Board of Directors – Open

SUMMARY REPORT	Meeting Date:	28th September 2022
	Agenda Item:	16

Report Title:	**Use of Force Annual Report**
Author(s):	Salli Midgley, Director of Quality Lorena Cain, Nurse Consultant for Least Restrictive Practice
Accountable Director:	Beverley Murphy, Director of Nursing, Professions and Operations & Deputy CEO
Other meetings this paper has been presented to or previously agreed at:	Mental Health Legislation Committee, 21/09/2022
Key points/ recommendations from those meetings	There was concern about the potential use of CC cameras in a newly refurbished inpatient unit and in the decisions unit. The point was debated and clarified and is noted here because the human rights impact of unnecessary or ill governed surveillance is recognised. The committee was assured and positive about the reduction in the use of seclusion across SHSC inpatient services.

Summary of key points in report

Taken from the Least Restrictive Practice Oversight Group: Quarter One Update and Annual Report: the implementation of the Use of Force statutory guidance. Governance and assurance processes: significant progress and completion of actions for Year 1 related to Use of Force Act statutory guidance. One action remains in progress related to Use of Force relating to G1 reporting of restraint for personal care.

Areas of risk to note are lack of full compliance with V5 dataset and Use of Force statutory guidance – whilst this was launched and the new fields of recording and reporting introduced, extracts from the data run show that there are gaps for both post incident reviews and the recording and length of time of restraint. The dementia unit (G1) continues to under report restraint for personal care however work is ongoing to review how this can be delivered without significant administration burden.

Recommendation for the Board/Committee to consider:

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

To receive the assurance via the report that implementation of the Act has taken place

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*		*No*	
CQC Getting Back to Good – Continuing to improve	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards?					State specific standard
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?					

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 and Experience	*Yes*	***X***	*No*		***Restrictive practice impacts on the experience of people using our services***
Financial (revenue &capital)	*Yes*	***X***	*No*		***Potential financial resource required to deliver the strategy***
Organisational Development /Workforce	*Yes*	***X***	*No*		***Skills and compassion are key elements of the workforce requirements***
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		
Legal	*Yes*	***X***	*No*		***Failure to comply with legislation is a breach and could result in legal challenge***
Sustainability	*Yes*		*No*		

Least Restrictive Practice/Use of Force - Annual Report

2021-2022

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

September 2022

Authors: Lorena Cain, Nurse Consultant for Restrictive Practice; Salli Midgley, Director of Quality and Responsible Person for Use of Force; Henry Harrison Business and Performance Manager, Quality Directorate.

Contents

1.0 Introduction and Background – The Use of Force

Welcome to the first annual report to outline our compliance with the Use of Force Act and progress against our Least Restrictive Practice Strategy.

The report sets outs the key objectives identified and achieved for Year one (June 2021 – June 2022), along with the aims of the Trust in line with statutory requirements and the genuine commitment 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 have committed to providing safe and positive care and ensuring the wellbeing of all our patients, service users, carers and staff. This is in line with the Use of Force Act (2018). Our co-produced Least Restrictive Practice Strategy will enable and deliver this over a 3-year period.

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

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

We aim to achieve these responsibilities through:

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

1.1 The team

The Least Restrictive practice strategy and Use of Force plan is directly supported by the Director of Quality/Responsible Person for Use of Force, 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 Deputy Lead and 4 Practitioners.

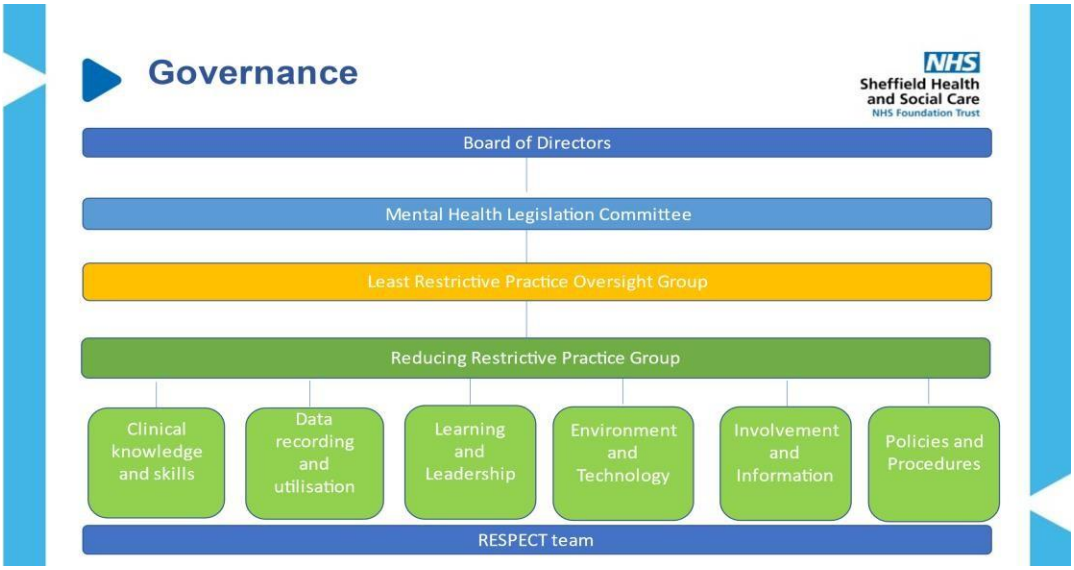
Delivering the strategy has also been supported by our Business and Performance Manager, who has assisted in developing the dashboards to monitor use of restrictions and the Project Management Office (PMO) in developing the workplan tracker, deadlines and action owners.

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

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

1.2 Governance and reporting

1.2.1 Internal Governance and Assurance



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

A monthly operational group (Tier3) supports the coming together of team 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 and action leads.

The Least Restrictive Practice Oversight Group (LRPOG-Tier2) commenced oversight in July 2021 receiving the first assurance report and improvement plan supported by PMO. Reports are produced quaterly for the LRPOG and are submitted to Mental Helath Legislation Committee for further assurance and approval.

LRPOG meeting dates and quarterly report submissions

13/07/2021 – Quarter One
02/11/2021 – Quarter Two
18/01/2022 – Quarter Three
24/05/2022 – Quarter Four

1.2.2 Audit and monitoring

Progress against the achievement of our quality objectives and workplan is monitored on a quarterly basis through our clinical directorates and restrictive practice groups. Progress is reported through to the Quality Assurance Committee. We also share our progress, together with any concerns on achievement, with external partners including the CCG (now Sheffield PLACE, Care Quality Commission and NHSE regional leaders).

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 along side service users, staff, teams and partners to truly represent the needs and wants of all the groups and individuals, diversity and characteristics.

Over the year, and through the development of the strategy until its launch in November 2021, work took place to engage and work with individuals and groups via 1-1 meetings, attendance at existing forums, via big conversations, ward community meetings and just day to day conversations and feedback.
Service users with lived experience joined restrictive practice forums such as the Operational group, the safe wards forum and other tasks and finish groups looking at how we might improve the experience and care to service users, those who support them and staff. Service users delivered their feedback at the November conference via written and video feedback, and we appointed to a co-chair of the LRPOG with lived experience. Connections and work with Sheffield Voices, Disability Sheffield, Advocacy, Flourish and SACMHA were developed and have grown over the year. Now delivering weekly advocacy support to our inpatient teams for those from an ethnic diverse background, easy read leaflets on the Use of Force, SafeWards and search; and planned sessions on working with men from a black community to name a few.
Contributions have been made to our training packages mainly that of the RESPECT training and rapid tranquilisation training. People with lived experience have shared

their stories of these areas of restrictive practice informing care planning, staff approach and considerations on how we might improve.

There is an already established network of collaboration with the Restraint Reduction Network and Navigo who support our developments and implementation plan.

We have joined the National Patient Safety collaborative related to reducing restrictive practices and are in the early stages of utilising the work on two of our adult acute wards.

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 Use of Force (Mental Health Units) Bill was tabled by Steve Reed, MP for Croydon North in 2018 and received Royal Assent in 2018.

His Parents worked with a range of voluntary bodies and MPs to bring about change.

Aji Lewis, Seni's mother said: *"I want Seni here with me but they took him away. The police dangerously restrained him to death with mental health hospital staff watching on. The enactment of this law is important to us because we do not want anyone else to suffer like this.*

It's so good to see the guidance published today and the Act being commenced. This is my son's legacy, and I hope it will mean what happened to Seni will not happen to anyone else.

I look forward to continuing to work with the government and mental health providers to make sure the Act is properly implemented, and real change is achieved."

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.

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

2. The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit. The written policy will set out the steps that the unit is taking to reduce (and minimise) the use of force by staff who work in the unit

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

4. The responsible person for each mental health unit must ensure staff receiveappropriate training in the 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

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

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 wear and operate a body camera at all times when reasonably practicable.

Implementation, delivery and assurance

All statutory requirements as set out by the Use of Force Act have been completed throughout the Year, with the exception of our Older Adult dementia ward (G1). A program of support and development is underway to report their Use of Force for personal care, supported by the Director of Quality, Nurse Consultant for Restrictive Practice and the Business Support and Patient Safety Team 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)

In May 2021 the Trust engaged in the consultation process of the statutory guidance and submitted its feedback as required. This enabled preparatory work across the Trust with both people with lived experience and staff in teams. Making a shift in the use of language from violence and aggression to Use of Force was a driving factor in helping people understand the requirements of the Act and the things we needed to prepare for implementation. Sharing Senis story with staff focussed the need to think long and hard about the impact of any restrictive practices on people and the harm it can cause.

Going forwards is evaluating the impact of the Use of Force information that we implemented towards the end of this annual cycle. Understanding how the coproduced leaflet might support conversations on prevention, care-planning and choice and how this in turn may reduce restrictive practices.

