Making Our Services Safer
Strategy
2015 – 2017

Making Our Services Safer

Personal Responsibility

Organisational Vision

SBU Assurance

Our Values
Welcoming Kind Positive Respectful Professional
Foreword - experts by experience

Co-production and Making Our Services Safer are two vital pre requisites for this organisation to fulfil its vision of being a leading provider of mental health and learning disability services.

This strategy reflects both these principles in its initiation and development. The inclusion of the lived experience has matched the contribution and openness of Trust staff and has embraced both the ‘converted’ and those whose initial response was cautious.

The trauma of mental illness with all its complexity demands a fresh and contemporary response. Making Our Services Safer provides an effective and evidence-based framework and methodology to implement this process.

The strategy is rightly ambitious in its goal setting, ensuring that all staff fully understand the theory and create environments that apply learning operationally.

We look forward to continuing this co-production approach and the ultimate arbiter of positive change will be service users themselves. We remain receptive to all contributions.

Chris Munt and Jane Foy

The Making Services Better group are made up of experts by experience, advocacy, Health Access Champions (people with a learning disability who work for the Trust supporting a range of person centred approaches) and staff.

The Making Services Better Group co-ordinates service user and family/carer/people who support consultation across the Learning Disabilities and Forensic Strategic Business Unit. The Making Services Better Group welcomes and fully supports the Making Our Services Safer strategy and shares its vision and aspirations.

The Making Services Better group support co-production and placing the person at the centre of their care and treatment. Far beyond this the Making Services Better Group feel passionate about breaking down the barriers that people with Learning Disabilities face on a daily basis and believe that person centred approaches and co-production that leads to informed choice and empowerment is the way forward.

The group are delighted that evidence based practice is detailed in the strategy and look forward to working with the Making Our Services Safer group to deliver on the action plans.
1. Introduction: Organisational Values and Vision

Hertfordshire Partnership University NHS Foundation Trust (HPFT) is at the forefront of providing integrated health and social care. The Trust provides services for people with mental health problems and learning disabilities. On the basis of need with the purpose of delivering excellence to help people make a positive difference to their lives.

The Making Our Services Safer (MOSS) strategy is in place to support greater collaboration and co-production with service users, carers and staff. The aim of the approach is to work together to understand how to minimise restrictive interventions. We aim to reduce the impact of such interventions on recovery, and enable us to work collectively.

The broad structure of MOSS sits in three areas:

- Organisational Vision: By developing a strategy with an associated an oversight group
- Strategic Business Unit (SBU) Assurance: To develop a local response to MOSS
- Personal Responsibility: individual engagement, through the Trust values at the point of practice, care, involvement and engagement.
2. The purpose of the ‘Making Our Services Safer’ Strategy is:

To complement the excellent work already in place, to align values and approaches, so they support national best practice and guidance. To reassure carers and families that:

- services are well informed and using best practice
- care is delivered in partnership
- the best interests of service users are served and prioritised at all times.

To integrate, develop and respond to guidance set out in the 2 year strategy - Positive and Safe; developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions (DH, 2014). This strategy and guidance offers clarity on what models and practice will be undertaken, to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and nominated lead.

To reduce restrictive practices (Physical Interventions (Restraint), Rapid Tranquilisation and Seclusion), so they continue to be used as a last resort and as a safety intervention only. To ensure that when restrictive interventions are required, that they are:

- transparent in use
- valid and appropriate to need
- legally and ethically appropriate
- any intervention is reviewed and monitored.

To promote the understanding and impact of restrictive practices for all involved, so all stakeholders understand across a range of settings, what best ethical practise is, preventing the misuse and misapplication of these interventions.

To reduce the numbers of incidents and interventions where staff and service users are harmed, so all involved report feeling safer through:

- evidence-based models of support and intervention
- by consolidating and standardising assessment processes, and support plans, so needs are considered with regards to challenges in ongoing communication
- through on-going monitoring of interventions as part of trust-wide and service-wide oversight and monitoring groups
- via the development of support, undertaken through awareness raising for all stakeholders and post incident support.

To ensure controlled environments (wards) are safe, with appropriate safeguards for managing risk with regards to structure and building fabric.

