NHS
Hertfordshire
Partnership University
NHS Foundation Trust

MOSStogether Strategy 2019-2022

The least restrictive practice starts with a conversation

as One

Our Values
Welcoming Kind Positive Respectful Professional

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Lived Experience of the MOSStogether Strategy

Let's talk about David…..a man in his 40s who had been acutely unwell on too many occasions in his adult life, and who had been admitted to hospital for the treatment of his poor mental health repeatedly, often under a section of the Mental Health Act.

Now, David had sadly become something of an expert on mental health services through his experience of them. He remembered the too frequent occasions when his mental health deteriorated and left him without his freedom and in a state of mind where conflict often followed. Sometimes when this happened it lead to him being locked away from others for his own and their safety, sometimes he was compelled to take medication to achieve the same ends. Rarely did either of these experiences leave him feeling grateful for them however. Reflecting on his experience he felt that what services did in these circumstances was to *react* to him in ways which left all parties unhappy…..surely there were ways of avoiding this?

It is perhaps inevitable that risk gets *reacted* to, and in ways which whilst well-meant are ultimately intended to simply make the problem go away. And what is wrong with this? Well, it often means that clients whilst kept safe, are left with very painful memories of their care, which of course make it harder to ask for help in the future. It also means that staff are left with painful memories too, and this erodes morale and makes coming to work difficult. It is however a complex and thorny issue, this process of keeping people safe whilst encouraging them to take control and responsibility.

So, how will things be different for David, and others going forward…..?

On his next admission David is met with a new approach, one which brings him and his views to the fore in planning for safety during his stay. What does this mean? Well, for starters, the values of the staff team and their willingness to develop a learning culture and one which optimises what is just and right, means that they spend more time getting to hear from him how to keep things safe – he becomes his expert and we learn from him. We are talking about safety now, rather than risk – things seem more positive somehow.

So, it all starts with this conversation about how we keep ourselves and each other safe. David learns that this conversation continues during his admission, for example in the experience of the client group taking part in what are called 'Safety Huddles', where they are encouraged and supported to share their experience of events on the ward and to learn and action change as a result. Further, David is repeatedly invited to share the decision making process around his care and its planning. He learns about positive risk taking, a new approach to managing risk and promoting safety. In the old model the goal, whilst very sensible, i.e. to minimise risk, sometimes meant that we unintentionally stripped people of their sense of ownership. Positive risk taking is something which David experiences as belonging to him – he takes responsibility for managing parts of his safety plan in a way which means he retains a sense of

ownership and agency. David now begins to evolve a different and more constructive experience whilst in hospital – staff value and act upon his views and they, as a result become much more meaningful and valued. Staff also feel that they are providing care in a clearly more Recovery focussed way. This doesn't mean that nothing difficult ever happens again, that's not the world we live in, but it does mean that David and the staff who work with him have a chance, from the beginning, to develop a constructive and shared responsibility for making things work, as one.

Introduction

Our *Good to Great Strategy* (2016-2021) describes how we, at Hertfordshire Partnership NHS University Foundation Trust (the Trust), are delivering our vision of '*Delivering Great Care, Achieving Great Outcomes – Together'*.

Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – '*We will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well.*'

Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services and their families and carers, by working in partnership with them and others who support them.

Furthermore, it means we keep people safe from avoidable harm, whilst ensuring our care and services are effective. That they achieve the very best clinical outcomes, support individual recovery and are of the highest quality.

Our *Good to Great* Strategy (diagram 1) demonstrates the key areas of focus for the Trust, in terms of the people, the organisation and partnerships. It focuses on the three domains of quality – safety, effectiveness and experience.

Diagram 1

Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – *"we will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well."*

This strategy will enable the Trust to deliver on the strategic objective - *"we will provide safe services, so that people feel safe and are protected from avoidable harm"*.

This MOSStogether Strategy aims to support this objective by ensuring the least restrictive practices are used, setting out how service users will feel safe across our services, and as a partner in their own care and treatment, enabling a positive experience. It also aims to support in the reduction of violence and aggression to both staff and services users, across all of our services.