Implementation Plan for the Use of Force Act

no	Requirement of the Act	Lead	Status	Further statutory guidance	Completion date	Notes
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	Salli Midgley	Complete	The responsible person should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in. It is important they are guided by the impact of trauma on their patients and the potentially re-traumatising impact of the use of force	31.12.21	SM attended training 6.12.21 Noted on Trust Webpages
2	The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit. The written policy will set out the steps that the unit is taking to reduce (and minimise) the use of force by staff who work in the unit	Salli Midgley Lorena Cain Greg Hughes Salli Midgley	Complete	a)Policy must reflect the needs of the patient population using the services and are tailored to the specific services being provided. Where an organisation is providing different types of services across several units the policy should clearly set out the different needs or considerations that may be relevant, for example, adults, women and girls, patients with autism or a learning disability, and people who share protected characteristics under the Equality Act 2010.	As soon as possible	Complete
			Complete	b)The policy should include a statement which sets out the organisation's commitment to minimising the use of force.		In current policy
			Complete	c)The policy should set out the plan or approach the organisation is taking to reduce the use of force within their mental health units.		Aligns to strategy in current policy
			Complete	The policy should (as a minimum) include the following:		Aligned and to be reinforced with Human

				a) the organisation's commitment to protect human rights and freedoms		Rights training and workplan
			Complete	b) the organisation's commitment to minimising the use of force, recognising the potentially traumatising impact the use of force can have		Aligned and reinforced through clinical and social care strategy
			Complete	c) information about how the organisation will monitor the use of force on people who share protected characteristics		Within the policy
			Complete	d) what action the organisation will take if the inappropriate use of force is identified		Within the policy
			Complete	e) details of the types of force and specific techniques which the organisation may use, which may be different in services for adults or older people. This should include information about the risk assessments undertaken prior to the techniques being approved by the organisation or trust board, and an assessment of the training needs of staff in using these techniques. See below for further detail about the types of force used		Within the policy
			Complete	f) examples of the circumstances in which the use of force may or may not be used, and when a use of force is considered negligible (in accordance with this guidance – see section on guidance on the negligible use of force below)		Within new policy
			Complete	g) information on how the risks associated with the use of force will be managed		Within the policy
			Complete	h) details of relevant staff training programmes and how learning and knowledge will be transferred into the		In policy

				workplace. This should also include the importance of all training complying with Restraint Reduction Network National Training Standards		
			Complete	i) details of how patients, their families, carers, and independent advocates will be involved in care planning which sets out the preventative strategies to the use of force, through for example advance statements		Fundamental Standards.
			Complete	j) information about how staff will use and follow individualised patient plans		In policy
			Complete	k) details of how patients, their families, carers, and independent advocates will be involved in post incident reviews following the use of force, and how the impact (physical or emotional) will be reflected in the patients' follow up care. The NICE Quality Standard, Quality Statement 5 provides further information on post incident debrief		In policy
			Complete	l) clear information on the expectations for recording and reporting of the use of force within the organisation		In policy
			Complete	m) detail on how local management information will be used to inform development and review of the policy (see below)		Data utilised
			Complete	n) details on how organisations will work to co-produce policies with their local patient populations to reflect their needs and experiences		In the policy
			Complete	o) details of how the policy will be communicated to patients, families, carers and independent advocates		In the policy

			Complete	p) Details of how often the policy will be reviewed and by whom		Policy template
			Complete	Before publishing the policy, the responsible person must consult with whoever they consider it appropriate to consult. This should include both current and former patients, their families and carers, bereaved families, and any relevant local third sector organisations. This may be carried out through existing networks, user groups and forums. The policy should also include details of who or which groups were consulted		Completed
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	Salli Midgley Lorena Cain	Complete	The information provided should (as a minimum) cover the following: • a clear statement that the use of force is only ever used proportionately and as a last resort and that it can never be used to cause pain, suffering, humiliation or as a punishment • which staff may use force and in what limited circumstances, and what approaches and steps will be taken to avoid using it • details of the types of force (techniques and approaches used) which staff may use with a distinction between, adults and older people and sex • details of how patients, their families, carers, and independent advocates must be involved in care planning	implementation	Complete, Easy read to be made available.

				which sets out the preventative strategies to the use of force, through for example advance decisions • details of how patients, their families, carers, and independent advocates must be involved in post incident reviews following the use of force • what action the organisation will take if the inappropriate use of force is identified • the patient's rights in relation to the use of force; this includes rights protected by the Human Rights Act 1998, the Mental Health Act 1983, Mental Capacity Act 2005, and the Equality Act 2010 (including the duty to make reasonable adjustments) • the patient's legal rights to independent advocacy and how to access organisations who can provide this service, and the role of the Independent Mental Health Advocate and Independent Mental Capacity Advocate (if applicable) • the organisation's complaints procedure and the help available from an independent advocate to pursue a complaint in relation to the use of force • the process for raising concerns about abuse and breaches of human rights, and the help available from independent advocates		

				• clear information on what will be recorded and reported on the use of force • details on how organisations will work to co-produce policies and information with their local patient populations • a glossary of the terms used by staff and the organisation or trust in relation to the use of force • contact details of independent advocacy services and other relevant local and national organisations • details on where the policy on the use of force can be found • details of how often the information will be reviewed and by whom		
4	The responsible person for each mental health unit must ensure staff receive appropriate training in the use of force.	Salli Midgley Caroline Parry	Complete	A. How to involve patients in the planning, development and delivery of care and treatment in the mental health unit B. Showing respect for patients' past and present wishes and feelings C. Showing respect for diversity generally D. Avoiding unlawful discrimination, harassment and victimisation	In progress	A/B/C :careplanning and risk assessment training development RESPECT training Equality, Inclusion and Diversity training
		Salli Midgley Greg Hughes	Complete	E. The use of techniques for avoiding or reducing the use of force F. The risks associated with the use of force		Aligned with RRN standards

				G. The impact of trauma (whether historic or otherwise) on a patient's mental and physical health H. The impact of any use of force on a patient's mental and physical health I. The impact of any use of force on a patient's development J. How to ensure the safety of patients and the public K. The principal legal or ethical issues associated with the 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	Salli Midgley Performance team	Complete	It is already mandatory for NHS organisations or trusts and independent hospitals (where they are providing NHS-funded care), to submit data on the use of force to the NHS Digital Mental Health Services Data Set. The Act requires that the record of the use of force used on a patient by a member of staff must include the following: a) the reason for the use of force b) the place, date and duration of the use of force	Action complete	Aligned to V5 MSDS October 2021 where required. Additional recording is included in the care records

				c) the type, or types of force used on the patient d) whether the type or types of force used on the patient formed part of the patient's care plan e) name of the patient on whom force was used f) a description of how force was used g) the patient's consistent identifier h) the name and job title of any member of staff who used force on the patient i) the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient j) the patient's mental disorder (if known) k) the relevant characteristics of the patient (if known) l) whether the patient has a learning disability or autistic spectrum disorder m) a description of the outcome of the use of force		

				n) whether the patient died or suffered any serious injury as a result of the use of force o) any efforts made to avoid the need for use of force on the patient p) whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan		
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	Salli Midgley	Complete	• National Guidance on Learning from Deaths; National Quality Board – March 2017 • Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers; NHS Improvement – July 2018 • Serious Incident Framework; NHS England, updated March 2015 Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services – November 2015		This would be classified as a serious incident and a safeguarding investigation.
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 wear and operate a body camera at all times when reasonably practicable	Salli Midgley SY Police	In progress	All use of police is incident reported on units. SHSC would not request access to footage unless an incident occurs.		Complete

2.0 Our Strategy and Quality Objective

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

2.0.1 Year one delivery and assurance

Supported by 6 workstreams the strategy has given structure and focus to the improvements required over year one and beyond. This has been enabled by linking the strategy to other strategic work across the Trust such as the People Strategy and Health and Safety Strategy, and by the support of people to lead on workstreams and task and finish groups that support co-production and outcomes.

Year one has seen this work grow and develop at pace. The work streams have been set up with well-populated membership, each progressing and producing outcomes, which show a change in practice, culture and engagement.

Key to the success so far has been task and finish groups for each work stream, action owners taking accountability and the mobilisation of monitoring contexts such as the daily incident huddle, review of restrictive practice data, and wider connection with partners such as FLOURISH and SACMHA where strong links are being developed to help ensure and promote the inclusion of lived experience and consideration and action to ameliorate racialised care.

For Year one - we said we would:

- Implement the Least Restrictive Practice Strategy
- Ensure teams can review their own ward level data on the use of restrictions like physical restraint, seclusion, rapid tranquilisation and consider this by gender, ethnicity, age and other factors
- Revise Respect training (Respect is our staff training on how to manage and de-escalate behaviours of concern) - Respect is linked to the national contract for the Use of Force Act (2018)
- Consistently debrief staff and service users following restraint and seclusion.

How have we done?

- 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 on 9 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
- 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 – Year 2 will see the implementation of this.

- Respect training has been reviewed and a broader training review has been undertaken to strengthen the training provided to ensure that staff have the skills they need to work effectively and safely
- We have removed seclusion on our all-female ward and we have not seen significant increases in other forms of restrictions as a result.