To provide up-to-date and robust policy frameworks to support staff and service users so they feel safe and assured when working in partnership to achieve agreed goals. This will cover all areas of trust working, including specifically the role of the Lone Worker.
To align MOSS with the principles of recovery and co-production so recent national and international evidence and best practice is considered.

To apply continuous evaluation, so training remains relevant and responsive for all who practice and experience our services.

To ensure there is a clear process, with a memorandum of understanding in place to strengthen communication between the Police and services when required.

### 3. National context and future practice

*The Francis Report* into the failings at Mid Staffordshire and the *Berwick Review* into patient safety, highlighted and emphasised the importance of ensuring that patients are central to what we do. The nursing response and approach to the Francis Report influenced the introduction of six C’s highlighted to further engage nurses at the centre of what we do in care, by offering the guiding framework, with six key areas, emphasising values and commitment:

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage
6. Commitment

The shocking events at Winterbourne View highlighted that several of the individuals cared for, were subject to physical restraint (restrictive practices) on a regular basis, and that staff did not use these interventions as a last resort to prevent harm. Since then, there has been much debate and discussion on how this should be addressed both at national and local level.

*Closing the gap: priorities for essential change in mental health* (DoH, 2013), (point 9), committed to the radical reduction of restrictive interventions and face down restraint, known as prone. This resulted in a round table debate, precipitated by the recently released MIND report. This fuelled an ongoing consultation on the subject in late 2013 - which HPFT was part of. This event was chaired by Norman Lamb, MP; as a result of this *Positive & Safe* was later produced.

*Positive & Safe* is a two year plan for all partners within health and social care to review, reduce and rethink the function of restrictive practices - whilst considering leadership, culture and professional practice, underpinned by key areas of development.

*Positive & Safe* expects a clear organisational response, with leadership and vision, led from the board and developed at service level, with a clear process of accountability and assurance. This approach focuses on restraint reduction, assessment of needs in context to behaviour and behavioural support, related debrief when required and ongoing surveillance of incidence and data.
The Positive & Safe framework highlights four key action areas:

- Improving Care
- Leadership, assurance and accountability
- Transparency
- Monitoring and oversight.

*Positive & Safe* articulates the expectation for a clear organisational response, for the reduction of restrictive interventions, associated with increased behavioural support and the related support plans. The framework sets out the assurance and governance approaches expected, expounding the leadership approach and vision, led from the board and developed at service level, with a clear process of accountability.

This approach focuses on restraint reduction, assessment of needs in context to behaviour and behavioural support. This is related to the core principles of ‘last resort’ interventions:

- when debrief is required
- ongoing surveillance of incident data
- transparency of thematic reporting.

*Positive & Safe* is included in the *Making Our Services Safer Strategy (MOSS)* as it is a key national driver and it is the HPFT response to reducing and managing behaviour that challenges, from the perspective of all stakeholders.

*Positive & Safe* is applicable across the health and social care spectrum. The guidance advocated in the framework will inform the CQC’s programme of monitoring and compliance in specific relation to restrictive interventions (restraint, restraint led medication, seclusion and long term segregation), which must be seen in context to a range of other approaches such as:

- Recovery and co-production
- Models of behavioural support
- Post incident support
- Restrictive intervention reduction / reduced conflict management
- Evidenced based practice and proactive interventions
- Robust and transparent governance, board leadership and monitoring
- Ethical and lawful interventions as a last resort.

Of relevance to HPFT, are those who may be at risk or who may be exposed to restrictive interventions. This applies to services and people who have:

- Mental health conditions
- Autistic spectrum conditions
- Learning disability or / dementia
- Personality disorder.
The MIND report, ‘Mental health crisis care: physical restraint in crisis care: A report on physical restraint in hospital settings in England - was published on 19 June 2013. It highlighted 42,000 recorded incidents of all kinds of physical restraint in England during 2011-12, resulting in 1,000 injuries to people with mental health issues. Some of these incidents over time had been associated with severe harm and death, which is both unpalatable and unacceptable.

A particular focus has been around restrictive interventions for those at their most vulnerable, when distressed and unwell. Evidence tells us this is particularly relevant when previous trauma exists, common for many who have a lived experience. This has been reported as making re-experiencing of restrictive interventions a more traumatic experience, impacting on recovery. This has highlighted the requirement for assessment of need in a collaborative way via examples such as:

- Advanced decisions
- Care plans
- Behavioural support plans
- Support for those effected (both service users and staff), debrief and regular review of practice and incidents.