What is Restrictive Practice?

Restrictive Practice refers to the implementation of any practice restricting a service user's movement, liberty and/or freedom to act; it can take a number of forms (diagram 2), defined by the Royal College of Nursing in December 2013 (table 1).

Where an individual service user's behaviour places themselves or others at imminent risk of significant harm, a restrictive practice may be necessary as a proportionate and reasonable response. To enable a reduction in the use of restrictive practice, high quality and safe services need to be provided in therapeutic environments with staff engaging in therapeutic relationships, providing value-based care that is person-centred and focuses on recovery.

To create and maintain a safe and supportive environment for staff, service users and carers, we need to ensure processes are designed and in place, learning about what works well and why, and to replicate and optimise these behaviours and processes.

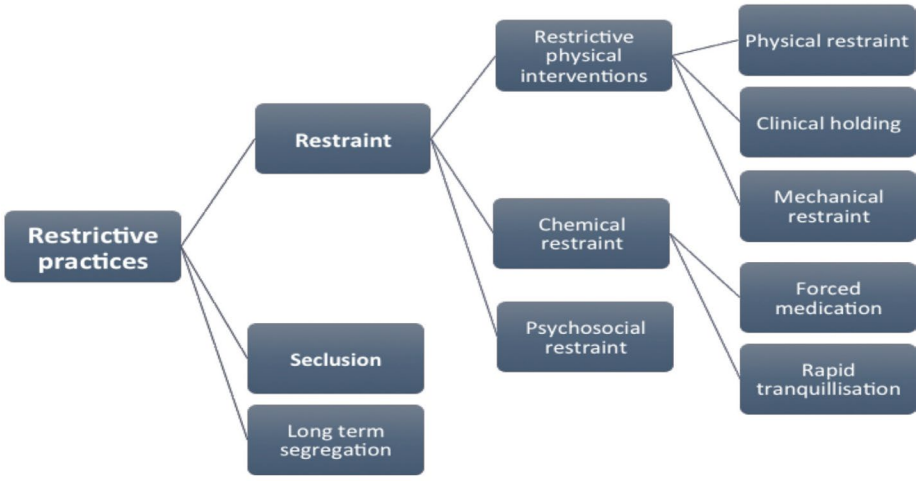

Diagram 2

Restraint	Use of or threat to use force, to make a service user do something that they are resisting, or restrict their freedom of movement, whether they are resisting or not
Restrictive Physical interventions	The use of force to control a service user's behaviour and can be employed using bodily contact or mechanical devices
Physical restraint	Any direct physical contact, with or without resistance, where the intention is to prevent, restrict or subdue movement of the body, or part of the body of a service user
Clinical (therapeutic) holding	The use of physical holds to assist or support a service user to receive medical care or treatment in situations where their behaviour may otherwise limit the ability to meet their clinical needs, or where their behaviour may present a safety risk to themselves, members of the care team or others
Mechanical restraint	The use of a device to prevent, restrict or subdue movement of a service user's body/part of the body, for the primary purpose of behavioural control
Chemical restraint	The use of medication to control or subdue a service user's behaviour, be it regularly administered or 'prescribed as required' (PRN) and where it is not prescribed by a registered medical practitioners for treating a formally identified physical or mental illness
Forced medication	The administration of intramuscular medication by force or by definite psychological pressure i.e. announcing intramuscular medication if medication is not taken orally at once
Rapid tranquilisation	All medication given in the short/term management of disturbed/violent behaviour (including PRN medication taken from an agreed rapid tranquilisation protocol)
Psychosocial restraint	The use of coercive social or material sanctions, or verbal threat of those sanctions, in an attempt to moderate a service user's behaviour
Seclusion	The confinement of a service user alone, as an immediate response to severely disturbed behaviour, at any hour of the day or night, in an area from which their egress is actively prevented through the deliberate actions of another, or consequences thereof
Long term segregation	A situation where, in order to control a sustained high risk of serious harm to others, which is an almost constant feature of their presentation, a service user is not allowed to mix freely with other service users.