Overall, our key successes:

- Coproduction, development and launch of strategy
- Workplan with PMO to support strategy implementation
- Trust wide consultation on Use of Force statutory guidance and preparation for release of guidance
- Use of Force statutory requirement implementation
- Launch of safe wards via sessions with national lead
- Trauma informed practice implementation
- Review and implementation of key policies – Use of Force, Seclusion and Segregation, Search
- Review of surveillance to ensure in line with national standards and human right compliant
- Development and implementation of audit programme
- Developed dashboards and reporting
- Implementation of V5 data set
- Partnership working with Flourish, SACMHA, Sheffield voices, Advocacy and Disability Sheffield
- Sustained RP oversight and operational groups
- Reviewed and implemented RESPECT training to include Day 2 of level 3 course covering key areas of practice – race equity, carers, activity and care planning.
- Additional resource into RESPECT team and identified leadership
- System of review and support via daily incident huddle
- Information for service users and those that support them – safety pod, Use of force, safe wards, search
- Introduction of Human Rights officer and training and development plan
- Introduction of Race Equity worker and PCREF
- Introduction of Engagement and Experience officers
- De-escalation spaces
- Post incident support and review project

Key improvements

- Record keeping, compliance with standards and language used to be compassionate, trauma informed and reflect options and alternatives used/tried

Improvement Plan - Reducing Restrictive Practice - Short Term Goals – Year one

1. Clinical Knowledge and Skills

Action	Ref.	Action Owner	Start Date	End Date	Status
Relaunch SafeWards as the model of choice to support the reduction of conflict and containment	ST1.1	Lorena Cain	01/05/2021	01/07/2021	Complete
Finalise the Human Rights Training package and begin Introduction Human rights training across the Trust to include a framework to support the assessment of care in line with Human Rights and evidence where breaches may be required aligned to the Mental health act	ST1.2	Tallyn Gray	01/10/2021	29/04/2022	Complete
Introduce (map) Trauma informed care training and sessions and ensure integrated into RESPECT/ restrictive practice training all training (inc RESPECT) aligned to the Clinical and Social Care Strategy.	ST1.3	Kate Oldfield / Sue Walsh	01/04/2021	31/3/22 (Annual Evaluation)	Complete
Evaluate the provision of RESPECT training, ensuring alignment to the contractual standards for de-escalation training.	ST1.4	Greg Hughes / Lorena Cain	01/09/2021	17/12/2021 (revised programmes to commence July 2022)	Complete
Undertake a training needs analysis to consider the broader scope of training which will enable staff to deliver care appropriate to needs in a compassionate manner	ST1.5	Salli Midgley, Lorena, Greg Hughes, Jennie Wilson	24/09/2021	29/04/2022	Complete
Build capacity within the Trust to support the introduction and roll out of the Patient and Carer Race Equalities Framework.	ST1.6	Salli Midgley	01/11/2021	31/12/2022	Complete
Coproduction of Involvement “training” guidance on how to engage and involve people.	ST1.7	Mia Bajin / Teresa Clayton	01/11/2021	31/03/2022	Complete

Review Personal safety training and ensure all staff have a Personal Safety plan (links to ST1.4) needs splitting into 2 actions - should link with the violence reduction standards for staff and remove from here.	ST1.8	Sam Crosby / Greg Hughes	01/11/2021	31/01/2022	Complete
Develop new training packages to support medicines optimisation across the disciplines with coproduction of training plans. Staff will be confident in managing medicines and utilise appropriately with good quality aftercare.	ST1.9	Emma Butcher/ Lorena Cain / Salli Midgley / Jen Losing	TBC	31/03/2022	Complete
Activity will be embedded and a programme of activities developed including: 1. Meaningful activity to be a core part of induction and staff training (30/12/2022) 2. Completing a review of the community meetings on the wards to develop meaningful activity (30/09/2022) 3. Ensuring AHP's are working 6-days per week. (30/12/2022)	ST1.10	Caroline Greenough	01/05/2021	30/12/2022	Exception

2. Data Recording and Utilisation

Action	Ref.	Action Owner	Start Date	End Date	Status
Integrate V5 Mental Health Data Set (definitions) to incident reporting and embed into practice – key areas include recording Restraint when undertaking physical/personal care.	ST2.1	Tania Baxter / Debs Cundey	01/08/2021	01/11/2021	Complete
Development of dashboards from ward to Board level on the use of restrictive practices.	ST2.2	Henry Harrison	01/02/2021	01/10/2021	Complete
Demonstrate that the process to monitor and review RP via Incident forms is embedded and establish system for reporting themes and learning, monitor use of police and work collaboratively with them to understand roles and responsibilities (links to ST2.2)	ST2.3	Lorena Cain	01/04/2021	31/12/2021	Complete
Introduce Tendable / Audit to demonstrate compliance with Code of Practice to interventions	ST2.4	Adele Eckhardt	01/08/2021	30/04/2022	Complete

3. Learning and Leadership

Action	Ref.	Action Owner	Start Date	End Date	Status
To align with the Trust organisational development programme, encourage clinical leaders of all levels to grow and develop as the guardians of safe and quality practice, upholding human rights and treating everyone with respect	ST3.1	Sarah Bawden		31/03/2022	Complete
Every ward team member has contributed to and is working towards achieving the ward pledge on least restrictive practice. The pledge is personalised to the ward and is achievable. Success and learning will be celebrated.	ST3.2	General Managers	01/06/2021	30/08/2022	In progress
Ensure effective and regular clinical supervision and reflective practice for ward teams, introduce peer support/mentoring for ward managers with time given to focus on least restrictive practice	ST3.3	Leadership to be decided	01/06/2021	29/04/2022	Exception
Apply Quality improvement methodology to underpin developments and innovations in practice, attend staff network across the country to keep appraised of good practice.	ST3.4	Jo Evans	01/05/2021	31/03/2022(annual review)	Complete
Post incident reviews	ST3.5	Stacey Robson / Lorena Cain	01/04/2022	30/09/2022	In progress

4. Environment and Technology

Action	Ref.	Action Owner	Start Date	End Date	Status
Dormitories are removed, wards move to single gender where possible, improvements are made to general ward environments and consideration given to space and privacy for people who are admitted.	ST4.1	Helen Payne / Richard Scott (interim)	01/04/2021	30/06/2023	Complete
Review the use of body worn cameras, CCTV, body scanners and other technology that will promote safety, reduce restrictions but also preserve human rights and dignity.	ST4.2	Khatija Motara, Sam Crosby, Ian Wright/Kim parker	01/07/2021	17/12/2021	Complete
A delivery framework is agreed for the contracting of transport services which aims to deliver restraint free transport and eliminates the use of mechanical restraint.	ST4.3	Neil Robertson	01/04/2021	31/03/2022	Complete

5. Involvement and Information

Action	Ref.	Action Owner	Start Date	End Date	Status
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 agenda	ST5.1	Salli Midgley/Teresa Clayton	01/10/2021	31/03/2022	Exception - will be moved to LT action, and can close once migrated
There is an Engagement, Experience and Liaison Service available to inpatients to understand the experience of care and resolve concerns as near to the point of care delivery as possible.	ST5.2	Salli Midgley	01/10/2021	31/12/2021	Complete
The Triangle of Care is reviewed and mechanisms to ensure family carer involvement are embedded into the clinical and social care strategy.	ST5.3	Jenny Hall	01/10/2021	31/07/2022	Complete
Undertake a review of the advocacy provision, ensuring regular reports and experience surveys are undertaken with patients to understand access, quality and resolution.	ST5.4	Jamie Middleton / Lorena Cain	01/06/2021	31/03/2022	Complete
Information leaflets are developed and available on the units related to restrictive practices, additional resources are available on the Trust website. Information is also shared via community meetings on the wards.	ST5.5	Lorena Cain / Mia Bajin / Teresa Clayton	01/06/2021	31/03/2022	Complete

Improvement Plan - Reducing Restrictive Practice - Short Term Goals in Exception

Five actions are in exception, with the plan for them to be moved and achieved in Year Two. For each of the exception the work has commenced but due to lead action owner identification or a revision of the timescales set to achieve the action more time is required to sufficiently and effectively complete the work commenced.

Activity will be embedded and a programme of activities developed including: 1. Meaningful activity to be a core part of induction and staff training (30/12/2022) 2. Completing a review of the community meetings on the wards to develop meaningful activity (30/09/2022) 3. Ensuring AHP's are working 6-days per week. (30/12/2022)	ST1.10	Caroline Greenough	01/05/2021	30/12/2022	Exception
Every ward team member has contributed to and is working towards achieving the ward pledge on least restrictive practice. The pledge is personalised to the ward and is achievable. Success and learning will be celebrated.	ST3.2	General Managers/Matrons	01/06/2021	30/08/2022	In progress- initial objectives set June 2021, revised pledges due Aug 2022
Ensure effective and regular clinical supervision and reflective practice for ward teams, introduce peer support/mentoring for ward managers with time given to focus on least restrictive practice	ST3.3	Leadership to be decided	01/06/2021	29/04/2022	Exception
Post incident reviews	ST3.5	Stacey Robson / Lorena Cain	01/04/2022	30/09/2022	In progress
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 agenda	ST5.1	Salli Midgley/Teresa Clayton	01/10/2021	31/03/2022	Exception - will be moved to LT action, and can close once migrated

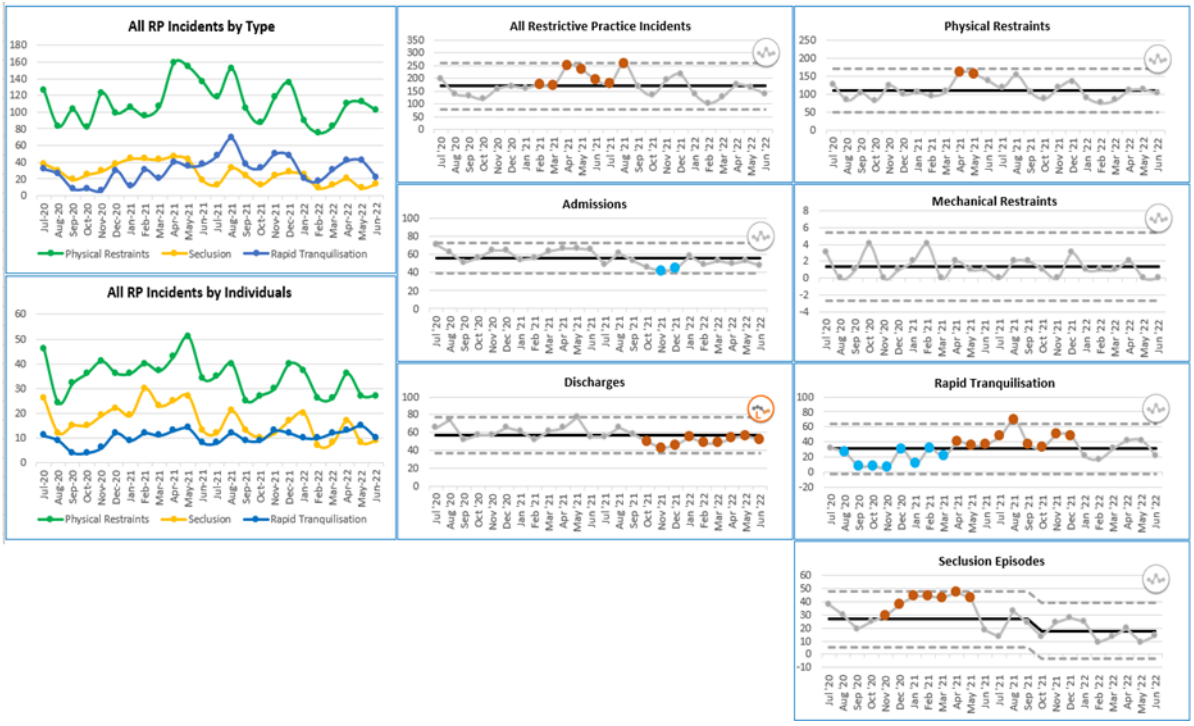
3.0 Data

3.1 Collecting and using data: summary of improvement

Over the year we have significantly progressed with development and implementation of our Service to Trust level dashboards. Work commenced with a session with colleagues from Cumbria Northumberland Tyne and Wear NHS Trust to learn from good practice and seek out where use of data was useful, and improvement based. This enabled a development programme with Business Performance and Patient Safety colleagues to develop and design our own. This then supported team-based conversations of what their data was telling them and how they might set out objectives for the coming year linked to data. An example is the length of stay people were spending in seclusion on our PICU unit.