Alongside the emerging feedback of experience and evidence, we have a greater understanding of what should be in place to reduce such events and what works. Making Our Services Safer (MOSS), is how we at HPFT wish to respond. This strategy focuses on a partnership between those with clinical experience and those with the lived experience and it is through this we can Make Our Services Safer.

To summarise a range of concerns about the culture and practice within health and social care has been prominent with regards to managing behaviour that challenges. This concern is pervasive in nature, being reported internationally and nationally within the health and social care economy and from the perspective of different stakeholders at different levels.
4. Restrictive Practice - setting the scene

**Restrictive Practices:** As cited in the Safewards methodology, two areas that categorise restrictive interventions are:

- Control through interventions such as physical restraint and rapid tranquilisation
- Containment, when interventions such as seclusion and isolation are used to manage behaviour that frustrates usual practice interventions.

Best practice indicates we should aim to eliminate or reduce such approaches to a minimum or as a last resort, (MHA 1983, Code of Practice, 2008, chap 15). As cited in some enlightened American models of restraint reduction, the last resort is seen as a ‘Safety Intervention’. Unfortunately, this has not historically been the case, with such approaches being seen, in some areas of practice as systematic, institutional and criminal in some instances, damaging reputation and perception of services.

Both nationally and internationally, there is evidence to show that restrictive practices - and the impact of such interventions - have a direct and negative impact on those who experience such events. There is an increasing understanding that those experiencing mental health problems are more likely to have been exposed to previous trauma and that any restrictive practice needs to be used with thought and care, thoroughly reviewed, as they have the potential to negatively impact on recovery.

The services we provide, and the values we subscribe to, have a function in supporting people across the wider health and social care spectrum. These are based on the principles that recovery is a possibility and can be attained by all and that people can achieve satisfying and fulfilling lives in accordance with their own preferences, goals and aims, through feeling empowered, self-determined, with unconditional engagement within wider society - and with regards to MOSS.

*Recovery in context to MOSS should mean that staff and service users should work in partnership to improve both their clinical and social outcomes.*

5. Recovery and the relationship to MOSS

Recovery-based principles are essential to the success of this strategy, and are implicit in our organisational values. Such values are now well embedded in many of our mental health services.

The *Implementing Recovery through Organisational Change* (ImROC) is an approach and example undertaken through learning sets engaged in by mental health trusts. They are aimed at helping those with lived experience, and changing how the NHS and its partners operate, so that the focus is more on helping those with lived experience recover.

The aim of ImROC, is to blend recovery orientated practice - by building upon approaches to improve the quality of the service and support people more effectively. These are based around 10 key challenges.
10 key challenges:

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive user-led education and training programmes
3. Establishing a ‘Recovery Education Centre’ to drive the programmes forward
4. Ensuring organisational commitment, creating the ‘culture’
5. Increasing personalisation and choice
6. Changing the way we approach risk assessment and management
7. Redefining user involvement
8. Transforming the workforce
9. Supporting people in their recovery journey
10. Increasing opportunities for building a life beyond illness

Adapted from Implementing Recovery: A new framework for organisational change Boardman, J and Shepherd, G. (2009) Centre for Mental Health

As part of the ImROC initiative, HPFT has been part of the learning sets, which have strongly advocated the review of the following in developing alternatives to restrictive practices:

- No Force First
- Six Core Strategies
- Safe Wards

Positive and Proactive Care includes six key principles that offer, amongst a wealth of evidenced based approaches, some direction on developing an approach to minimise restrictive practice:

1. People’s human rights must be protected and honoured at all times.
2. Understanding people’s behaviour allows their unique and individual needs to be identified and quality of life enhanced.
3. Involvement and participation of service users, their families, carers and advocates is essential.
4. People must be treated with compassion, dignity and kindness.
5. Health and social care services must keep people safe and free from harm
6. Positive relationships between the people who deliver services must be protected and preserved.
6. Evidence Based Practice

Positive Behavioural Support and related planning, has developed in the field of Learning Disabilities, with wider applications in the care of people within our services.