Table 1

Approach

The MOSStogether Strategy sets out an approach which aims to ensure that safety is at the heart of everything we do in order to deliver our *Good to Great Strategy*.

It ensures that safe services are provided, so that people feel safe whilst receiving our services. It sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services and has been developed from and builds upon the Trust's previous Making Our Services Safer (MOSS) Strategy. This is the next stage of our journey, incorporating Continuous Quality Improvement (CQI) methodology, a just and learning culture and Shared Decision Making.

Core to this Strategy is the Trust's values and related behaviours. These apply to how as a Trust we value our workforce as well as service users, carers, colleagues and members of the public:

- We are *welcoming* so you feel valued as a person
- We are *kind* so you can feel cared for
- We are *supportive* so you can feel supported and included
- We are *respectful* so you can feel listened to and heard
- We are *professional* so you can feel safe and confident.

The MOSStogether Strategy describes a consistent and integrated approach to providing safe services with regards to restrictive practice. It is an enabler of the Trust's vision and is supported through the Trust's organisational development of work. Core to the MOSStogether Strategy is that ***the least restrictive practice starts with a conversation.***

Aim, Objectives and Priorities

The MOSStogether Strategy supports the aims of the Quality Strategy (diagram 3) to deliver *Great Care and achieve Great Outcomes together,* using the least restrictive practices. The objectives, focusing on the safety domain are:

- *Delivering safe care in top quality environments,* with regards to the seclusion and restrictive practice
- *Fostering a learning and just culture*
- *Fostering a culture of safety*.

Diagram 3

Keeping our service users, carers and staff safe is a key priority and we achieve this through the implementation of this MOSStogether Strategy using Shared Decision

Making and promoting a just and learning culture. This means that those who use our services have choice and control over the way their care is planned and delivered, ensuring that they are supported to be as involved in the decision making process as they would wish. This includes positive risk taking. It also means that staff will make positive changes as a result of learning from incidents.

Working together, staff, individual service users and carers will enable an understanding of what is important, supporting the service users' recovery and the achievement of outcomes that matter.

For the service user, carer and staff this will mean different things (table 2).

For service users	I will experience safe and compassionate care in an environment that safely and effectively delivers my treatment and uses the least restrictive practice
For carers	I will feel confident that safe and compassionate care is delivered consistently in partnership and in top quality environments, with regards to seclusion and restrictive practice
For staff	I feel confident that we are working together with the right skills and environment to deliver safe and compassionate care and enabling the least restrictive practices to be used

Table 2

The priorities of the MOSStogether Strategy are:

- To introduce the HOPE Model, resulting in the least restrictive practice being used
- To use the least restrictive practices, as a last resort, and as a safety intervention, considering alternative approaches to ensure safe care
- To reduce the negative impact on service users and staff when restrictive practice is used
- To involve service users in their recovery and care through shared decision making
- To ensure that practice is responsive to the changing needs of service users and services as well as best practice and the evidence base.

Inpatient services

To achieve these priorities, the MOSStogether Strategy's approach to using the least restrictive practice is to have a 'menu' of proactive approaches that can be used in response to the changing needs of service users and services. These include SafeWard methodologies, Safety Huddles, Safety Crosses, Safety Pods and Positive Behavioural Support (PBS) plans (Appendix A).

This menu will be regularly reviewed in light of emerging evidence, best practice and consultation with service users and staff to ensure best practice is delivered.

The foundation for every inpatient service area will be to implement, through co-production with service users, carers and staff, the 10 SafeWard methodologies. Monitored by the Clinical Director and Head of Nursing, CQI methodology will be used with the Practice Development and Patient Safety Team who will lead on monthly reviews of the implementation, the incident data relating to violence and aggression and the use of restrictive practices and the feedback from service users, carers and staff regarding feeling safe. This will include all reported incidents across all of our services relating to violence and aggression, cross referenced with data from other sources including RIDDORs (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations), claims and workforce data.

