National Mental Health and Learning Disability Nurse Directors Forum

Influencing and advancing care in mental health and learning disabilities

LeadingMinds

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Leadership, Culture and Quality Improvement in Nursing

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At each conference we publish a newsletter which we use as an opportunity for sharing good practice, examples in the areas of work that senior nurses and nurse directors lead on.

Celebrating Inpatient Care; Delivering a Culture of Care and Safety

08.30-09.15 **Registration, coffee & sponsor stand**
Sponsored by Derbyshire Healthcare NHS Foundation Trust, Patchwork, Reliance Protect

09.15-09.25 **Welcome by Chair**
Carolyn Green | Deputy Chief Executive | Derbyshire Healthcare NHS FT.

09.25-09.45 **Safer staffing**
Ann Casey | Head of CNO Safer Staffing Faculty | NHS England.

09.45-10.05 **Ligature risk clinical safety standards for mental health inpatient settings – update**
Heather Caudle | Chief Nurse | Northern Care Alliance & Amy Davidson | Director of Nursing & Quality Fylde Network.

10.05-10.20 **Experiences of working with self-harm by ligature: a mixed-method survey of inpatient mental health services staff**
Samantha Groves | Research Assistant I Oxford Health NHS Foundation Trust.

10.20-10.45 **Sexual safety in mental health: an evidence-informed framework**
Dr David Francis Hunt | Research Lead | Oxford Healthcare Improvement (OHI) | Oxford Health NHS Foundation Trust.

10.45-11.05 **Reducing restrictive practice: innovation and standard practice**
Laura Pemberton | Divisional Director of Nursing and Allied Health Professionals | Portsmouth & South East Hampshire | Southern Health NHS Foundation Trust.

11.05-11.25 Panel questions from above speakers.

11.25-11.55 **Break**

11.55-12.05 **Review of therapeutic engagement & observation: a case study in leadership intervention on a quality improvement project**
Clare McAdam | Deputy Director of Nursing and Allied Professions | Devon Partnership NHS Trust.

12.05-12.35 **Acute care: safety and retention through competency**
Kyri Gregoriou | Deputy Director of Nursing and Quality Governance | Derbyshire Healthcare NHS Foundation Trust.

12.35-13.05 **"My, Safewards, haven't you grown!" (Delivering cultures of care and safety for (nearly) 10 years)**
Geoff Brennan | Safewards supervisor for Children and Young People's Project | King's College.

13.05-13.35 **Journey to, and experience of, Nurse AC on inpatient wards**
Jan McAdam and Matt Houhton | Nurse Consultant/Approved Clinician | Tees, Esk & Wear Valleys FT.

13.35-14.30 **Lunch**

14.30-14.40 **Safer staffing data**
Matthew Hammond (BSc, RMN) Trust Lead – Safer Staffing | Corporate Nursing | Nottinghamshire Healthcare Foundation Trust.

14.40-14.50 **Clinical practice educator: suicide prevention**
Ria Clarke | Band 7 | Oxford Health NHS Foundation Trust.

14.50-15.00 **Reducing restrictive practice: think person, think positive practice**
Laura Holt | Head of Nursing & Professional Practice (MH & LD) | Lancashire and South Cumbria NHS Foundation Trust.

15.00-15.10 **Using technology for observation, engagement and physical**
Nicole Vutabwarova | Assisant Director of Clinical Digital Practice | Derbyshire Healthcare NHS Foundation Trust.

15.10-15.20 **Vision-based observation policy guidelines**
Peter Hasler | Forum Development Officer.

15.20-15.30 **Closing comments**
Refreshments served.

Sharing good practice on inpatient care

"Today we are focusing on sharing good practice on inpatient care and I am looking forward to hearing from our clinical staff about the innovations they are leading."

When we were all last together, we focused on celebrating our services, teams and the effort and dedication demonstrated in supporting each other and services users through the Covid pandemic.

Today we are focusing on sharing good practice on inpatient care and I am looking forward to hearing from our clinical staff about the innovations they are leading. In the past 30 years we have seen Mental Health community services grow and innovate and the Transformation of Community services along with the MHIS is exciting and well overdue.