This approach recognises that any form of behaviour that represents a challenge to practice, is a frustrated or dysfunctional form of communication and with certain skills / training can reduce / support behaviour by the following broad principles:

- We should not try to control other people, but should support them in their own behaviour change process
- There is a reason behind most behaviour that challenges practice, such as not meeting an unmet need
- Everyone has unique strengths and talents that can be utilised
- Everyone should be treated with compassion and respect regardless of their behaviour
- Everyone is entitled to quality of life and appropriate services to meet their needs
- Combined with organisational values and the growing evidence base, knowledge about how to provide support for positive behaviour can make a big difference
- Positive responses will be more effective than coercion and punishment

‘No Force First’ (NFF) and a similar methodology (Six Core Strategies – 6Cs) have spread as an initiative within mental health inpatient units in the United States. These approaches have been used internationally and have shown dramatic reductions in restrictive practice such as restraint and seclusion events.

The two methodologies have been introduced and positively evaluated to tackle institutional practice in areas where high levels of restraint and seclusion were causing inpatient deaths and subsequent financially damaging legal action against healthcare providers

Central to NFF and 6Cs, are the following broadly translated points:

- Any restrictive practice, is a safety intervention and a failure of treatment
- Any safety intervention has the potential to degrade the ultimate recovery goal
- All safety interventions (restrictive practices) should be reviewed to learn lessons, which should include de-brief for both staff and service user
- The principles of trauma-informed care, should be applied, which recognises services users may have a previous trauma and any restrictive practice may re-traumatise and make the situation worse
- Additionally having in place advanced decisions about care and treatment.
**Safewards** is a recommended set of evidenced-based interventions, evaluated in adult acute environments, with applicability in other service areas, which could form part of any interventions or agreed local approaches.

The above slide is a simple version of the Safewards model, describing the key areas that are thought to impact on conflict and containment:

- All wards are a temporary mix, an environment of changing circumstances and situations (originating domains), these have the potential to develop ‘flashpoints’

- Patient Modifiers / Staff Modifiers: Modifiers are how groups may respond when there is a flashpoint - which can lead to conflict and containment

- The principles used in Safewards advocate the use the 10 key interventions, so when ‘flashpoints’ present, they can be used to reduce potential conflict or containment.
The interventions, which proved statistically significant in reducing both conflict and containment, are as follows:

**These interventions follow 10 themes, used within the clinical environments:**

1. **Clear mutual expectations**: clear support on how to communicate and why - developed by staff and service users and posted on the unit for all to see.

2. **Soft words**: being respectful and polite.

3. **Talk down**: staff using agreed advanced de-escalation techniques, whilst remaining calm and friendly.

4. **Positive words**: positive talk during handover.

5. **Bad news mitigation**: being aware when bad news is being given and received and develop approaches to support.

6. **Know each other**: sharing common interests so relationships are developed.

7. **Mutual help meetings**: thanking people, making suggestions, requests or offers, encourage or support – run by service users.

8. **Calm down methods**: having a box of calm down equipment: IPODS, scented towels, massage balls, herbal tea – the list is not exhaustive.

9. **Reassurance**: being mindful of events on the ward – offering support, giving reassurance post incident, checking in handover that all have been reassured, if there has been shouting or upset.

10. **Discharge messages**: previous service users write post cards to offer support and hope, highlighting what went well – via posters or trees with cards on branches.

7. **Background and challenges**

Alongside the emerging national and international developments - *Making Our Services Safer* has been produced in response to the staff reporting violence and aggression consistently over the past three years, with little change in the staff survey.

The experience of staff is directly related to that of the service user, and vice versa, and as such it is essential that this relationship is maximised to develop and enhance the best practice. The evidence on service user experience tells us that previous trauma is key in assessing needs and supporting service users. Previous trauma is higher in those with the lived experience and unnecessary restrictive interventions can make this worse.
The level of reported violence within HPFT has been decreasing overall, though the focus for all parties must be on the experience. Positive behavioural support and research such as Safewards and related needs assessment approaches need to be in place so restrictive practices are justified and minimised.

