Health Innovation Network

Mental Health Safety Improvement Programme

End of programme report

May 2024

NHS England

IMPROVING MENTAL HEALTH SAFETY
Reducing restrictive practice

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Contents

Executive summary **2**
Results 2
Background **3**
Definition of restrictive practice 3
Methodology 4
Measurement framework 5
Engagement **6**
Change ideas **7**
Findings **8**
Benefits and impacts **10**
Benefits and impact on patients and staff 11
Qualitative impacts 11
Challenges **12**
Covid-19 pandemic 12
Staffing 12
Ward capacity, engagement and buy-in 12
Media coverage 12
Data 13
Senior support 13
Culture 13
Quality improvement infrastructure 13
Sustainability 14
Acknowledgements **14**

Executive summary

The NHS England Mental Health Safety Improvement Programme (MHSIP) was developed following a pilot involving 38 wards in 2018. The pilot demonstrated a 15% reduction in restrictive practice (RP). It was therefore hypothesised that if the programme was spread across England and if PSCs were to reduce restrictive practice at a rate of 15% this would result in 19,000 fewer restrictive interventions per year. The programme started on 1 April 2021 and finished on 30 September 2023.

The programme began as Covid-19 restrictions were being lifted and the NHS was going into the 'restoration and recovery' phase. This meant face-to-face meetings were reduced and hospital visits were subject to Covid-19 restrictions. Mental health staff were exhausted and there were many vacancies resulting from a high turnover of staff which led to the use of temporary staff and agencies.

Wards were invited to take part in the programme and PSCs were encouraged to 'work with the willing'. The PSCs engaged with 246 wards of wards, representing 15% of NHS and private providers across England.

Data was collected using safety crosses at ward level. A cross represented a restrictive intervention. These were classed as, physical, chemical (rapid tranquilisations), and the use of seclusion (isolation).

A theory of change was developed and a number of change ideas were identified. Implementation was through a quality improvement approach using the Institute for Healthcare Improvement (IHI) model for improvement or a breakthrough series.

Results

The PSCs worked with 15% of wards including NHS and private providers across England and engaged with 246 wards.

- 31 wards showed no significant improvement from baseline
- Where wards showed a reduction in physical restraint, this was up to 75%
- Where wards showed a reduction in rapid tranquilisation, this was up to 84%
- Where wards showed a reduction in seclusion, this was up to 66%
- 14 wards showed an increase in restrictive practice

Three key areas of focus were identified in both the pilot programme and national roll-out. Learning from both programmes suggests that if in-patient wards can generate and test ideas in one or more of these areas, they are more likely to reduce their use of restrictive practice:

1. Increased participation in activities
2. Reviewing blanket restrictions and ward rules
3. Building relationships with the ward community

There were also qualitative outcomes:

- An increase in staff engagement and awareness.
- An increase in staff confidence in applying interventions, particularly when managing complex patients.
- The promotion of a culture of recovery, through developing therapeutic relationships with patients

There were a number of lessons learned:

- Working with the willing often meant those wards with low baselines had little to gain and a reduction in RP was difficult to see. It would have been better to identify wards with high numbers of RP.
- The high turnover of staff affected engagement, as well as having a known effect on the incidences of restrictive practice, coupled with Covid-19 service users were required to isolate if they became infected and visiting was restricted.
- Data returns were relatively low and the data quality could be poor with a number of missing data points.
- There was no system to gather data across all the wards which could be aggregated.

Despite these setbacks there were many examples of improvement and feedback from service users, commissioners and staff was positive.

Background

The Mental Health Safety Improvement Programme was commissioned by NHS England Mental Health Learning Disability and Autism Transformation Programme and delivered by the Patient Safety Collaboratives from April 2021 to September 2023. This programme was overseen by NHS England's Patient Safety Team.

This scale-up programme followed a pilot in 2018 where the National Coordination Centre for Mental Health (NCMMH) supported 38 impatient mental health wards across England to reduce their use of restrictive practice using a quality improvement approach. The scale-up programmes built on the learning from the pilot. More information on the original pilot can be found here.