We end the year with each team receiving their monthly data in a timely fashion that is discussed at team governance meetings, reducing restrictive practice meetings and IPQR. It has focused attention on themes and actions that might need to be supported to address areas of worry or concern. The Quarterly LRP reports now has a full set of data that has expanded over time to include time of day or week of RP, gender, ethnicity, post incident review data, searches undertaken etc. Work will continue into the next 2 years as part of the long-term actions to further develop the data fields and embed the use of data at team level with service users. This will connect to the capabilities of the new Electronic Patient Record system.

Overall data



Data to note

A downward trend related to the use of Restrictive practice is noted across the year, with the caveat that peaks and troughs do occur. On enquiry this is noted to be related to key points within the yearly cycle around holiday periods and weekends and out of hours (Easter, post-Christmas and into the new year).
The removal of seclusion on one of the acute wards (July2021) will have accounted for some of the reduction in use of seclusion.
Restrictive Practice related to self-harm/self injury is noted as an area of increase and accounts for much of the physical restraint and rapid tranquilisation. This is to be further explored in Year 2.

3.2 Report of use across types

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

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

SHSC submits data as required to NHS Digital aligned to version 5. We can say with confidence that we accurately and effectively report all of our Use of Force incidents, with the exception of our older adult dementia ward (G1), whom we are working to support their recording of Use of Force for personal care. Over the year, with the implementation of the workplans, we have seen a significant improvement in the level of detail in incident forms, details regarding alternatives and de-escalation attempted prior to the Restrictive Practice and trauma informed language and care. We have ensured support to improve at team and individual level and have undertaken regular positive feedback where incident forms are of a high standard. We have also used this to inform practice elsewhere. Further improvements, such as consistent reporting of time of restraint episodes, are required and will form part of the Year 2 plan.

Work was completed related to Rapid tranquilisation reporting and recording as staff were not always getting this right. The trustwide daily incident huddle has supported quality checks of the reports submitted which supports follow up with teams and has impacted positively on the quality and detail of reporting.

Work commenced in April in improving the process, skill set and confidence in staff in Post incident reviews and this continues into Year 2 as a project of support. This was also a Back to Good CQC action, being highlighted as it has a direct link to staff and

service user wellbeing, stated within the Use of Force Act (2018), an outcome of the staff survey and has an impact of prevention and care planning.

Post incidents undertaken with SU

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
No	108	78	136	107	64	75	94	103	86
Yes	55	170	170	89	86	93	114	121	122
Total	**163**	**248**	**306**	**196**	**150**	**168**	**208**	**224**	**208**

Where necessary we have examined further specific incidents of Use of Force either by a request for further review such as 48-hour report, Significant Event Analysis or a learning event with staff. An example is the exploratory work on the use of wheelchairs or sheets to move a person in distress and whether this constituted mechanical restraint.

During the first part of the year requests were made for further investigation related to

- Harm to service user following Use of Force
- Use of mechanical restraint by the police and our support and follow up of the service user

Two incidents were triggered for a Serious incident review and one as a safeguarding S42 enquiry during this annual reporting cycle

1. Endcliffe – harm caused due to inadequate search procedures
2. Endcliffe – Inappropriate care in seclusion. Section 42 safeguarding enquiry
3. Health based place of safety - Use of Force by police and delay in subsequent follow up care

Learning and actions from SIs

1. Rewrite of the search policy and new training and equipment for all wards.
2. Reflective practice and support to the ward team to manage people at risk in seclusion, learning shared across all wards.
3. Development of a system to review conveyance providers, including new procurement and reporting procedures to support the examination of conveyance for safety or experience issues.
4. Review of people in seclusion – supported by local team and group training sessions, Easy guide for staff and follow up.
5. Review of guidance when pepper/irritant spray used and how this will be included in training.

3.3 Key findings related to protected characteristics

Over 2021/22 we have developed our lines of enquiry to understand the protected characteristics of the people we provide services to and the use of restrictions. We know nationally that people with a learning disability or autism and people from diverse racial backgrounds are more likely to experience restrictions.

Drawing on the information from the CQC Out of Sight report (Oct 2020) it was clear that certain groups of people were more likely to experience restrictions in a way that retraumatised and prolongs hospital admission or length or volume of restrictions such as seclusion.

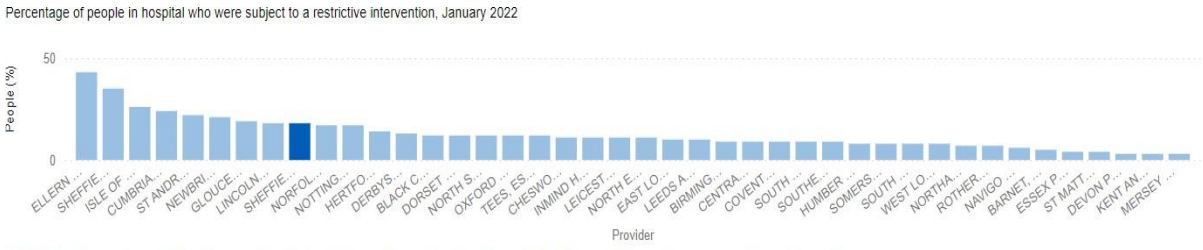
Our work plan has included examining our data to not just provide the numbers of restrictions but the types/groups of people that are subject to them. In doing this we have been able to commence the conversations, which in turn have influenced our work programme to look at what we might do to tackle this. This is supported with our partnership arrangements with FLOURISH and SACMHA, along with the PCREF work (patient and carer equality framework)

Our focus this last year has been related to gender and ethnicity.

Firshill, the learning disability inpatient unit paused for admissions during 21/22 and we have managed anyone who has required admission during this period across our acute inpatient estate. NHS Greenlight standards for admission of people with a learning disability or autism have been enacted to ensure appropriate care and treatment.

What have we found?

From national benchmarking we were one of the highest users of detentions under the mental health act, and high in reported use of RP



NOTE: Providers who carried out types of restrictive intervention on less than 5 people in the month have been removed from these data.

Sheffield Health and Social Care features 9th in the table, indicating we were in the highest quartile of use of restrictive practice.