It is recognised that enormous efforts are undertaken by staff to report incidents. We have good quality data and are recognised as being very good at reporting. It is further recognised that the experience of violence, through behaviours has not changed in the staff survey, which needs clear action. Making Our Services Safer is in place to support and guide services in how they can develop this.

Reported violence as a trend is reducing with a minimal increase during 2013-14. We have much work to do to develop and improve this position, so services report lower levels of behaviour that challenges and all parties feel supported and safe.

8. Organisational Response

Nevertheless these higher than anticipated figures still remain a challenge for the Trust. The Executive Board commissioned an independent review in partnership with staff side (Royal College of Nursing, Unison) of the Trust’s management systems in reducing and tackling violence and aggression (this was undertaken by Rick Tucker).

The report findings highlighted many positive approaches in minimising and managing the impact of aggression throughout the Trust:

- Violence reduction initiatives within the LD & Forensic services
- Data analysis and mapping of incidents
- Providing / developing ‘bespoke’ training for SBU in management of aggression and violence
However some of the challenges the Trust must face in the future are:

- Review training to meet the needs of staff
- Developing a consistent training approach across all services
- Developing an overarching strategy for *Making Our Services Safer*

*Making Our Services Safer* aims to systematically review policy and practice so the principles of best practice and national guidance are agreed by all stakeholders.

**RESPECT: a message that supports dignity and respect**

HPFT aims to be an employer of choice in Hertfordshire, Norfolk and Essex. It is important that we all feel safe and supported in our areas of work, whilst being ourselves and feel like we are being treated with RESPECT.

RESPECT is designed to give all staff working for HPFT support and help so they are more valued in the workplace, ensuring that staff are treating each other with dignity and respect. This is essential part of Making Our Safer Services strategy.

RESPECT is the trust message to support our Equality and Human Rights agenda, offering a simple message, covering all of these areas to enable better assessment of our environments to ensure compliance, as well as reinforcing the need to treat everyone with dignity.

Dignity and respect are essential to all staff working in an inclusive environment as it is important that we know how we should be treating others as well as how we deserve to be treated ourselves.

**RESPECT Training Solutions: a model to pro-actively manage behaviour that challenges practice.**

The Trust uses Prevention of Management and Aggression (PMA) and RESPECT Training Solutions models across Hertfordshire, Essex and Norfolk. Within this strategy there is a clear objective to review and develop a standardised approach as part of MOSS, this approach aims to further reduce incidents where restrictive practices are used.

The techniques employed in any restrictive practice and where they happen, they should be reviewed and understood. A higher degree of scrutiny, in what we do and how we record, will be key development within this strategy.

RESPECT / PMA – has to be values-based and link with the RESPECT campaign, which focuses on managing appropriate behaviour and making improvements to the care environment, especially regarding dignity.

At HPFT, staff who work directly with service users are being given a range of training in techniques to de-escalate difficult and challenging situations. Physical restraint is only used as a last resort when there is a risk to the individual or others that cannot be averted in any other way.
How to respond to serious abuse against staff

This process is about responding to situations where there has been a use of inappropriate words or behaviour causing serious distress and/or constituting harassment against staff

OR

Where there has been the intention – through use of force – to harm another person, without lawful justification, resulting in physical injury or personal discomfort

**STAGE 1**

Staff should discuss the incident in the first instance with their Line Manager or most senior person on duty at the time of the incident to discuss and agree on the most appropriate action to take.

**STAGE 2**

If it is agreed by all parties involved in the incident to contact the police this can be done by phoning 101 (non emergency) or 999 (emergency) and Complete ‘Untoward Incident’ form. Manager should keep all records and statements of incident.

**STAGE 3**

Post Incident review should take place by the nurse in charge/manager jointly with the medical team to ascertain the levels of risk the service user poses and whether they should remain in the service.

**STAGE 4**

Staff involved are provided with critical incident debriefing by calling 07659 1000 89 and – if appropriate – a review of their needs re: ‘respect training solutions’ (formally SCIP)

**STAGE 5**

If police decide to not prosecute, Andrew Wellings (Lead Accredited Local Security Management Specialist) will liaise with the staff member and manager regarding potential next steps.