Safety huddles will be routinely used in all inpatient service areas proactively per shift for the staff as a 'pulse check' on the 'temperature' of the environment – does it feel safe, are there any concerns, what do we need to be aware about. Furthermore, a safety huddle will be used following an incident in all of our services – both inpatient and community - enabling staff to group and agree their focus to enable a safe environment. Safety huddles for service users will be used, working with an identified staff member, where they too can talk through any concerns they may have at that time and how safe they are feeling.

Community services

To achieve these priorities within the community services, the MOSStogether Strategy's approach to embedding a safety culture is for regular liaison with staff to support in the management of violence and aggression. This requires risk assessment and management considering lone working as well as risks related to the variety of environments community staff are required to work in, both in and away from Trust premises as well as out of hours.

Training provided regarding restrictive practice considers violence and aggression relating to work, and shall also include preparing for and responding to personal safety risks when working in the community.

Appendix A also includes proactive approaches that can be used for community services, including tracing systems and personal safety alarms.

Risk Assessment and Management.

Risk assessment and management should be embedded in everyday practice. Positive risk management should be in collaboration and as part of a constructed plan, using Shared Decision Making, recovery focused and building on the recognition of strengths of individual service user.

Its aim is to prevent any negative event from occurring and minimising harm caused and is integral in identifying the most appropriate level and kind of intervention for individual service users.

Review

The MOSStogether Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. It will be reviewed annually along with the actions and outcomes and any changes will be considered and approved by the Quality and Risk Management Committee.

It will be reviewed at the Restrictive Practice Committee meetings, chaired by the Deputy Director of Nursing and Quality. Using CQI methodology and with representation from each of the Strategic Business Units (SBU), service user and carer representative, data will be analysed, discussed and shared, learning what works well and why, so to replicate and optimise the behaviours and processes.

Updates from the Restrictive Practice Committee will be reported to both the Quality and Risk Management Committee on a quarterly basis and to the SBU's Quality and Risk meetings as well as the Trust's Safety Committee.

4. Conclusion

This MOSStogether Strategy has been developed through reviewing the Trust's MOSS Strategy and a number of consultations. It talks to the Trust's Quality Strategy and is the next stage of our journey, using CQI methodology it considers Just Learning and Culture and Shared Decision Making. It sets out three objectives under the Safety domain:

- *Delivering safe care in top quality environments,* with regards to the seclusion and restrictive practice
- *Fostering a learning and just culture,* following the use of restrictive practice
- *Fostering a culture of safety*.

Furthermore, it details the priorities and the methodologies used to ensure the least restrictive practice is used and to risk assess and manage in the community services.

Appendix A – Proactive Approaches and Methodologies

Positive Behaviour Support (PBS) is a person-centred approach to supporting service users who display or at risk of displaying behaviours which challenge. It involves understanding the reasons for the behaviour and considers the individual service user as a whole to implement ways of supporting them, using proactive strategies. Although they originated from the field of learning disabilities, PBS has been effective in mental health services to deliver key elements associated with restrictive practice reduction models.

Safety Huddles have been widely used across sporting teams: where team players gather around usually with the coach for a huddle. This provides a discussion of what is going on with the play on the pitch; clarifying the strategy, designating specific team roles and acting these out. This concept originated from American football.

Within the clinical area, this concept is transferrable. For a huddle to be instigated, usually, the temperature of the clinical area has changed and there is a concern for a person's safety. Any member of staff could call for a safety huddle and they are held for a maximum of 15 minutes in which all the attending members stand-up, and discuss the pressing risks; identify a strategy for managing these risks, key roles and actions.

The safety huddles can be **reactive** where they are triggered by an event to assess how it could have been prevented, what can be learnt and what could be done differently in that moment. A real time conversation rather than a full debrief. **Proactive** huddles are to prevent service user safety issues and staff concerns. The team gather together to talk about the day, the shift, the next few hours, at any point in the day.

