tower Hamlets Violence Reduction Collaborative following the success of a pilot project in 2012. The project resulted in incidents of violence on one ward reducing from four every month during the period of January to April 2012, to a sustained level of about one every two months. The project brought together all the inpatient wards in the Borough of Tower Hamlets, four acute admissions wards and two psychiatric intensive care units to build on this approach to reducing violence. The same approach was tested further across all of the trust's adult inpatient admission wards in London (City and Hackney and Newham) between 2016 and 2017.

Learning and planning

All wards set up a small multidisciplinary project team, which included registered nurses, healthcare assistants, allied health professionals, doctors and administrators. The wards adopted quality improvement methodology, using plan-do-study-act cycles to test ideas for change. The ward staff came together at six weekly learning sessions where they could learn from each other and look at data over time to understand whether changes were resulting in improvement. The trust's central quality improvement team focused on keeping stakeholders engaged with the nature, purpose and meaning of the improvement work. They also maintained strong partnerships with others, such as ward managers and patient representatives in order to sustain improvement.

The teams developed ideas for change by sharing theories about why violence was occurring and what would help to mitigate this. This was then compared with available evidence. A facilitated workshop was then held to discuss these ideas. Staff of all levels of seniority and different professional backgrounds, people who use services and the trust's police liaison officer all came together at the workshop. The ideas they developed built on the learning from the pilot project, and formed the theory of change that underpinned the testing of the violence reduction project in other locations.

Predicting and managing the risk of violence

The teams at the workshop felt there was a need to improve multidisciplinary team working, particularly around how wards identified, predicted and managed risks of violence and aggression. Two ideas for change were developed:

- Brøset Violence Checklist (BVC) – this is a simple validated risk assessment tool, developed in Norway. Staff on wards can use it to predict the likelihood of a patient being violent in the next 24 hours through rating the presence or absence of three characteristics and three behaviours (confusion, irritability, boisterousness, verbal threats, physical threats and attacks on objects). This tool is used for the first seven days of the person being on the ward and then whenever staff feel it is subsequently needed.
- Safety huddles – these are stand-up micro-meetings of no more than 15 minutes. As many ward staff as possible come together to discuss safety issues and individual patients. The team immediately identifies and allocates any actions to manage and mitigate risks. All six of the wards aimed to huddle at least two or three times a day at set times (once in the morning, once mid-afternoon and once during the night shift). In addition, a member of staff could also call a safety huddle when they felt the risk level was increasing outside of these times.

Sharing concerns about violence

The teams also felt they needed to improve the way the ward community (patients ward team and visitors) engaged with each other around the issue of violence. Specifically, they felt wards needed to develop a more open approach to sharing their experience of violence and aggression so that it became more of a ward community issue, which everyone worked through together. Two ideas for change were developed:

- Displaying safety crosses in the public area of the ward. This is a simple wall calendar that staff can mark in colour to show red days (when there was an incident of physical violence) or green days (incident-free). This evolved to include orange incidents, reflecting a near miss or build-up of hostility – which are not usually recorded in any form. This was an accessible way to share incident data and provided a focal point on the ward for staff, people using the service and visitors. Safety crosses also served the purpose of manually recording incidents, which was important as the team believed that there was initially under-recording of violence through the electronic incident recording system.
- Safety discussions in ward community meetings. The teams in the Borough of Tower Hamlets chose to integrate these discussions into the weekly ward community meetings. The discussions referred to the safety cross and summarised any safety incidents over the past week in a brief and non-judgemental way. Patients and staff were invited to talk about any emotions or feelings related to being in the detained setting.

The safety discussions have run in three London boroughs since April 2016. They have helped to retain a focus over a period of testing and implementation. Not all teams adopt new ideas at the same rate and need help, guidance and encouragement to test them reliably. Sharing data and telling stories about this has been a key feature in engaging a wide range of teams and leaders in this work.

The trust found that keeping both senior leadership and ward-level leadership focused on the ideas for change and the importance of improvement, had a significant impact on success. Because of the complexity of daily work, it was sometimes hard to maintain this focus and to find the time and energy to incorporate new ideas into familiar patterns of behaviour. Senior, executive-level sponsorship of the project, with attention to the progress and any operational problems, helped to ensure that the violence reduction improvement work remained a visible priority.

As a result of the improvements, the trust experienced a 40% reduction in physical violence across the six wards in the London Borough of Tower Hamlets (12.1 incidents per 1,000 occupied bed days in 2014 down to 7.2 in 2015). Across the four general acute admissions wards there was a 57% reduction in physical violence. The other boroughs also saw significant reductions in violence in 2016/17:

- The five wards in the City of London and London Borough of Hackney saw violent incidents reduce by 74% (from 43.8 to 11.5 incidents each week)
- The four wards in the London Borough of Newham saw violent incidents reduce by 54% (from 16.8 to seven incidents per 1,000 occupied bed days).

East London NHS Foundation Trust is now focused on improving quality control, particularly looking at joining resources at a hospital level to strengthen behaviour change around violence reduction.

For more information about East London NHS Foundation Trust, email communications@elft.nhs.uk.

Next steps

Our *State of Care in mental health services 2014 to 2017* noted our concern that providers do not define, record and report restraint consistently. This means that CQC cannot use the reported number of incidents as a reliable indicator or make valid comparisons between providers on the frequency or type of restraint used. We also found that training provided to staff varies in type and quality, and that there is no widely accepted standard of what good looks like in specific settings and no widely used system for assuring the quality of training for staff.

We will be working with national partners to address these issues and build on the good practice, including work commissioned by the Department of Health to develop standards to help prevent and manage violence and aggression, which is due to publish shortly. We will also consider how providers may benefit from the high secure training manual accredited by the National Institute for Health and Care Excellence (NICE).

We would like providers to think about how they can improve their restrictive intervention reduction programmes to improve the quality of care for people using services.

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