*All staff should read this poster in conjunction with the Non-Physical and Physical Assaults Policy*
Bibliography and references

1. A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health


4. The Berwick Review: A promise to learn - a commitment to act, Improving the Safety of Patients in England

5. DH: Closing the Gap: Priorities for essential change in mental health

6. DH: (In preparation) Positive and Proactive: guidance on support and care of children and young people

7. DH: Mental Health Act Code of Practice Skills for Health and Skills for Care (2014)


11. IMROC – Implementing Recovery through Organisational Change http://www.imroc.org/

12. MIND: Mental health crisis care: physical restraint in crisis - a report on physical restraint in hospital settings in England


15. NHS Protect: Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings


18. Positive and Proactive easy read guidance –

19. Positive and Proactive executive summary -

20. Resources for Safewards implementation –
    www.safewards.net

21. Winterbourne View - Summary of the Government Response:
<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Expected Outcomes</th>
<th>Responsible Parties</th>
<th>Target Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making Our Services Safer Action Plan</td>
<td>MOSS strategy is agreed and launched, to include all involved stakeholders</td>
<td>MOSS Group (Trust Lead), Communications</td>
<td>February 2015</td>
</tr>
<tr>
<td>2. A communication approach will be agreed and methodology for ensuring all stakeholders are aware of the main principles of the MOSS strategy are agreed</td>
<td>MOSS Group (Trust Lead), Communications</td>
<td>March – April 2015</td>
<td></td>
</tr>
<tr>
<td>3. A Trust lead is agreed in this area and this is communicated to all stakeholders</td>
<td>MOSS Group (Trust Lead), Communications</td>
<td>March 2015</td>
<td></td>
</tr>
<tr>
<td>4. A programme of restrictive practice reduction is agreed</td>
<td>MOSS Group (Trust Lead), Communications</td>
<td>March – April 2015</td>
<td></td>
</tr>
</tbody>
</table>
5. Targets for the reduction of incidents, relating to harm from behaviour that challenges services is agreed:
   - Continued reduction of incidents will be the target, so that interventions are more therapeutic and recovery orientated.
   - Each SBU will have reviewed their specific needs and requirements, making adjustments to the practice pathway so respondents are able to access support in a timely manner.

6. The increase of behavioural support and related plans / similar approaches are agreed:
   - A programme of behavioural support will be developed to support and clarify the needs of service users.
   - The principles of recovery and the work already in place will be reviewed and integrated to ensure an agreed format.

7. Associated recovery based planning for a form of positive behavioural support:
   - The principles of recovery and the work already in place are reviewed and integrated to ensure an agreed format.

8. A review of training is undertaken to ensure key points of the strategy are reviewed and updated.
   - An SBU wide reference group will consult upon and review current training and future needs.

9. Each SBU will develop their own local MOSS approach to reflect specialist needs and requirements:
   - Each SBU will have reviewed their specific needs and requirements, making adjustments to the practice pathway so respondents are able to access support in a timely manner.

10. Policies involving restrictive practices and or that impact on restrictive practices are reviewed:
    - Policies involving restrictive practices are reviewed and co-produced, so the ‘voice’ of those with the lived experience is considered.
    - The ‘voice’ of those with the lived experience is considered.
    - The ‘voice’ of those with the lived experience is considered.

11. Policy leads and associated recovery based planning:
    - Policies that involve restrictive practices and or that impact on restrictive practices are reviewed and co-produced, so the ‘voice’ of those with the lived experience is considered.
    - The ‘voice’ of those with the lived experience is considered.
    - The ‘voice’ of those with the lived experience is considered.

12. Policies involving restrictive practices and or that impact on restrictive practices are reviewed:
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    - The ‘voice’ of those with the lived experience is considered.

