April 2017

Yorkshire and Humber Involvement Network

Reducing Restrictive Practice Bulletin 6

Next meeting: Thursday 1st June 2-4 @ Sandal

At the last meeting of the Reducing Restrictive Practice CQUIN group on the 30th March we started off with a presentation looking at the CQC guide to the use of blanket restrictions on mental health wards. This can be found on pages 2 and 3.

We then had a debate about Takeaways. Moorlands View presented the view that Takeaways can be good for you (against their wishes I might add!) and then everyone else argued against that view, about how they can actually be very bad for you! This can be found on pages 4 and 5.

We then had some group work asking everyone to spend some time thinking about the RRP CQUIN group and writing down our thoughts on the meetings so that we could use it for a submission for the RCPsych Newsletter as they were looking for articles to share best practice about RRP. You can read the article that we submitted and the information from the group work on pages 6 and 7.

We then finished with a presentation and discussion from Caron Smith NHS England Senior Supplier Manager about the new CQUIN guidance and ways of reporting that are coming into effect for Yorkshire and Humber secure services for the coming CQUIN year from Quarter 1. Information about this can be found on page 8.

Contents

restraint reduction network

Reducing Restrictive Practice CQUIN Group Agenda

Sandal Rugby Club Wakefield

Thursday 30th March 2017 14.00 – 16.00

1. **Welcome** and Introductions
2. **Presentation** – Holly and Jo
   – CQC Guide to the use of blanket restrictions on mental health wards
3. **Debate** – Take it or Not!

COFFEE BREAK

4. **Group** work – Quality Network Newsletter
5. **Presentation and Discussion** – Commissioning Team
   - New ways of reporting

Developed by Holly Alix and Jo Harris on behalf of the Yorkshire and Humber Secure Services

Brief guide: the use of 'blanket restrictions' in mental health wards

Mental Health Act Code of Practice

- Blanket restrictions are "rules or policies that that restrict a patients liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application"
- Blanket restrictions "should be should be avoided unless they can be justified as **necessary** and **proportionate** responses to risk identified for particular individuals"

The code does allow that secure services will impose blanket restrictions on their patients

- Where blanket restrictions are identified as necessary and proportionate there should be a system in place which ensures these are reviewed within a regular time frame, and with an overall aim at the reduction of restrictive practices.

Evidence required

- Evidence that there is a **policy** on blanket restrictions that acknowledges the principle of least restriction.
- The service can give an account of why any blanket restriction is **necessary** and **proportionate**, as well as:
  - A system that ensures a regular review of any blanket restriction that is not an inherent part of ward safety
  - Where it is considered an inherent part– staff are permitted to relax it for an individual patient if this doesn't compromise the overall security of the service
  - There is a system to identify and challenge practices that may amount to blanket restriction, to make sure care and treatment is provided according to the principles of least restrictive option and maximising independence (Code of Practice)

Reporting

- For their report they will state what blanket restrictions are in place and whether they were unwarranted, as well as whether there is a systematic regular review of these under **'assessing and managing risk to patients and staff'** in the section **'safe'**.
- In **'well led'** under **'good governance'** they will report on the quality of the providers oversight of blanket restrictions and the support provided to staff to actively review and manage these. No form of blanket restriction should be implemented unless expressly authorised by the hospital managers on the basis of policy and governance.

Restricting access to items

- Where access to items is restricted, specially if these are not normally restricted there should be auditable standards for:
  - How items are identified and the risk assessment required
  - What information and the reasons for the restriction is provided to patients and visitors
  - How is adherence monitored
  - Arrangements for audit and review

Appendix 1: Normative expectations regarding blanket restrictions at different levels of security