Definition of restrictive practice

The Mental Health Act defines restrictive practices as 'deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to: 'Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and end or reduce significantly the danger to the patient or others.'

'Restrictive practice' can be described as making someone do something they don't want to do or stopping someone doing something they want to do. It can include stopping people from going outside or from using the internet or phone.

The Mental Health Act Code of Practice says these restrictions should not be imposed as blanket rules (where they apply to everyone on a ward regardless), but only if they are necessary because of a specific individual risk. 'Restrictive interventions' include observation, seclusion, manual restraint, mechanical restraint and chemical restraint, which may include rapid tranquillisation. These are all deliberate acts that restrict someone's movement or freedom so as to take control of a dangerous situation or to end or reduce danger to the person concerned or others. Acts like these all have the potential to violate the person's human rights.

For the purposes of this report we will refer to restrictive practice as categorised into three main types:

- Physical
- Rapid tranquilisation
- Seclusion

Methodology

The aim of the programme was to:

Improve safety by reducing harm caused to people using mental health, learning disabilities and autism in-patient services by end September 2023.

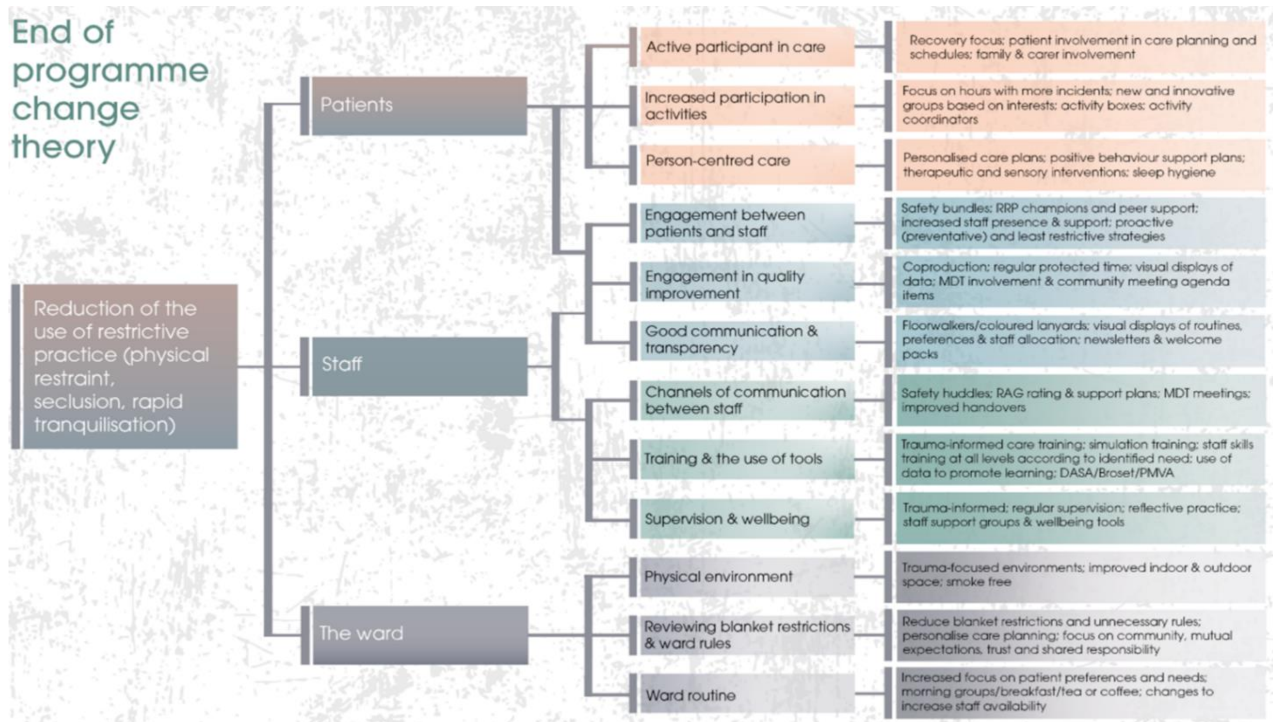
The programme was developed to support wards engaged in testing the reducing restrictive practice theory of change and change package, developed and refined for the MHSIP by the National Collaborating Centre for Mental Health in a national reducing restrictive practice pilot collaborative*.