All members of the huddle stand to enable the process to be fast and effective. The huddle will ask the same three questions:

1. *Do you feel safe or do you have a concern?*
2. *Which service user is unhappy with their care?*
3. *What is the plan (and who is going to implement this and when?)*

The UK Safety pod is a piece of equipment used as an aid in physical intervention. It makes physical intervention safer, reducing the risks to both staff carrying out an intervention and to the people who require manual support.
The context to any physical intervention is the avoidance of holding a person down on the floor or any surface (cited in Positive and Proactive Care, DoH, 2014). The UK Safety Pod allows a less restrictive approach to managing restraint; reducing the risk of harm through excessive holding on or against hard surfaces.

SafeWards includes a range of approaches by which routines and environments may be modified, challenging situations avoided, de-escalation achieved and alternatives to restrictive practice consolidated into practice.
The use of Safewards methodologies has shown reductions in incidents and restrictive practice across acute mental health settings and is a recommended set of evidence-based interventions. The principles used, advocate the 10 key interventions so when

there are challenging situations present, they can be used to reduce potential conflict or containment, as listed below:

- *Clear mutual expectations:* proving clear support on how to communicate & why – developed by staff & service users & posted on display in the clinical service areas for all to see
- *Soft words:* being respectful & polite
- *Positive words:* positive talk during shift handover
- *Bad news mitigation:* being aware when bad news is given & received & develop approaches that may be used to support
- *Knowing each other:* sharing common interests so relationships are developed
- *Mutual help meetings:* thanking people, making suggestions, requests or offers, encouraging or supporting; these are run by service users
- *Calm down methods:* having a box of 'calm down' equipment, such as iPods, scented towels, massage balls, herbal tea - the list is not exhaustive
- *Reassurance:* being mindful of events that are occurring in the clinical service area & offering support, giving reassurance after an incident or challenging situation, checking in shift handover that all have been reassured
- *Discharge messages:* service users who have been transferred or discharged from the clinical service area writing messages on post cards to offer support & hope, highlighting that went well, this can be via poster or tree murals with the messages & post cards on the branches.

Safety Cross is a simple and visual data collection tool used to count an area for improvement. These may be used for the type of restrictive practice used, the amount of violence and aggression received/witnessed/reported. The purpose of the safety cross is to make the issue transparent and to support the collection of data in an easy way.

Dynamic Appraisal of Situational Aggression (DASA) is a tool used to assess the likelihood that a service user will become aggressive within an inpatient environment. This is a helpful tool to use with service users who can add their specific triggers in Shared Decision Making.

Brøset Violence Checklist is a 6-item checklist which assists in the prediction of imminent violent behaviour (from a 24 hours perspective) and can be used by all staff working with service users to help assist in preventing unwanted behaviour.

Tracing Systems

A designated colleague ('buddy') to be informed about the whereabouts and contact details of a specific employee while they are lone working, including out of normal office hours. This would include travel details, the exact location and time of appointments as well as name and contact details of the person they are meeting, where relevant.

Personal Safety Alarms and Lone Working Devices

Depending upon the outcome of the risk assessments, staff to use a personal safety alarm to carry to distract an aggressor where appropriate and aid escape from a personal safety incident.
Lone working is defined by the Health and Safety Executive as ‘those who work by themselves without close or direct supervision’. Staff to use their lone working device at all times when working in the community services.

Appendix B - Background information

Approach to developing the strategy

The MOSS*2gether* Strategy was developed through consultation with service users, carers and staff and built on a number of pieces of work that have taken place in recent times and the associated consultation with the staff, service users and carers. This included, but was not solely, in relation to:

- Trust Strategies
- Quality Accounts
- Quality Report
- Care Quality Commission inspection reports
- Audit results including Safety Culture audit
- Research and evidence base.

National Context

The Care Quality Commission (CQC) in their *'Quality Improvement in Hospital Trusts'* refer to the significant improvements they have seen in their quality of care through their regulatory processes, citing good examples of practice.