	Security level				
	General (acute)	PICU	Low	Medium	High
Banned items	All services will have banned and restricted items: alcohol, weapons, illicit drugs (see appendix 2).		All services will have banned and restricted items in addition to those found in general (acute) ward policies (see appendix 2).		
Random or routine searching	Not without specific cause (see appendix 2)	Policy on searching should require clear rationale given on the purpose of any search.	Random searching likely, may be routine at times in response to specific issues	Routine searching likely. Pre-discharge/ recovery wards may have random searching.	Expected to be routine due to inherent risk of population.
Access to mobile phones and the internet.	Wards should provide personal access to the internet and mobile phones, particularly to communicate with friends and family. Restrictions on access should be individually justified and not be a blanket measure. Wards may provide non-camera phone handsets and arrange for safe charging of patients' electronic items (electrical leads can be a ligature risk), e.g. with short-lead chargers or charging in the nursing office).		Some units are piloting access to mobile phones. Dependent on the risk profile of the patient group.	All access to internet likely to be supervised and restricted as part of ward security.	All access to internet will be supervised and restricted as part of ward security.
Access to money	Restrictions on access to money should be based upon individual risk assessment, and justifiable on grounds of best interests.		Restrictions on access to money will be part of security fabric of ward.		
Buying takeaway food	No restrictions		Restrictions on take away food may be in place to ensure that therapeutic activity of the ward environment is not undermined.		
Food restrictions	During inpatient care staff should review the physical health of the patient as well as the mental health. Advice and encouragement should be given to patients to have a healthy well balanced diet. Restrictions of access to certain food should not be part of this and can be viewed as a blanket restriction.				
Smoke free	NHSE have issued guidance on mental health units becoming smoke-free. This should be considered to be as a blanket restriction that is justifiable.				
incoming or outgoing mail	Staff have no legal powers to interfere with postal items but may withhold outgoing post from a detained patient where addressee has requested that this be done (MHA s.134(1)(a)). Staff may ask patients to open mail in front of them if there are concerns over contraband items or the patient's likely reaction to mail. Staff should justify as necessary and proportionate to an identified risk. It should not amount to an interference with the postal item itself. Staff should not read patients' mail in such arrangements.				Security directions allow monitoring and interference with postal items (see appendix 3).
Telephone monitoring	No legal powers to monitor patients' telephone calls. Patients should expect privacy when using the telephone. In exceptional cases (e.g. when a patient makes nuisance or unwarranted emergency service calls) access to the telephone might be restricted.				Security directions allow monitoring of phone calls (see appendix 3).

Appendix 2: Prohibited and restricted items in mental health wards[1]

Prohibited items

All mental health inpatient services have some prohibited or 'contraband' items. Inspectors should not challenge the enforcement of such prohibitions as a blanket restriction. The following are typically banned in all inpatient services:

- Alcohol and drugs or substances not prescribed (including illicit and legal highs)
- Items used as weapons (firearms- real or replica, knives or others sharps, bats)
- Fire hazard items (flammable liquids, matches, incense)
- Pornographic material
- Material that incites violence or racial/cultural/religious/gender hatred
- Clingfilm, foil, chewing gum, blue tack, plastic bags, rope, metal clothes hangers
- Laser pens
- Animals
- Equipment that can record moving or still images (camera, web cameras)

Although CQC encourages secure services to adopt the least restrictive approach to IT items commensurate with the security requirements of the unit, secure mental health units may also prohibit:

- Mobile phones (though may be allowed in some rehabilitation low secure units)
- Computers, tablets, games devices with hard drives or sharing capabilities
- Items with voice recording capabilities
- Other items with enabled WiFi/internet capabilities
- Items considered as an escape aid

Restricted items

Restricted items are items where the access is controlled and may be directed according to policy and individual risk assessment. Examples of items that may fall into this category include:

- Disposable cigarette lighters
- Toiletries- aerosols, razors
- Identity documents, bank cards, items of stationery
- Cutlery, tinned materials, glassware

Risk assessments and personalised care related to restricted items

Access to items will depend on many factors, some of which may be fixed and others subject to change. The risk assessment and ensuing management of access to security items should take a procedural and individualised approach, where possible in collaboration with the patient, which avoids the implementation of unreasoned blanket bans. For items that may be considered suitable only for restricted use, staff

should complete a thorough risk assessment and provide the patient with a transparent rationale that explains the management outcome. A dynamic and personalised risk assessment considers:

1. **Personal risk:** individual's historical risk and current mental state
2. **Interpersonal risk:** direct risk to others- patients and staff
3. **Environmental risk:** ward dynamics; general service safety (level of security, rehabilitative/acute)
4. **A common sense consideration** of the item in question

Items can then be categorised:

GREEN- access to the item can be facilitated with a collaboratively formed care plan in place with the patient. A service may choose to have a standardised approach for the item which can then be adapted to the individual's need.