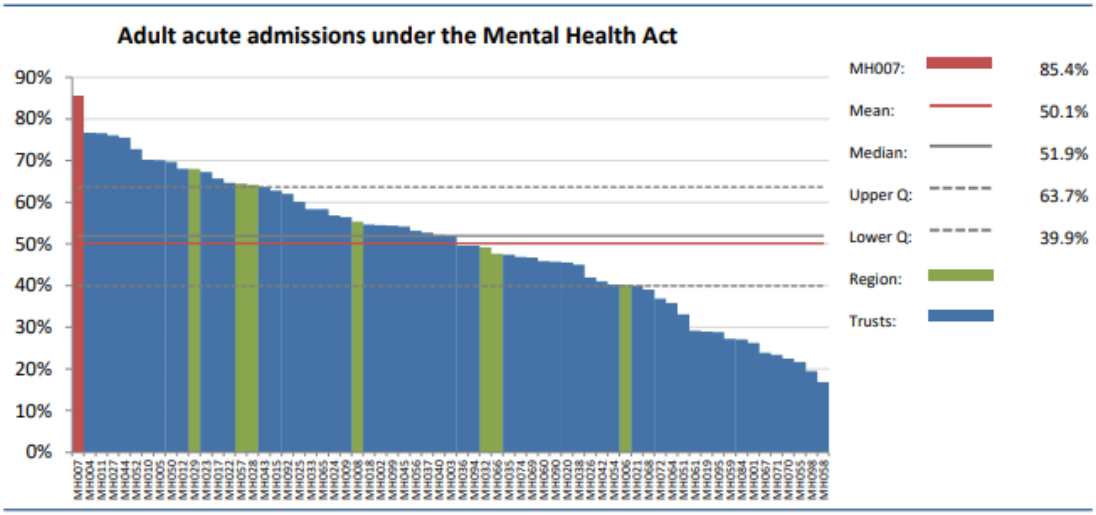


Figure 9

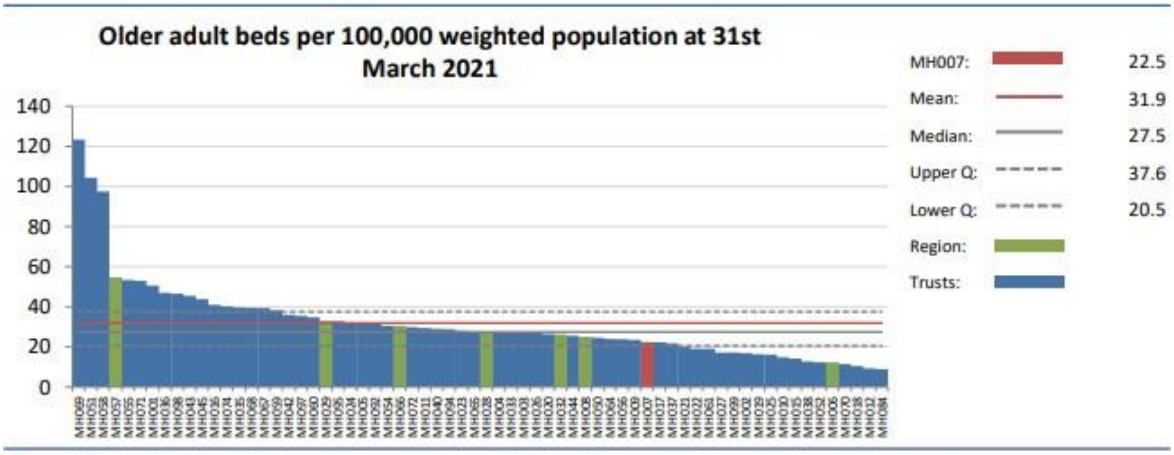


Figure 14

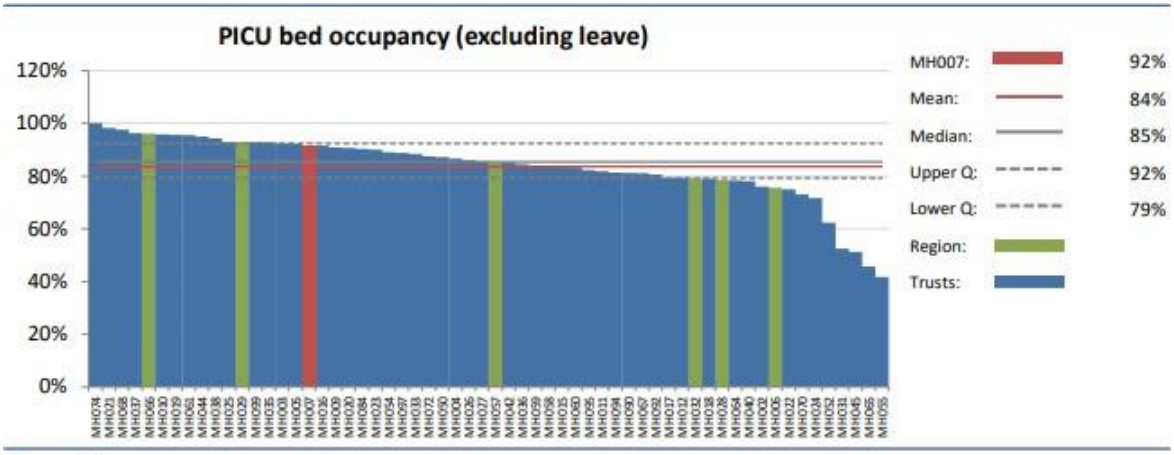


Figure 20

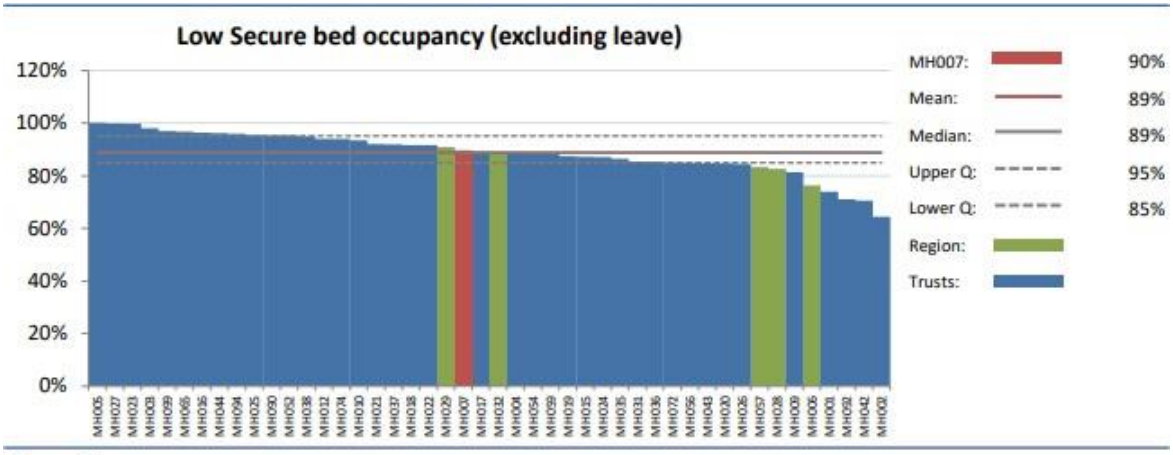
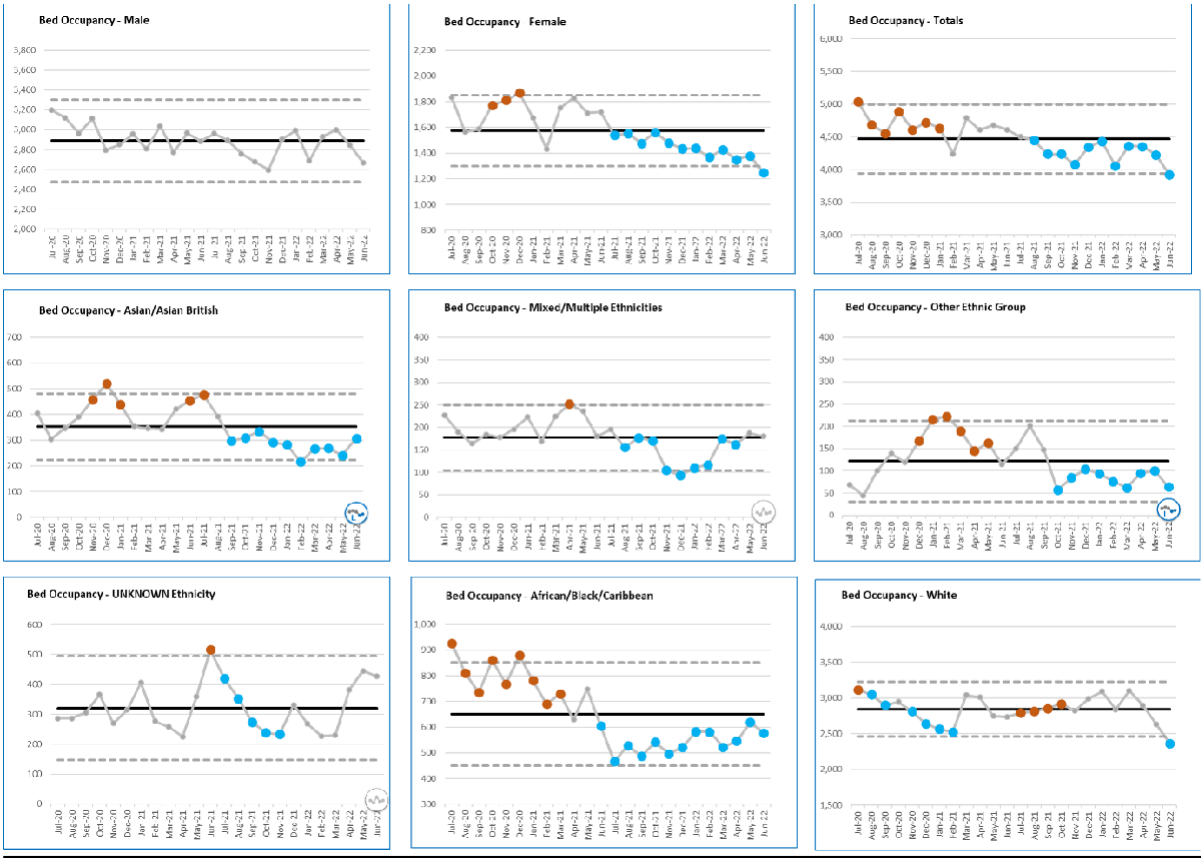


Figure 24

Source: NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking 2020/21.



We have a high detention rate and high occupancy across our bed base, except for our older adult dementia ward. We disproportionality admit from ethnic minority groups and disproportionally subject them to restrictive practice. An example to support this is during Q4, four service users were subject to 8 episodes of prolonged seclusion. Three of these people werefrom a BAME background. During June 2022, 11/16, service users on the male acuteward were from a BAME group. This has been a similar picture on our mixed gender PICU unit.

Unknown ethnicity is an area being explored to understand how this category is used and how it may influence care provision.

Prolonged restraint (over 10 minutes) is majority females, with a trauma history (EUPD) having been restrained for the longest periods, mainly related to preventing to or responding to self-harm. Feedback from the National collaborative work is that this represents the national picture.

Rapid tranquilisation has been consistently highest in the white female population. It peaked for our female only ward at the point they removed the seclusion room but has started to come down to normal limits.

Seclusion is predominantly male.

4.0 Training

4.1 Annual stats and training compliance

RESPECT training

RESPECT was introduced into SHSC in 2012 in response to a review of the provision of training for staff to prevent the escalation of incidents and to manage individual behaviours where there was a risk of harm to staff/patients and visitors. RESPECT was identified as the appropriate training methodology following consultation with community groups as it avoids the use of prone restraint and overly restrictive interventions.

The last significant review of RESPECT was in 2017.

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.

https://restraintreductionnetwork.org/wp-content/uploads/2020/04/RRN_Standards_1.2_Jan_2020.pdf

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.

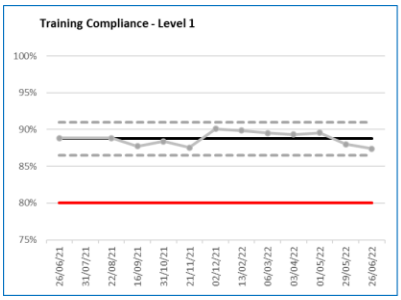
The delivery of RESPECT training is to ensure staff are able to risk assess their environment, the people they engage with (including patients and the general public) and have the knowledge (and as required practical skills) to effectively prevent and reduce the risk of violence against them.

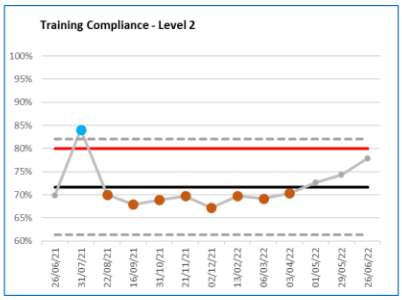
As part of the above change requirement this annual cycle has seen a full review of the RESPECT training program, aligning it to both the RRN standard and the Use of Force Act. These changes were approved toward the later end of the year and implemented as part of the Year two requirements with the new program coming into

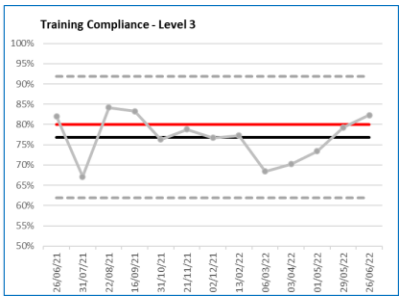
effect in July 2022. This has included reviewing competency levels for certain staff groups and teams.