13. Policy leads and associated recovery based planning:
    - Policies that involve restrictive practices and or that impact on restrictive practices are reviewed and co-produced, so the ‘voice’ of those with the lived experience is considered.
    - The ‘voice’ of those with the lived experience is considered.
    - The ‘voice’ of those with the lived experience is considered.
11. Regular aggregated data sets will be produced and reviewed relating to incidents and reported to the SBU’s as part of an oversight group, to allow timely response, action and assurance around:
   a. Incident data relating to restrictive practice
   b. Development of behavioural support and related care plans
   c. Review of de-brief and post incident support

   Interim Report: 2017
   o Full annual report 2016
   o March 2015

   Annual oversight by the Board, on key aspects

   b. Oversight of data will take place, to understand:
      o Themes
      o Lessons be learned
      o Effectiveness of the MOSS
      o Assurance to commissioners
      o CQC

   c. Agree actions / interventions to develop and improve

12. As an outcome of any last resort, restrictive intervention, systems for systematic de brief for all involved will be developed for quarterly review – between 2015 and 2017
   • MOSS group
   • Patient Safety Lead
   • Performance Development and Patient Safety Manager

   • Review by April – September 2015

   Annual oversight by the Board, on key aspects

13. Each area of the plan will
   a. Through agreed forward objectives / targets
   b. Progress with key milestones
   c. Development of systems for systematic review of data will be reviewed and evaluated in an annual report presented to the Board, this will include:
   o Outcome of audit
   o Accountability / Board to ward
   o Assurance of MOSS will be in place, to offer:
   o Lessons be learned
   o Themes
   o Outcomes of the MOSS

   Interim Report: 2015
   • MOSS group
   • Performance Development and Patient Safety Manager

   • Review – between 2015 and 2017

   Annual oversight by the Board, on key aspects

   a. Incident data relating to restrictive practice
   b. Development of actions / interventions to develop and improve

   Interim Report: March 2015
   • Full annual report 2016
   • Full annual report 2017

   Annual oversight by the Board, on key aspects

   a. Incident data relating to restrictive practice
   b. Development of actions / interventions to develop and improve

   Interim Report: March 2015
   • Full annual report 2016
   • Full annual report 2017

   Annual oversight by the Board, on key aspects

   a. Incident data relating to restrictive practice
   b. Development of actions / interventions to develop and improve
14. All SBU will ensure systems are in place to support lone workers

- All lone workers are aware of best practice and policy
- All lone workers have the correct / appropriate risk assessments in place for Lone Working, with the correct personal protective equipment and devices
- Quarterly review as part of Health Safety and Security Committee
- To cross reference with Health Safety and Security Committee annual report for key issues
- LSMS RESPECT team and lead MOSS group

15. All Counties will have in place the appropriate Memorandum of understanding with the Police

- To ensure the appropriate support systems are in place to offer staff support via the Police and Crown Prosecution Service, where applicable
- Quarterly LSMS review with police
- Cross reference with the Police and Crown Prosecution Service, where applicable
- LSMS RESPECT team and lead MOSS group
- HSSC

16. All inpatient controlled environments such as ligatures and anchor points are assessed and managed for potential risks. Lone Workers will have in place the appropriate systems and procedures to support lone workers in controlled environments

- Issue annual report for key security commitments with Health Safety and Security Committee
- To cross reference regarding incidents
- Quarterly review as part of the MOSS group
- All lone workers are aware of best practice and policy
- All SBU will ensure systems are in place to support lone workers
- LSMS RESPECT team and lead MOSS group
- HSSC
If you require this information in a different language or format please contact the Patient Advice and Liaison Service. 
Tel: 01727 804629

W razie potrzeby powyższy tekst można otrzymać w innym formacie lub innym języku. Informacji w tej sprawie udziela: Patient Advice & Liaison Service. 
Tel: 01727 804629  
(Polish)

Se avete bisogno di queste informazioni in una lingua o in un formato differente, vi preghiamo di contattare: Patient Advice & Liaison Service. 
(Servizio relazioni e consigli per i pazienti) 
Tel: 01727 804629  
(Italian)

আপনি যদি এই লেখাটি অন্য কোন ভাষায় বা অন্য কোন প্রকারে পেতে চান তাহলে অনুচিত করে নিচের নামাজে যোগাযোগ করবেন:  
পেশেন্ট অ্যাডভাইস অ্যান্ড লিয়েজন সার্ভিস  
(রোগীদের পরামর্শ দেওয়া ও তাদের সাথে যোগাযোগ রাখার পরিষেবা) 
টেলিফোন: 01727 804629  
(Bengali)

ارٹچب كيورك دوسری زبان شم یاکس دوسری قالي بروند سپن سپه شم سپا نالنک:  
(Patient Advice & Liaison Service)  
01727 804629  
(Urdu)

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