In 2021, an average of **10,756** restrictive interventions took place across NHS mental health in-patient wards each month.

A **15%** reduction applied nationally would represent over **19,000** fewer restrictive practices per year.

Scaling up work across all mental health and learning disability trusts in England (currently working with **246** in-patient wards), including all major private providers of NHS mental health in-patient services, to significantly exceed the 15% reduction in restrictive practices.

*The mental health safety improvement programme: a national quality improvement collaborative to reduce restrictive practice in England (British Journal of Healthcare Management)



Theory of change driver diagram.

Measurement framework

Data was collected using safety crosses to record the number of incidents of restrictive practice). Data was collected for 10 weeks to understand the baseline. Data collection from week 11 of the programme continued until the end of the programme and was presented using SPC charts (statistical process control charts).

An example of a safety cross used to record the number of restraints on a daily basis.

Some wards refused to use the safety cross as they already used DATIX to collect incident data. They saw this as recording data twice and unnecessary. Safety cross data is known to be a more reliable data collection method. In this case they were unable to continue with the programme.

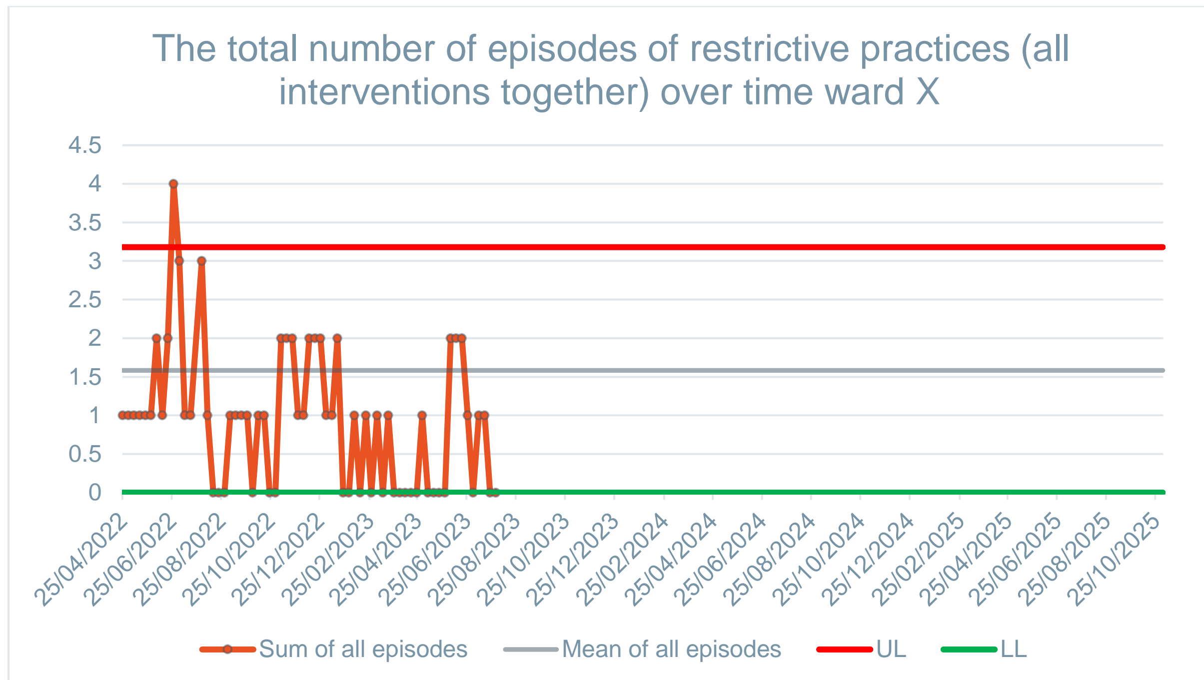


Figure 3. An example of a SPC chart used.