AMBER- with the information provided and risk assessment completed so far, it is inconclusive whether access to the item can be safely facilitated. Refer the issue for further assessment and discussion to the MDT/ward round or security liaison nurse.

RED- personalised risk assessment has determined that access to the item cannot be safely facilitated. The patient is provided with an explanation for the restriction, and if applicable a timeframe for when the access can be reviewed.

Appendix 3: Powers to monitor and intercept telephone calls and postal items in the High Security Hospitals (HSH)

The Benefits of Takeaway's

Presented by Moorlands View

Brings people together

Some takeaway's can be healti

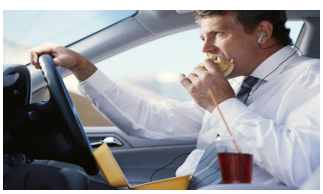
Quick, efficient and time effective

More cost effective

Can try food from different cultures

Keeps local businesses going

Can eat takeaways on the go



The negatives of Takeaway's

Empty calories

Unhealthy – lots of trans fats

Expensive

Weight gain

Digestive problems

Ingredient quality

Full of salt

Quality Network's Newsletter for Medium and Low Secure Care

This edition's theme is **least restrictive practices**. Articles on topic in relation to forensic mental healthcare, as well as any areas of good practice and how any challenges have been addressed, would be welcomed.

Yorkshire and Humber Reducing Restrictive Practice CQUIN Group

The CQUIN Workshops have been running in Yorkshire and Humber since January 2014. They are facilitated by 2 Involvement Leads that work across the whole Network and are open to staff and service users from the Network; which consists of all 16 NHS and Independent secure services within Yorkshire and Humber. They are also supported and attended by commissioners and case managers from NHS England. The groups follow the CQUIN's, which has included one around Reducing Restrictive Practice this year, and this will continue for a second year for 2017/18.

Each of the CQUIN's have a planning group made up of 2 or 3 lead services and service users and staff from those lead services attend and support the planning and facilitation of the workshops. The workshops take place on a quarterly basis in a central community venue.

The workshops are interactive, informal and fun. They consist of a mixture of presentations and group work which seeks to involve everyone to the extent they wish to get involved. The group work is facilitated in a fun and creative way which motivates and engages with everyone present – and with different ways for people to get involved. Each CQUIN group is planned, facilitated and run by ourselves as Involvement Leads alongside service users and staff from the lead services, ensuring it is accessible, relevant and inclusive to all.

There is around 50 – 60 people in attendance at the workshops.

The purpose of the workshops are to 'bring alive' the CQUIN's, to share best practice, and improve quality of services for everyone. They are a place for everyone to bring their challenges, solutions, progress and feedback to share with the group and to plan a way to move forward on each topic. It stretches people to the highest level as it is an opportunity to do all of these things, and together the movement is greater than if any one service was doing the work in isolation.

Following each meeting we put all of the information, the 'minutes' and pictures of any group work into a quarterly bulletin that is used to send out all the information to services so that they can share this amongst the service users and staff in an accessible format.

Some of the issues we have been looking at since it became a CQUIN have been around: the barriers to reducing restrictive practice, we had a quiz to look at reducing specific restrictive practices and to get everyone thinking about it in a practical way.

We had some group work thinking specifically about observations. We also looked at training in relation to reducing restrictive practice and we thought about outcome measures and how it is all evidenced. We looked at reducing restrictions around technology in the last meeting. We also finished the meeting by getting everyone to write down a New Year's Resolution about what they want to see change over the coming year. This will then be revisited next year to see what progress has been made. We have heard from lots of services and they all help to facilitate group work and present to the group about the progress in their services. Here are some quotes from the people that attend the CQUIN meetings about what they get from attending the meetings.