Training compliance

Compliance has fluctuated with staffing challenges and covid outbreaks during the last year. Compliance was raised as part of the CQC inspection with a requirement to achieve 80% compliance in RESPECT by the end of June 2022. This was achieved for both level 1 and level 3, with level 2 falling just below this.







	26/06/2021	31/07/2021	22/08/2021	16/09/2021	31/10/2021	21/11/2021	02/12/2021	13/02/2022	06/03/2022	03/04/2022	01/05/2022	29/05/2022	26/06/2022
Level 1	88.8%	88.8%	88.9%	87.7%	88.4%	87.6%	90.1%	89.9%	89.5%	89.3%	89.6%	88.0%	87.4%
Level 2	69.9%	84.1%	70.0%	67.9%	68.9%	69.7%	67.2%	69.7%	69.2%	70.3%	72.6%	74.4%	77.9%
Level 3	82.0%	67.1%	84.2%	83.3%	76.3%	78.8%	76.7%	77.3%	68.4%	70.3%	73.4%	79.3%	82.3%

Other training

Human rights

To support the workplan and increase the knowledge base of all staff on human rights the Trust appointed to a Human rights officer and commenced a programme of training in April 2022.

Trauma informed

To support the workplan trauma informed training has been delivered either to individual teams via local sessions and/or away days or via other programmes such as the PIPA work (Purposeful Inpatient admission)

Autism

Work has commenced to identify and deliver appropriate level of training for relevant staff teams and staff groups.

Care planning, equity and race, carers and activity

Following the review of the Trust RESPECT training programme during this annual cycle we have successfully launched the new training sessions to include a day 2 of the level 3 course (700 staff). This supports the specific requirements from the Use of Force statutory guidance and gives staff an opportunity to explore areas that affect service user experience and care and inform practice going forwards.

Search training

Search training was introduced in April 2022, linked to learning from a SI review, and continues to progress

Seclusion standards

Local team sessions were delivered to assist in the implementation of the revised seclusion policy.

3.2 Team feedback and staff feedback

The Respect training consistently receives positive feedback and during the annual cycle has received several credits from individual staff on Jarvis and other forms of social media such as twitter and Facebook. The co-delivery with a person with lived experience is noted as one session that has the greatest impact on staff, making them think about experience and approach. The team receive positive praise for the way in which they supportively challenge practice and approach and how they ensure supervision and follow up of trainees.

A word I rarely use… ever about services but it was "outstanding", safewards throughout the programme. Our service User rep was amazing. 15/10, trauma informed excellence.

The Respect team themselves report a busy and challenging year, with change to leadership, course structure and expectation. They have either led on or significantly contributed to the revisions of the course content, numerous policies and procedure reviews and enhanced ways of working in line with the Use of Force Act. They have done this with passion and commitment and report that they feel part of something important and necessary and feel recognised and valued for the work that they do. The Year ahead continues to challenge as we have increased the requirement of levels of training. To meet this the team will need to run courses five days a week with two courses running three of these five days. A business case remains in progress, to enable additional capacity in the team to ensure training compliance is met and the team can continue to offer the valued support into clinical areas.

5.0 Learning and Reports

5.1 Back to Good – actions resolved following CQC inspection

A number of Regulations related to Restrictive Practice and the Use of Force were enforced following the Well led inspections during the annual cycle. Each which created a subset of actions to improve. Each of the actions has been progressed over the annual cycle and either been completed with approval, completed awaiting approval or moved into exception with a new end date agreed.

CQC BacktoGood actions

August Reporting Cycle

Overall end date: 30/06/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End Date	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
The trust must ensure that compliance with training achieves the trust target in all mandatory training courses including intermediate life support and restraint interventions.	**23**	Overall status Exception									
Monitor that all ward teams are 80% compliance for all mandatory training courses, including evidence of future booked courses where training is due to expire	A23.1	Acute Wards and Psychiatric Intensive Care Units	Khatija Motara, General Manager / Jennie Wilson, Mandatory Training Lead	Ward Manager / Jennie Wilson	01/09/2021	31/12/2021		Quarterly Performance Review	Complete	All wards meet at least 80% compliance on mandatory training (safeguarding 90%)	Mandatory training compliance reports
Ensure the Trust has reached minimum 80% compliance for all mandatory training courses	A23.1A	Acute Wards and Psychiatric Intensive Care Units	Khatija Motara, General Manager / Jennie Wilson, Mandatory Training Lead	Jennie Wilson	01/09/2021	30/06/2022	31/12/2021 31/03/2022	Quarterly Performance Review	Exception	All mandatory training courses are 80% compliant.	Mandatory training compliance reports
Establish an escalation route to monitor and recover any reduction in mandatory training compliance due to non-availability of training courses	A23.2	Acute Wards and Psychiatric Intensive Care Units	Khatija Motara, General Manager / Jennie Wilson, Mandatory Training Lead	Jennie Wilson	15/09/2021	31/12/2021		Quarterly Performance Review	Complete - Awaiting Approval	Recognised escalation route to identify and recovery dips in mandatory training compliance due to non-course availability in-situ	Reports monitoring anticipated dips and plan for recovery

Overall end date 30/06/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End Date	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
The trust should ensure all staff are up to date with mandatory training	**68**	Overall status Exception									
All services to reach a minimum 80% compliance for all mandatory training courses.	A68.1	Acute Wards and Psychiatric Intensive Care Units	Khatija Motara, General Manager / Jennie Wilson, Mandatory Training Lead	Khatija Motara	01/09/2021	30/06/2022		Quarterly Performance Review	Exception	All mandatory training courses are 80% compliant.	Mandatory training compliance reports

Overall end date 30/04/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End Date	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
A45 - The trust should ensure that when patients are in seclusion or they have received rapid tranquilisation, there is an accurate record of whether they have been offered food and fluid and whether they accepted or declined it.	**45**	Overall status Complete									

To audit compliance in relation to the seclusion and rapid tranquilisation policy regarding the offer of food and drink after each seclusion or episode of rapid tranquilisation.	A45.1	Acute Wards and Psychiatric Intensive Care Units	Salli Midgley, Director of Quality	Adele Eckhardt / Matrons	01/11/2021	30/04/2022	31/12/2021 31/03/2022	Restrictive Practice Group	Complete	Patients have an accurate record of when they have been offered food and fluid while in seclusion or have received rapid tranquilisation	Copy of seclusion and rapid tranquilisation audit reporting from Tendable to restrictive practice group

Overall end date 31/12/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End Date	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
The trust must ensure that staff assess and monitor patient's physical health throughout admission as required and following the use of intra-muscular medication	**56**	Overall status Open on track									
Monitor and report weekly the consistent implementation of Standards for Physical Health Monitoring on Acute & PICU Wards in line with NICE guidance via Tendable.	A56.1	Acute Wards and Psychiatric Intensive Care Units	Lorraine Murphy, Matron / Naomi Hebblewhite, Matron	Naomi Hebblewhite	01/03/2022	31/07/2022		Physical Health Monitoring Group	Exception	Standards and SOPs aligned to the Physical Health Strategy	Standards for Physical Health Monitoring signed off and monitored through PHMG
Monitor and report compliance on a weekly basis, individual service user care needs and following all instances of IM administration via Tendable App.	A56.2	Acute Wards and Psychiatric Intensive Care Units	Adele Eckhardt	Naomi Hebblewhite	01/08/2022	31/12/2022		Clinical Quality and Safety Group	Open	Tendable reports for evidence	Audit findings from Tendable reported to CQ&S Group / PMHG

Overall end date 31/05/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
The trust must ensure that there are sufficient numbers of **suitably trained staff on duty** at any one time to care for patients, provide de-escalation, and if necessary physical interventions	64	Overall status Exception									
Confirm planned safer staffing skill mix for acute and picu wards, with sign off from the Director of Nursing.	A64.1	Acute Wards and Psychiatric Intensive Care Units	Emma Highfield, Head of Nursing	Emma Highfield	01/03/2022	30/04/2022	30/04/2022	Safer Staffing Group	Exception	Safer staffing skill mix and training requirement signed off	Final document with evidence of DoN sign off
Ensure the training requirements for all staff on acute and PICU wards per shift are adhered to through the E-roster system including bank and agency staff.	A64.2	Acute Wards and Psychiatric Intensive Care Units	Khatija Motara, General Manager	Khatija Motara	01/03/2022	31/05/2022		Safer Staffing Group	Open	E-roster is updated with training requirements	Snapshot of training requirements aligned to each ward and policy requirements
Any breaches of upholding safer staffing and required training establishments will be escalated immediately through the management structure for resolution and mitigating risk with follow up incident reported as a breach of requirements.	A64.3	Acute Wards and Psychiatric Intensive Care Units	Khatija Motara, General Manager	Khatija Motara	01/03/2022	31/05/2022	31/05/2022	IPQR	Complete - Awaiting Approval	Regular reporting of any breaches	Incident reports and evidence of appropriate escalation and mitigation by managers