Furthermore, to have an understanding of quality meaningful engagement and involvement with service users in service development is essential, systematically integrated into Quality Improvement

The CQC's Fundamental Standards are key to this MOSS*2gether* Strategy and are the standards below which the care we provide must never fall and which everybody has the right to expect:

- *Person-centred care* – providing care or treatment tailored to the individual which meets their needs and preferences
- *Dignity and respect* – treating individuals with dignity and respect at all times whilst receiving care and treatment
- *Consent* – obtaining consent from individuals (or anybody legally acting on their behalf) before any care or treatment is given
- *Safety* – not giving unsafe care or treatment or putting individuals at risk of harm that could be avoided
- *Safeguarding from abuse* – ensuring individuals do not suffer any form of abuse or improper treatment whilst receiving our care
- *Food and drink* – ensuring individuals have enough to eat and drink to keep them in good health whilst receiving our care and treatment
- *Premises and equipment* – providing clean, suitable and looked after property and equipment used in it
- *Complaints* – enabling individuals to complain about their care and treatment

- *Good governance* – providing plans that ensures the care can meet these standards
- *Staffing* – having enough suitably qualified, competent and experienced staff to make sure we can meet these standards
- *Fit and proper staff* – employing people who can provide care and treatment appropriate to their role. Having a strong recruitment procedure in place and carrying out relevant checks
- *Duty of candour* – being open and transparent with individuals about their care and treatment
- *Display of ratings* – displaying our CQC rating in a place where it can be seen.

The *Five Year Forward View* describes the need for a single, shared goal to maintain and improve quality, to improve health outcomes requires a focus on planning and delivering services which both improve quality and reduce avoidable costs. This is underpinned by three principles:

- *Right care* – doing the right thing, first time, in the right setting will ensure service users get the care that is right for them, avoiding unnecessary complication and longer stays in hospital and helping them recover as soon as possible
- *Minimising avoidable harm* – a relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduced costs associated with the litigation
- *Maximising the value of available resources* – providing high quality care to everyone who uses health and care services requires organisations and health economies to use their resources in the most efficient way for the benefit of their community – any waste has an opportunity cost in terms of care that could otherwise be provided.

Supporting documents

This strategy is also supported through:

- The Good to Great Strategy
- The Organisational Development Strategy. Our staff and staff teams are integral to delivering high quality services. This work is delivered through the organisational development strategy and the framework and approach to developing of sustainable high performing teams
- The Carer Plan (2019-2021) which specifically sets out the Trust's approach to carers' support
- Service Strategies
- Digital Strategy – That sets out our goal to improve our service users' health and well-being through the effective use of data and digital technology-enabled care to deliver Great Care and Great Outcomes – Together

- Continuous Quality Improvement Agenda – Our approach to create a culture and environment where we constantly learn, improve and innovate to deliver Great Care and Great Outcomes
- HPFT Equality Plan 2018 – 2022
- HPFT Carers Plan 2019 – 2021.

Appendix C - Assurance and Compliance

The Trust governance structure will provide monitoring and assurance for this strategy. There are different operational levels of quality governance within the Trust:

- Board of Directors
- Assurance Committees (Integrated Governance Committee, Equality, Diversity and Inclusion Group)
- Executive Team
- Strategic Business Unit (SBU) or Corporate Governance meetings
- Department/speciality level
- All staff reporting on quality.

Quality Assurance by the Board is underpinned by a number of systems of control. These include:

- The Board Assurance Framework (BAF) which provides a structure and process enabling organisations to focus on quality issues which may compromise the achievement of its most important strategic objectives, to map out the key controls in place to manage those objectives, to confirm the Board has gained sufficient assurance about the effectiveness of these controls and to enable the Board to confirm that its responsibilities are being discharged effectively. All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have evidence to support this Statement. The BAF brings this evidence together
- The designated assurance committees of the Trust Board are the Integrated Governance Committee and the Equality, Diversity and Inclusion Group. It is the responsibility of the assurance committees to report to the Trust Board any areas of concern relating to quality identified and gaps in assurance.

Equality Impact Assessment

The Trust is committed to promoting equality of opportunity for all its employees and the population it serves. The Trust aims to design and implement services, policies and measures that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. No detriment is intended.