Meeting across different levels of security. Sharing ideas and best practice. Presenting hospital based initiatives. Build confidence. Talking about every day things that happen at different services. Seeing service users moving on through the services. A chance to have your say and voice your opinions. Time out meeting new people. Change the future. Sharing of ideas – neutral space. Getting to know other services. Service users being involved – collaborative working. Service users can see through things being implemented. Challenge the norm. Positive changes to people's lives. Ownership. Normalisation. Influence the CQUIN. Enjoyable. Peer support and direction – refocus. Contagious. Competitive. Service users benefit from conversations about reducing restrictive practice. Staff attitudes and culture spreads the word. Back up – everyone else is doing it. Sharing policies and procedures. Think about our own practice. Set regional and national standards. Pioneer in CQUINs. Reassurance – 'not alone' or when things don't go quite right. Reinforces support. Solutions to problems. Understand the reasons behind why changes are happening/CQUINs are put in place. Social aspect. Service user involvement. Yorkshire and the Humber is the best!

New ways of reporting CQUIN for the coming year

The following information is to give you notice that some of the key outcomes on the CQUIN schemes and the reporting processes will be changing for this year. The commissioners have been to the recent CQUIN workshops where they have given an overview of the changes to the reporting process.
As soon as the new outcomes for each CQUIN are announced then we will let you know, it should be within the next few weeks.

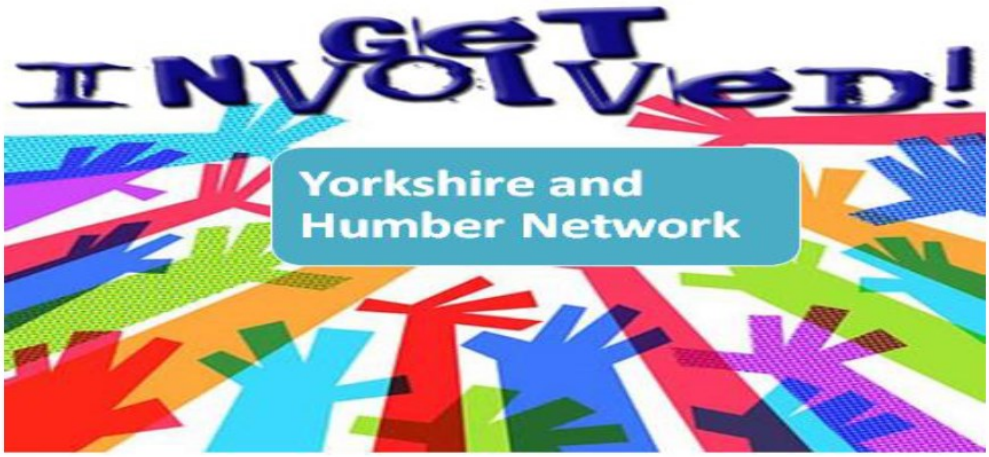
17-19 CQUIN Schemes and Reporting - Adult Secure Services

In 2016/17 the CQUIN schemes have been assessed for achievement based on the submission of quarterly reports by each provider, with the reports submitted in their own format. It has been identified by attending the CQUIN workshops hosted by the Y&H involvement team that there is more often than not a disconnect between the work undertaken by the staff and service users to deliver the CQUIN schemes and the paper based evidence reports. Therefore working with the service users and the involvement team we are changing the reporting process for the Adult Secure CQUINs in 2017/18 so that it is a more interactive and standardised process, which better reflects the work being carried out.

As we will have more capacity within the Specialised Mental Health team in regard to case managers than in previous years, it will also enable them to be more involved in engaging and monitoring the delivery of CQUIN together with the support of the involvement team.

A brief summary of the process for reporting the above CQUIN schemes is:

- Quarterly presentations delivered collaboratively by staff and service users. Presentation to be delivered at quarterly contract review meetings if possible within your service.
- Standardised reporting template developed by commissioner once the Year 2 outcome measures have been finalised. This will be a maximum A4 report which provides the audit trail evidence of the presentations. The report will not include any additional documents it is the back up to the presentation.
- Attendance at the CQUIN workshops with expectation of one presentation per year to be part of reporting.
- Case Managers to be more involved in monitoring.
- Achievement will be assessed based on the qualitative information from the presentations and the standardised supporting report.



Reducing Restrictive Practice CQUIN Group

Dates for 2017

Thursday 1st June

Thursday 14th September

Sandal Rugby Club Wakefield

2 – 4 pm - Refreshments Provided

Role Description for attending Yorkshire and Humber Network meetings:

Represent your service and share experiences and ideas

Celebrate achievements and share learning

Find out what is happening in other services

Give your perspective

Meet staff and service users from other services

Take back and share what you have learnt with people in your service