Engagement

The MHLDA SIP engaged 51 of 52 NHS trusts and a number of private providers with 246 wards representing 15% of all NHS and private provider wards across England. There was good uptake and engagement across England. However, we did see the number of wards engaged reduce as the programme came to a close.

There was a diverse and broad range of wards participating in the programme which included: acute adult in-patients; children and young people's services; psychiatric intensive care units (PICUs); older adults services; medium secure units; low secure units; and learning disability wards.

Specialty-based informal networks enabled similar ward types to come together to share learning and experience pertinent to their specialised areas. Across the country there has been much work undertaken to accelerate improvement through the power of people, including patient and carer co-design, building quality improvement (QI) capability, achieving patient safety equity by addressing inequalities and supporting participating teams to understand safety culture.

Change ideas

There were a number of change ideas (see earlier driver diagram) tested and implemented across the wards. The types of change ideas can be categorised into three main areas: those that were patient-centred, those aimed at staff, and those aimed at improving the ward environment. Examples are given below:

Patient-centred

- More activities
- Testing new activity ideas e.g. virtual reality technology, regular ward walks
- Project focusing in increased leave
- Co-designed care plans and templates
- Safety surveys
- Using the Safewards model to reduce conflict
- 'Getting to know me' boards
- 'Chill' trolley
- Reduction of blanket restrictions (vaping, TV, WiFi etc.)
- Increasing choice and autonomy
- New therapies

Staff-focused

- Safety huddles
- Staff training
- Debriefing

Improving the ward environment

- Environmental changes as well as to outdoor spaces
- 'About me' board for people's rooms
- Blackboard walls
- Improved outdoor space
- More art work
- De-escalation / calm rooms

Findings

Since Q1 2022/23, PSCs have been engaging with those wards that they are directly supporting with the reducing restrictive practice change package and collecting data on:

- The number of episodes restrictive practices
- The number of episodes of seclusion
- The number of times rapid tranquilisation was administered

Other measures also included:

- Numbers of restraints (reduced from baseline)
- Time between restraints increased
- Time in restraint (reduced from baseline)
- Type of restraint (less severe)
- Improvements that focus on improving the environment
- Improvements that lead to improved safety culture

The programme has led to a greater understanding about the use of restrictive interventions and how these were applied in the ward setting. There was not always a universal understanding and definition of what constituted restrictive practice. This remained very subjective.

It has not been possible to aggregate all the wards' data because of a number of factors:

- Some wards recorded zero restraints for a number of weeks over the programme. These wards usually had very low baseline levels of restrictive practice. As a result, a number of wards with low levels would record the days between an intervention rather than the number of interventions.
- Some wards, whilst still continuing with the programme, did not submit data. Whilst every effort was made by the PSCs to encourage and support, this was voluntary and not mandated. Many wards submitted incomplete data.
- The types of wards were very different, so comparisons between wards were difficult. For example, seclusion units would measure the length of time patients were out of seclusion or engaged in activities, rather than a count of restrictive practices.

Below is an example of how the findings were calculated:

In one PSC across three wards, wards X and Y were participating in the programme and ward Z was not. Overall, across all wards physical restraint reduced by 41%, there was a 16% decrease in the use of seclusion and 68% reduction in rapid tranquilisation.

BASELINE Average per week (Jan 22 – Feb 22)	Restraint	Seclusion	Rapid Tranq
Ward X	0.7	2.1	0.3
Ward Y	2.6	1	0.7
Ward Z	0.8	0.1	0.2

Testing average per week (March 22 – Feb 23)	Restraint	Seclusion	Rapid Tranq
Ward X	1.2	1.86	0.25
Ward Y	1.5	0.3	0.3
Ward Z	0.8	0.25	0.19

BASELINE vs Testing increase/ reduction %	Restraint	Seclusion	Rapid Tranq
Ward X	71% increase	11% reduction	16% reduction
Ward Y	42% reduction	70% reduction	57% reduction
Ward Z	No change	15% increase	1% increase

Data returns were variable: some wards in the above example reached 80% at best and others as low as 60%.

