Department of Health

Positive and Safe Champions' Network

December 2014 Newsletter. (Issue 1)

Content

An overview of Positive and Proactive Care

Dr Faisil Sethi

As a Consultant Psychiatrist in Psychiatric Intensive Care (PICU) I work with a multidisciplinary team which cares for and manages some of the most acutely unwell patients in the adult mental health service structure. The patients in the PICU have severe mental disorders, often with comorbid physical health problems, and more often than not, with a significant risk of outward aggression or violence. I see first-hand the distress and trauma caused by severe mental disorders, and both the benefits and risks associated with a wide-range of restrictive interventions. Balancing care and containment, in the face of immediate risk concerns, is a daily pursuit for PICU clinicians, and this requires considerable clinical skill, emotional intelligence and a milieu which enables therapeutic recovery.

It is timely to reinvigorate a debate which has been driving the philosophy of care in mental health settings for decades. The principle of least restriction is one of the five guiding principles informing decisions made under the Mental Health Act, and this has been brought to the fore in recent investigations highlighting abuses in the use of restrictive interventions. If it isn't already apparent, the national scandal emanating from the Winterbourne View Hospital investigation will probably be seen as a watershed moment in mental health care, where the call for action in this area can no longer be ignored.

In April 2014, the Department of Health launched the Positive and Safe initiative which aims to reduce the use of a wide range of restrictive interventions across health and social care settings. Such interventions should be employed as a last resort in a legal and ethical manner, within an effective framework of clinical governance. The guidance accompanying the initiative focusses on improvements in clinical care; the need for leadership, assurance and accountability; the promotion of a culture of transparency; with regulatory monitoring and oversight. The approach sets out a top-down vision for change in the philosophy of care for patients, who can in equal measure, be highly challenging and yet acutely vulnerable.

Although the Positive and Safe initiative relates to the whole spectrum of restrictive interventions, much of the immediate focus will be on the practice of physical restraint and seclusion. These are emotionally sensitive areas of clinical practice,

and the debates can display a divergence of opinion across clinical and academic lines. The moral, ethical and legal debates surrounding physical restraint and seclusion can lead to passionate polarisation, which can be unhelpful to a degree.

Physical restraint in the mental health setting is usually employed in response to a perceived risk of violence or aggression. As an intervention, it is laden with risk for both patients and staff; it is hard to come up with another clinical intervention in medicine or nursing which places patients and staff in such a position. There is significant variation in the methods and degree of force used in physical restraint in mental health settings, and such questions are challenging our professional ethics and morality. The Positive and Safe initiative places a direct spotlight on physical restraint practices, and it is for clinicians, managers, commissioners and academics to identify the methods which are more likely to therapeutically contain risky behaviour, whilst minimising risk to patients and staff.

Seclusion has long been used to contain those suffering with mental disorder. The ethical debate over *"to seclude or not to seclude"* has progressed much since the days of Connolly and Tuke, but there continues to be a lack of evidence-based guidance in this area. In 2004 the Bennett Inquiry posed the tricky question: which is preferable, prolonged restraint or seclusion? In 2014, in the UK, when presented with serious outward risks of aggression and violence in the context of acute mental disorder, and when less restrictive interventions have failed to contain, many mental health facilities will use seclusion.

The work has already started, and in November 2014, the Department of Health hosted the first in a series of Positive and Safe Champions' Network events. These events bring together senior practitioners from a wide range of disciplines to share good practice with the common aim of reducing and better utilising restrictive interventions. The network already boasts around seventy champions from mental health and learning disability sector; the plan is to widen the scope to include older adult's care, dementia and social care.

Recently the Department of Health concluded a series of Positive and Safe Culture Change events. These invited organisations to take on the challenge of changing the culture in their workplaces to make restrictive interventions a consideration of last resort.

Work is underway to look at the data around the use of restraint. The data snapshot, which was collected by the Benchmarking Network, may well lead to improvements in the quality of data collected as part of the future Mental Health and Learning Disability Minimum Dataset.

Workforce training and development will be key, and the Department of Health are planning an online awareness course around the theme of reducing restrictive interventions. Other training and development resources are being considered.

These are early days, and there are many strands to the implementation of Positive and Safe. There are a number of challenging, even controversial questions to be answered, and a wide range of opinion amongst stakeholders. The Positive and Safe initiative is about using restrictive interventions in a safe and therapeutic manner. A systematic data-driven evidence-based analysis of the use of restrictive interventions is required, so that the most suitable intervention is applied correctly in the most appropriate circumstance. This is one of the critical issues in mental health today,

and the Positive and Safe initiative has the potential to positively change the culture of mental health care in years to come.

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Using data to improve patient care

Do you know how often restrictive interventions are used in your service and in your organisation as a whole?

How does your organisation's use of restrictive interventions compare with comparable services?

I'm not an analyst, why does the data matter?

Taking the last question first, the data matters because understanding what services and organisations are doing is crucial to improving patient care. Positive and Proactive Care requires Trusts or equivalent to have a named board member responsible for their restrictive intervention reduction plan. Understanding what is happening in their own organisation and how that compares with others is a vital part of the plan. Taking account of the good practice we are asking Champions to contribute to (see the article *The role of a champion*) is another step to improving care.

When Positive and Safe was launched in April 2014 there was a lack of robust data available about the use of restrictive interventions. Individual organisations' internal data may have been comprehensive and reliable but published data was incomplete and (even accepting the complexities of service design, patient acuity and staffing levels to name a few) did not enable comparisons to be made.

We have been working to change this and now need your help.