Overall end date 30/09/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End Date	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
The trust should ensure staff use and clearly **document the use of de-escalation** prior to physical restraint	69	Overall status Open on track									
Revise RESPECT training and refreshers to include the use of de-escalation prior to any restrictive intervention.	A69.1	Acute Wards and Psychiatric Intensive Care Units	Lorena Cain, Assistant Clinical Director / Ward Managers	Greg Hughes	01/03/2022	30/06/2022		Least Restrictive Practice Oversight Group	Complete - Awaiting Approval	Respect training planner	Respect training planner outline of content
All inpatient units have access to a de-escalation or relaxation space that adheres to the SHSC agreed standard.	A69.2	Acute Wards and Psychiatric Intensive Care Units	Lorena Cain, Assistant Clinical Director / Ward Managers	Lorena Cain	01/03/2022	30/09/2022	30/06/2022	Therapeutic Environments Board	Exception (complete Sept 2022)	Standard spec to be written	Photographs of the space and the standard spec
Documentation of de-escalation used prior to restraint should form part of the incident form and the clinical records.	A69.3	Acute Wards and Psychiatric Intensive Care Units	Lorraine Murphy, Matron / Naomi Hebblewhite, Matron	Lorena Cain	01/03/2022	31/05/2022		Least Restrictive Practice Oversight Group	Complete - Awaiting Approval	Ensure auditable evidence is on the Tendable audit and that the audit tool is being used weekly to perform a dip sample	Audit outcomes of notes
Post incident reviews will be offered by trained facilitators routinely to staff involved and to support learning to the wider workforce and care planning to support de-escalation	A69.4	Acute Wards and Psychiatric Intensive Care Units	Lorraine Murphy, Matron / Naomi Hebblewhite, Matron	Lorraine Murphy	01/03/2022	30/09/2022		Least Restrictive Practice Oversight Group	Open	Documented PIR in the diary	Evidence of dates/times of PIRs held - evidence is on the incident form at point of review and a new record form will also be evidence once is introduced

Overall end date 31/08/2022

Action	Action ID	Service	Regulation Lead	Action Owner	Start Date	End Date	Previous End Date	Reporting Group	Status	How will you know this has been achieved?	What evidence will be provided?
The trust should ensure that staff do not use the **green room on Endcliffe ward** to inadvertently seclude patients	75	Overall status Open on track									
An environmental assessment of the appropriate de-escalation space will be undertaken to ensure that the rooms and position are fit for purpose.	A75.1	Acute Wards and Psychiatric Intensive Care Units	Beverley Murphy, Executive Director of Nursing and Professions	Naomi Hebblewhite	01/03/2022	31/03/2022		Therapeutic Environment Board	Complete - Awaiting Approval	Date for the environmental assessment and outcome report	Estates document to evidence the assessment
Appropriate estates works will be funded to deliver the de-escalation and relaxation spaces on Endcliffe to ensure inadvertent seclusion does not occur	A75.2	Acute Wards and Psychiatric Intensive Care Units	Beverley Murphy, Executive Director of Nursing and Professions	Naomi Hebblewhite	01/04/2022	31/08/2022		Therapeutic Environment Board	Complete - Awaiting Approval	Dates are set and funding available to deliver the spaces	Completion of building works (Photograph)
Operational Policy will confirm location of Seclusion Room and identified de-escalation space on Endcliffe.	A75.3	Acute Wards and Psychiatric Intensive Care Units	Naomi Hebblewhite, Matron	Naomi Hebblewhite	21/02/2022	31/08/2022		Least Restrictive Practice Oversight Group	Open	SOP is available to all staff	SOP provided as evidence

5.2 Audit (Tendable)

In September 2021 following a procurement process we invested in an electronic audit system to support live quality audits across our inpatient services. Tendable was our preferred partner. Three audits were designed to monitor our adherence to national policy with respect to restrictive practices

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 tranquilsation – every episode must be audited.

Following a slow start which required clear identification of auditors and a clear system of support; each inpatient unit is now either using the tool consistently to audit as per the audit schedule or is part of the phase 2 roll out plan.

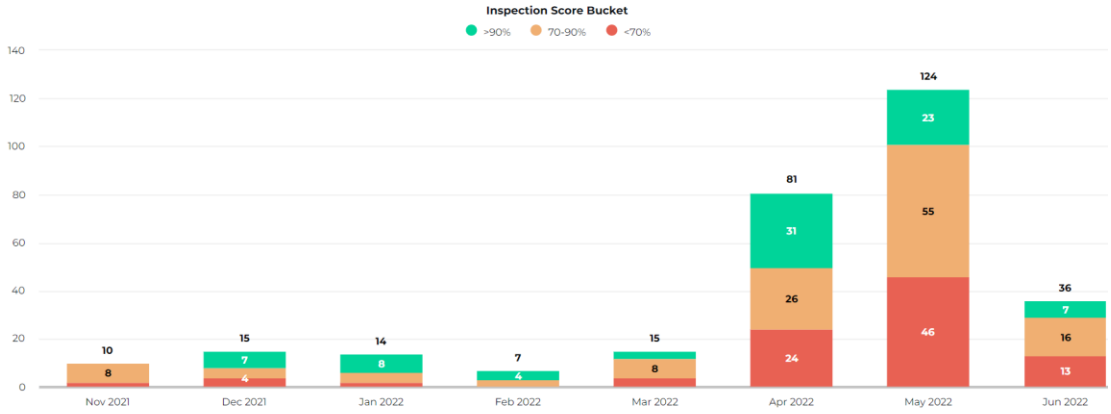
This works now forms part of a PMO project plan and is closely monitored for compliance. It forms part of the reporting cycle for the LRPOG. Phase one of the plan was focused on ensuring audits were completed and testing the audit questions. Phase two is now commencing to review the findings and plan actions to address shortfalls or areas of improvement.

An example of this is physical health monitoring following Rapid Tranquilisation (also a Back to Good action). Following reviewing the audit outcomes we have commenced work on making this an improvement area with a review of the policy and practice guidance, reviewing the use of the NEWS implementation and reviewing the use of diet and fluid charts to provide evidence of monitoring.

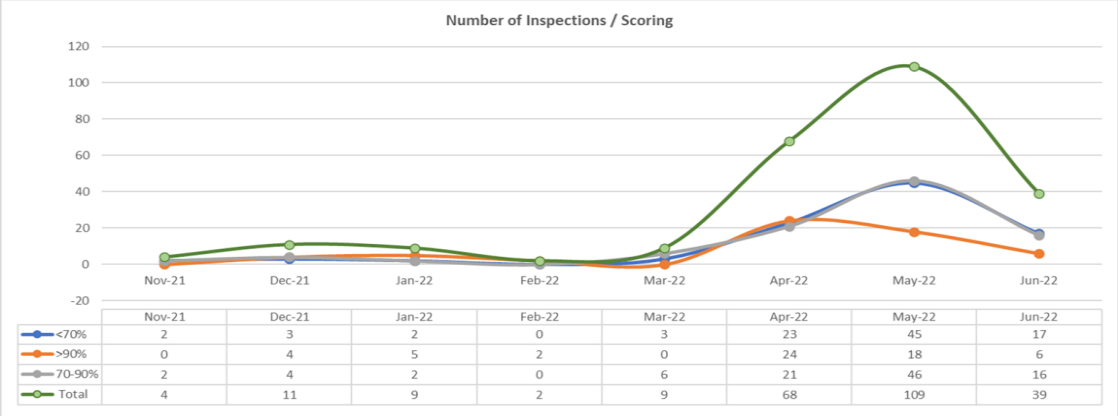
Phase 1
Audits: Rapid tranquilisation, Seclusion, Physical Health, IPC, Environment and Quality of Care Experience
Wards: Maple, Dovedale 2, Stanage, Endcliffe, G1, Forest Close and Forest Lodge

Task	Owner	Start Date	End Date	Status
Reaffirm Engagement and Experience Responsibilities for completion of Quality of Experience audit	Adele Eckhardt	23.05.22	26.05.22	Complete
Governance Officers to receive daily incident data relating to RT and seclusion	Vin Lewin	30.05.22	17.06.22	Complete
Individual meetings with wards who require further support in completion of seclusion and rapid tranquilisation audits	Lorena Cain	10.06.22	26.06.22	Complete
Develop a monthly audit report relating to RT and seclusion	Henry Harrison	25.05.22	30.06.22	Complete
Individual meeting with Ward Manager to understand current usage and challenges to it	Sue Barnitt / Adele Eckhardt / Paulette Cammidge	24.05.22	12.08.22	Complete
Individual meeting to conduct example audits to support learning	Sue Barnitt / Adele Eckhardt / Paulette Cammidge	24.05.22	12.08.22	Complete
Triangulate incidents and completed audits relating to RT and seclusion	Henry Harrison / Lorena Cain	01.07.22	26.08.22	On track
Follow on meetings to take place with Ward Managers to provide updated utilisation report and obtain feedback	Paulette Cammidge / Emily Carnall	23.06.22	09.09.22	On track

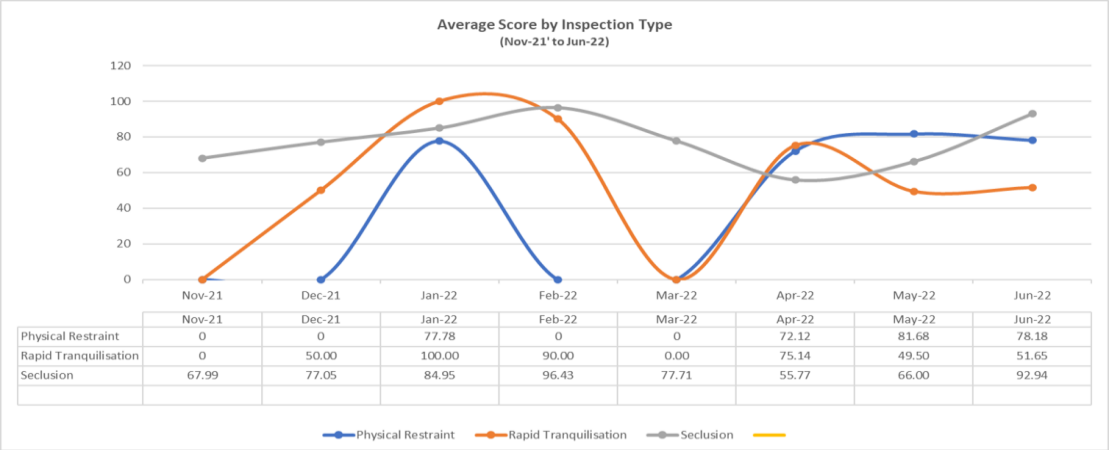
Number of Inspections Completed - Last 12 Months



Area Name	Inspection Type		
	Physical health monitoring - Equipment Check audit	Physical Restraint	Quality of Care Experience Survey
Dovedale 2 Ward			
Endcliffe Ward		100.0%	
Forest Close		68.3%	89.4%
Forest Lodge	71.4%		56.3%
G1		100.0%	
Maple Ward		82.8%	
Stanage		76.6%	