- The comparison ward that was not involved in the programme had very little use of restrictive practice during comparable baseline months and over the last 12 months of the programme maintained the small numbers. There was no significant increase or decrease in use but with such low numbers the percentage data is not always a useful indicator.
- The majority of the wards in the programme had very little use of restrictive practice.
- A number of people within the wards have suggested that there is an increase in chemical restraint via the use of as required medication but as this was not recorded as rapid tranquilisation this was not counted (not included within the programme).

Three key areas of focus were identified in both the pilot programme and national rollout. Learning from both programmes suggests that if inpatient wards can generate and test ideas in one or more of these, they are more likely to reduce their use of restrictive practice.

1. Increased participation in activities

Inpatient services are more likely to see a reduction in their use of restrictive practice if they can provide a larger number and variety of activities for patients on the ward. It is important to establish activities that are meaningful to patients and based on their interests.

2. Reviewing blanket restrictions and ward rules

On the ward, reducing blanket restrictions and unnecessary rules is another key area to focus improvement ideas. Several teams felt that some ward rules and safety policies were outdated, and often staff and management were not able to justify why certain rules were in place.

3. Building relationships with the ward community

By using QI methodology to reduce restrictive practice, and if truly using co-production, all change ideas help to build positive relationships in the ward community and are vital to the improvement of inpatient services. Building such relationships is vital to any improvement work and many of the participating teams have reported positive changes in the culture on their wards as a result of taking part in the programme.

Benefits and impacts

From the outcomes and feedback, it is clear that the RRP programme has raised the profile of the work. As a result, NHS trusts are investing more in reducing restrictive practice, in the following ways:

- Continuing the RRP work beyond the commission.
- Creating roles specifically to support in-patient wards.
- An increase in credibility of a QI approach to senior stakeholders in the trust.
- Reporting on reducing restrictive practices at the senior level.
- Reviewing operations and practices for service improvement. Including improvements to reporting systems leading to accurate reporting.
- Investing in improving ward environments including further support in the provision of sensory activities.
- Organisations establishing or re-launching their own RRP programme.
- Securing additional commission to continue work on RRP.
- Giving wider support for training in the management of violence and aggression.
- Creating solutions to address the gaps in the system where sharing knowledge can take place across providers.
- Investing in staff training, including trauma-informed care training.

Benefits and impact on patients and staff

It is clear to see that there have been benefits to both patients and staff taking part in reducing restrictive practices. Some of the benefits include:

- Organisations working in collaboration with service users, families, and stakeholders, promoting a collective approach to mental health safety improvement.
- An increase in staff engagement and awareness.
- An increase in staff confidence in applying interventions, particularly when managing complex patients.
- The promotion of a culture of recovery, through developing therapeutic relationships with patients.
- Staff and patients spending more time together in creative spaces provided for learning and knowledge exchange, facilitating the transfer of valuable insights and experiences.
- Enhanced communication skills through training and engagement, enabling staff to effectively de-escalate situations and engage in debriefing processes.
- Improved patient experience by promoting person-centred care, incorporating patients' insights and knowledge to inform decision-making and intervention development.
- Involvement of experts by experience in the programme's co-production efforts helped build trust, create a psychologically safe space, and fostered the sharing of challenges, brainstorming of feasible solutions and collaborative decision-making.

Qualitative impacts

The RRP programme has led to a greater understanding of restrictive practice and how reducing restrictive practice is understood in inpatient wards. Organisations have not only seen a reduction in the number of incidents relating to assaults on staff by patients but also noticed a change in culture.