NHS Benchmarking Network

DH commissioned the NHS Benchmarking Network to collect data about violence and the use of restrictive interventions during August 2014. We have received responses from all NHS mental health Trusts and 10 of the biggest independent providers. This data collection will be repeated during February 2015 for incidents in January and there is likely to be a third collection later in 2015.

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Key points from the data collection:

Restraint

Respondents to the survey reported that restraint was used a total of 8,466 times during August 2014. There is notable variation between different specialties. Restraint was most often used in:

- CAMHS (restraint used 15 times for every 10 beds during the month)
- Acute admission beds within specialised Learning Disability units and longer term complex/continuing care Learning Disability services (restraint used 14 times for every 10 beds during the month)
- PICU (restraint used 8 times for every 10 beds during the month)

For the purposes of this data collection, physical restraint was defined as: *Use of physical control and restraint techniques without additional mechanical or pharmacological intervention, with the aim of preventing, restricting or subduing a patient's movement.*

DH is now working with the NHS Benchmarking Network and representatives from the responding organisations to refine and improve this definition to avoid counting 'guiding hand' incidents and capture only incidents that were responses to safety incidents, or challenging behaviour, or similar. The change of definition will reduce comparability of data between the August and January collections but will increase robustness and comparability between organisations.

Prone restraint

Of the 8,466 incidences of restraint, 1,535 were uses of prone restraint.

Prone restraint was most often used in:

- CAMHS (prone restraint used 4.2 times for every 10 beds during the month)
- PICU (prone restraint used 2.5 times for every 10 beds during the month)

While restraint in general is used more frequently on LD wards than in CAMHS or adult mental health services, prone restraint on LD wards is much less common.

A clarification of the definition of prone restraint will be issued before the next Benchmarking Network data collection: prone restraint must be counted even if only used for a short time and even if the patient fell or put themselves in the prone position. Chest down and face down restraint must be counted as prone.

Seclusion

There were 1,459 incidents of seclusion reported across all organisations in August. Patients were most likely to have been secluded in PICU, forensic secure LD, medium secure MH and CAMHS services. Twelve organisations recorded 0 use of seclusion.

For the purposes of this data collection, seclusion was defined as: *The supervised confinement and isolation of a person in an area where the person is prevented from leaving, for the purpose of containing severely disturbed behaviour.*

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Future data collections

DH has also been working with the Health and Social Care Information Centre (HSCIC) to improve the quality of the data available through the Mental Health Minimum Data Set (MHMDS). This work has focussed on increasing the number of complete returns by organisations and on improving the definitions used. The 2016 iteration of the Mental Health and Learning Disability Data Set (MHLDMDS), which will replace the MHMDS will include the improved definitions.

Hopefully the reason for the first two questions is now apparent!

We're not expecting you to crawl all over the data but there is potential to help the implementation of Positive and Safe both locally and nationally by :

- Sense checking. Speak to the person in your organisation who submitted the data and consider whether you feel the data submitted accurately reflects your understanding of local practice
- Making comparisons. Use your own networks to look at the data submitted by your organisation in comparison to others and consider where attention should be focussed on driving improvement and change

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The role of a champion

Thank you for deciding to be part of the Positive and Safe Champions' Network. We recognise that for many of you this work is in addition to your daily roles. The following are some initial suggestions about how you can get involved.

6Cs webpage management

We will soon be launching a page on NHS England's 6Cs website and we are looking to recruit a small team of people to help us to manage the content and develop the page. We anticipate that the page will include a bank of case studies, videos, links to other useful pages, examples of good practice, discussion forums, articles, events, and news stories. Please let us know what would be useful for you and if you're interested in being part of this team.

Case studies

A key part of the Positive and Safe 6Cs webpage will be case studies describing what you and your organisations have done or are doing to reduce the use of restrictive intervention. We saw some at the first network meeting in November but know there are lots more out there. Please share your success and let others benefit from your experiences by sending your case studies to us. Awards will be presented at the next Positive and Safe Champions' Network event on 10th February for the most innovative and useful case studies.

Call for contributions: reducing the use of seclusion

The next issue of this newsletter will be published at the end of January and will focus on reducing the use of seclusion.

We are seeking examples of challenges and successes in reducing the use of seclusion. If you would be willing to write a short article or case study, or if you are aware of other articles or resources on this topic, please contact Grace Watkinson by 14th **January**.

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Newsletter development team

Have you found reading this newsletter useful and interesting? Would you be keen to develop it and be part of the team producing and editing it? If so, we would like to hear from you. Each newsletter will concentrate on a central theme. This is your newsletter so let us know what you would like to read about.

NHS Benchmarking Network data

Please see the article *Using data to improve patient care* for details on how to respond to the NHS Benchmarking Network's data collection on restrictive intervention.

Champion recruitment

We are pleased to announce that there are already twice as many champions today as there were at the Champions' Network event in November. Successful recent recruitment has focussed on those working with people with learning disabilities. We are also keen to recruit champions working in dementia and older people's care. Do you know self-advocates or people working in these areas, who work to reduce the use of restrictive intervention? Please forward this newsletter to those who may be interested and pass on details of the network.

Internal networking

Are others in your organisation aware of your membership of this network? Have you considered how you could use internal communication channels to spread information about reducing the use of restrictive intervention across wards or throughout your organisation? If you would like help with finding ways to spread the word please get in touch and we will be happy to help.

Date for your diary:

Meeting	Positive and Safe Champions' Network meeting
Date	10 February 2014
Time	10am-4pm
Venue	The Grand Connaught Rooms 61-65 Great Queen Street London, WC2B 5DA

Contact details

Suggestions, questions, case studies, contributions to future newsletters, applications to join the newsletter development team or 6Cs webpage management team should be sent to:

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