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
<70%	2	3	2	0	3	23	45	17
>90%	0	4	5	2	0	24	18	6
70-90%	2	4	2	0	6	21	46	16
Total	4	11	9	2	9	68	109	39



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Physical Restraint	0	0	77.78	0	0	72.12	81.68	78.18
Rapid Tranquilisation	0	50.00	100.00	90.00	0.00	75.14	49.50	51.65
Seclusion	67.99	77.05	84.95	96.43	77.71	55.77	66.00	92.94

Outcomes from audits completed

From a total of 64 questions as part of the 3 areas of Restrictive Practice audited (physical restraint, rapid tranquilisation and seclusion), 21 are below the standard expected (33%).
The key areas for improvement are related to

- Physical health monitoring inc fluids
- Involvement in careplanning (both users and carers)
- Post incident support and reviews

Question Text	Inspection Type	Score	Answers	Answer Question Id
Was fluid offered / recorded every 15 minutes for 1 hour?	Rapid Tranquilisation	14.28571429	14	149693
Has a post incident review taken place with the patient?	Physical Restraint	16.66666667	18	149912
If required, has escalation protocol been followed and the appropriate action taken?	Rapid Tranquilisation	33.33333333	3	149694
Were vital sign (News2) recordings continued every 15 minutes for the first hour?	Rapid Tranquilisation	35.71428571	14	149691
At the 1 hour mark, has frequency of on-going vital sign monitoring been decided?	Rapid Tranquilisation	42.85714286	14	149698
Was fluid intake monitoring started within 15 minutes of administration of rapid tranquilisation?	Rapid Tranquilisation	42.85714286	14	149692
Has the Care Plan been reviewed following the restraint?	Physical Restraint	45	20	149914
Has a post incident review taken place with the patient?	Rapid Tranquilisation	50	14	149702
If full vital signs refused at any point, have refusals been documented?	Rapid Tranquilisation	53.84615385	13	149696
Have vital signs and the patient been reviewed in person after 1 hour by trained staff (or earlier if indicated)?	Rapid Tranquilisation	53.84615385	13	149697
Was vital sign (News2) monitoring started within 15 minutes of rapid tranquilisation?	Rapid Tranquilisation	57.14285714	14	149690

If applicable, has the patient's carer been made aware of the restraint?	Physical Restraint	57.14285714	7	149915
Did the immediate careplan indicate the need for all appropriate items (see guidance)?	Seclusion	66.66666667	3	145039
Is there a recorded risk assessment related to the provision of a bedbase/mattress?	Seclusion	66.66666667	3	160319
Was a medical review undertaken within one hour of the commencement of seclusion?	Seclusion	66.66666667	3	145024
Was a seclusion careplan drafted within 1 hour of seclusion?	Seclusion	66.66666667	3	145038
Was there any evidence during any of the reviews that the careplan was updated?	Seclusion	66.66666667	3	145041
Was there a record of a copy of the careplan being discussed and given to the SU?	Seclusion	66.66666667	3	145042
Was there a basic check to ensure the patient's physical health after the restraint?	Physical Restraint	72.72727273	22	149910
Has a Care Plan been created/updated that identifies indicators of escalation and de-escalation that has been written with the service user?	Physical Restraint	75	20	149916
If full vital signs are refused at any point, are respiration rate and AVPU recorded as a minimum?	Rapid Tranquilisation	76.92307692	13	149695

5.3 Learning and plans for year 2

Year 2 will focus on the outcomes from learning from the CQC inspections, areas of concerns identified by our own internal audit program and what our teams are telling us. This will be supported by the Least Restrictive Practice strategy workplan for year Two, the tendable project group, the CQC back to good program and task and finish groups to support the improvements required.
Four key areas identified are

4. Restrictive Practice reporting for personal care
5. Post Incident review project
6. Physical health monitoring
7. Care-planning and involvement of service users and their families

5.4 Key risks and mitigations

Inadequate post restrictive practice support, physical health monitoring and ineffective engagement in care-planning have been identified from our internal audit programme and is in line with the Back to Good actions as per CQC inspection. Improvement plans are in progress to address these key risks with monitoring through the Back to Good, LRPOG and Mental Health Legislation committee.

6.0 Risks

At the start of the year several issues were apparent presented barriers to the effective implementation of the LRP strategy. Several policies were out of date and were not aligned to a progressive move away from the use of force. There was a lack

of direction and connectivity to a strategy to change practice, although there were pockets of excellence and trauma informed care, a number of teams were practicing high levels of restrictive practice, in particular physical restraint and seclusion. Record keeping around restrictive practice was not robust and comprehensive. There was regular use of negative language when describing service users' behaviour which could appear as blaming and not seeking to understand or show compassion / critical thinking.
In addition, the RESPECT team, a key enabler to mobilising the LRP strategy, was under resourced due to both staff absence, team composition and resource, and lack of funding.

Leadership and staffing are a key enabler in achieving the requirements of the strategy workplan and Use of Force Act and remain a risk for the programme.

Coercive practice is an area which we need to explore as we shift the culture from less Restrictive, reactive Practice. The risk of practice being coercive is a possibility and we want to understand this.

Recording the use of force for personal care remains a risk for us as we head into Year 2. We have clearly set out the requirements to report however the current incident reporting system needs adjustment to enable this is in an effective and efficient way. We have agreed an interim position related to this.

CCTV continues to remain at risk due to the lack of a Trust register, information for users and visitors and lack of a framework to report. An assessment has now concluded to register each patient facing CCTV system which will be presented to the Q1 LRPOG. A plan will emerge to ensure governance is established both at Trust and team level and information is developed where we do use CCTV, this will include it purpose.

7.0 Looking forward – key priorities for 2022/2023

Year two will focus on the embedding of year one actions and a continuation of the improvements achieved via demonstrable change, audit and evidence. Work across the Trust will expand into community services looking at the implementation of the reducing restrictive practice strategy and understanding Use of Force beyond inpatient settings. This will be informed by the strong alliances with the Trust and other agencies and will be influenced by changes to the Mental Health Act.

Focus is required on the number of people who require hospital admission and what prevention, and crisis plans looks like. Key to this is understanding our connections with communities particularly the Black communities to further understand experience and relationships and seek to reduce the number of black people whom we detain and admit.

Sharing of good practice and celebration will be key to our progress during Year 2. A further conference is to be planned with a focus on being proud of achievements and improvements and looking ahead to the coming year.

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

The priorities for 2022/23 are:

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

Improvement Plan - Reducing Restrictive Practice - Long Term Goals

1. Clinical Knowledge and Skills

Action	Ref.
Embed SafeWards and demonstrate impact through evaluation and measurement	LT1.1
Embed the use of a human rights framework to assess the provision of care and treatment to people in our care	LT1.2
Demonstrate trauma informed practice through lived experience feedback	LT1.3
Provision of appropriate training to reduce restrictions and increase skills in de-escalation line with national contractual standards.	LT1.4
Clear training plans and accessible development to equip staff with skills to work within services; implementation of a staff competency framework	LT1.5
Demonstrate cultural and race sensitive monitoring and performance indicators to clearly illustrate the use of restrictive practices.	LT1.6
Demonstrable evidence of shared and involved care planning, advanced plans and engagement	LT1.7
Staff feel safe at work through staff survey.	LT1.8
Use of medication is aligned to prescribing and administration guidance, patients are supported to be concordant and where rapid tranquilisation is utilised, monitoring is undertaken in line with NICE guidance.	LT1.9

2. Data Recording and Utilisation

Action	Ref.
Acquire learning from national data sets based on confident data quality submissions. Compliance with Use of Force Act 2018.	LT2.1
Teams access, utilise and can speak to their data on the use of restrictions. There is evidence of regular MDT debriefings and practice development forums to critically analyse incidents. Robust coproduction of care plans and engagement of patients in reflective practice to support advanced care planning. Summaries of care including restrictive practices are handed over on discharge	LT2.2
Strong working alliances between the Trust and other agencies to reduce use of force, demonstrable learning from practice through lessons learnt.	LT2.3
Robust audit data on compliance to NICE guidance monitoring	LT2.4

3. Learning and Leadership

Action	Ref.
People who use services, their families and carers can clearly identify the leadership values to have minimal restrictions and human rights are embedded into practice and conversation.	LT3.1
Teams achieve annual pledges which are supported by a robust communications and engagement plan. Opportunity is available to celebrate improvement, showcase good practice and give pride in the work that staff and patients are involved in.	LT3.2
Post incident reviews inform practice, staff feel supported and led by clinical leaders. Outputs are demonstrated through staff survey and audits.	LT3.3
Good practice is shared, a least restrictive conference is held to celebrate progress and quarterly reports demonstrate improvements.	LT3.4

4. Environment and Technology

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

5. Involvement and Information

Action	Ref.
Clear approach to coproducing all aspects of the strategy, workplan and individual improvement plans with people who use services and their families.	LT5.1
People who use our services are involved in all aspects of their clinical care and have individualised processes and plans to support them at times of crisis which are collaborative, clearly documented, accessible and recorded for the service-user and staff team.	LT5.2
Individuals who may be subject to restrictive practices will be given clear accessible information about the range of restrictive approaches approved and authorised within the service, the circumstances which govern their use, and whom to complain to if there is concern about how these measures are implemented.	LT5.3
To contribute to the review and audit of the advocacy service.	LT5.4

6. Policies and Procedures

Action	Ref.
Details of actions to be agreed	LT6.1

8.0 Conclusion/Summary

2021/2022 has proven to be a year of achievement and progress. Despite challenges across staffing and leadership, change and high acuity we have been successful in coproducing a strategy and implementing the Use of Force guidance in a way that has connected people to recognise the importance and value it has.

With the focus on ensuring key policies and procedures were in line with the current guidance this has enabled teams to be up to date with their knowledge and practice and that service users and the people that support them, can truly feel our commitment to being Least Restrictive, safe and positive.

It's a journey, with people, by people. Talking about the Use of Force and Restrictive practice has been the highlight.

"I've been in hospital for long time now and I have seen some of them used, I understand why staff may have to use force at times".

XX said he felt reassured when we went through the booklet.

He's had some pretty tough restraints in the past with other places (prison) so is happier with our approach.