Where teams have engaged in RRP, it is noticeable that there has been a shift in culture and an improvement in the care provided to patients. Key factors that have contributed to cultural changes at the ward level include:

- Reviewing blanket rules.
- Permitting teams to be curious and allowing them to do things differently.
- Fostering an environment that allows thoughts, processes and ways of working to be challenged.
- Stabilising the ward team leadership.
- Giving staff the space to share their voice through surveys about the ward culture, surveys about feelings of safety on the ward, sessions leading to the development of ideas, and open discussions.

Challenges

There were a number of challenges that were identified throughout this programme these related to:

Covid-19 pandemic

During the early stages of the programme, Covid had a number of impacts – firstly, the work from home regulations made it difficult to establish contact with board level staff in trusts were there were no existing relationships. Covid had a serious impact on ward staffing levels, which meant a delay in ward participation. Covid also had an impact on restrictive practice in terms of wards having to set up isolation areas. The introduction of mandatory vaccines meant that some wards were set to lose up to 50% of their staff.

The long-standing impact of the pandemic has placed strain on mental health services. There are examples of good practice and dedicated staff, however there are still high levels of vacancies, so the focus has been on delivering safe care to patients rather than quality improvement projects.

Staffing

Within mental health in-patient services there has been a high turnover of staff/managers and senior leaders which has led to engagement being difficult as relationships need to be re-established each time people have left. Often leadership for projects is not well-dispersed / shared collectively onwards, and this adds to the risks of disengagement of project leads when pressures mount.

Ward capacity, engagement and buy-in

This was the most significant risk as engagement was needed to embrace any support and change work. This was particularly acute during winter and would necessitate pausing the programme until such time pressures eased. There was a lack of buy-in from wards, as they were trying to focus on patient care and this was seen by some as an added burden.

Media coverage

During the programme a BBC Panorama programme aired, highlighting concerns around RRP in Edenfield (Greater Manchester). This presented a risk to engagement with the wards, but due to collaborative and supportive relationships this did not affect the

programme. Instead, it raised the profile of the RRP work at ICB level, which strengthened assurance routes for the work.

Data

Throughout the programme, wards have raised that collecting data using the safety crosses has been a challenge. This information is already being collected and they felt that this was not supporting clinical workload or practices, but instead another task to complete as many trusts had Life QI or other systems in place.

Some wards wanted to use incident data which was discouraged and this led to wards leaving the programme. In addition, the data needed to be submitted centrally using a workbook, and this was not always compatible with firewalls or the macros used would not allow this to work as needed. Teams created workarounds, with many PSCs inputting the data or producing bespoke seclusion spreadsheets to provide more insight on seclusion e.g. length of time spent in seclusion. This has supported teams to understand the importance of data collection and how to use SPC charts.

Senior support

Prior to the commencement of the programme there was a need for senior sign-up and discussions on what this would involve for the wards and teams taking part. It was not always evident that there was support from senior leaders and this meant wards participated because there was a champion. However, when the champion left the ward disengaged from the programme.

Culture

There was reluctance from some trusts to provide data from the wards that have higher incidents of RRP. A disconnect was noted between senior leadership and ward staff in some trusts.

There also seemed to be a lack of accountability within the trusts for the monitoring of the programme and it would often be difficult to ascertain who were the key stakeholders.

Quality improvement infrastructure

There was a lack of QI infrastructure and capability in many trusts, which undermined their readiness to take part in QI programmes.

Sustainability

There were some uncertainties surrounding the long-term sustainability plans for the implemented interventions, which required careful management and planning to ensure their continuation beyond the programme's duration. There was a possibility that the legacy of the programme's work on the Mental Health Safety Improvement Programme (MHSIP) would fade if sustainability was not effectively aligned with existing RRP work.

One PSC was able to establish a provider alliance in order to continue the programme after funding was stopped.

The identification of a new national programme of work meant that PSCs would signpost trusts to this. However, the PSC commission was discontinued in September and the new programme not launched until Jan 2024

Acknowledgements

Thanks to our commissioners, NHS England, the NCCMH, the patient safety teams, ward staff and service users.