However, what about Mental Health inpatient services, I hear you say! What investment and innovation have we seen here? With the greater demand on Mental Health services since the pandemic most wards are working on 100% occupancy making them difficult environments to work in or receive care. Difficulties in recruiting Registered Nurses have been a focus on workforce planning and our programme of safer staffing has focused on keeping people safe. As we strive for safer staffing levels what about therapeutic staffing levels? It occurs to me this is something worth exploring more - what does good inpatient care look like in 2022?

We would expect this to be person-centred and recovery-focused care, delivered by highly trained and educated MDTs. MDTs that include people with lived experience, therapists, gym instructors etc.

Patients would describe this as an individualised care, developed with them and their families and include a variety of activities including psychological interventions, psychoeducational programmes, exercise, mindfulness etc. being delivered over 7 days a week. Of course, there would also be 1 to 1s with the full MDT digitally enabled all planned in an interactive care plan.

Then there is the environment, modern, bright, hopeful, no seclusion rooms, with exercise gyms, access to IT, cafe access to relaxing external environments and welcoming for family and visitors.

Then there are the staff, highly educated, kind, dedicated, proud, respectful and valued!

Looking forward to the discussion today, enjoy the conference everyone and see you later.

Maria Nelligan

Chief Nurse and Quality Officer
Director of Infection Prevention and Control (DIPC)

Safety for recovery: engaging recovery in the context and constraints of risk management

The following is an outline of initial findings from a PhD qualitative study, interviewing patients to understand how recovery is engaged in the context and constraints of risk management within an acute mental health hospital. Recovery includes personal ways to foster a meaningful life despite mental illness, and may lessen risks via enriching desires to live, while risk management aims to minimise risks such as suicide and violence. The study is part of a growing critique about the impact of risk management on patient care. This involves questioning how risk management practices such as physical restraint and excluding patient views from risk assessments mitigates risk and improves mental health, with the suggestion that recovery and risk management are incompatible because of paternalistic practices.

Findings so far show the importance of considering recovery when patients are first admitted. The hospital environment can be confusing, exacerbated by poor mental health, alongside fears about staff and patient intentions. A central theme emerging from the study is a vicarious relatedness that can come from positive relations. Relatedness is more than connecting to another, it involves relating to the new environment, participation and understanding of interventions including risk assessment and to begin scaffolding recovery relatable to the person, including an acceptance of views about the world despite being potentially hampered by illness. It is a period we call "treating me safely" when the person is assisted to make sense of their new environment alongside care, acknowledging and assisting with distress rather than question the validity of the distressing experiences.

Other findings involve grounding to settle the mind, activities that again are relatable to the person, and appears a response to the unsettling atmosphere of acute wards, involving a sense of foreboding that something unpleasant can happen at any minute. Relatedness also concerns lessening separation between the outside world that the patient finds important. These are connections that help recovery, yet are threatening if not acknowledged

Kris Deering
PhD Researcher, DipHe Nursing (RMN), BSc Inpatient Mental Health Care, MSc, PGCert Ed, PGCert Research. Senior Lecturer & Researcher in Mental Health Nursing: Exeter University.

by the clinical team. Notably, maintaining links to significant others, work, financial support and advocacy. In terms of advocacy, staff seek support from people the patient can relate to, seemingly as they had a better understanding of patient views to lessen their distress.

Relatedness appears applicable also to language in that risk terms can be derogatory to some, and meaningful for others, while safety appears a term most interviewees found relatable, as to build up safety appears more attainable than lessening risk behaviours, especially if not aware of clinical risk concerns. Another important finding is building hope, informed by the person relating to themselves in terms of understanding possibilities, hence sits with the scaffolding of recovery. Hope requires to be tangible, based on things relatable to the patient drawing on recent events showing progress relevant to their life.

Essentially, findings suggest aiding patient sense-making when first admitted is beneficial, and while data continues to be gathered, sense-making appears vital to commence engaging recovery despite the possibility of risk management constraints.

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Mental Health Nurses and the Mental Health Act

Our voice against inequality

"Now is the time to raise our voices again in our local communities, and, with colleagues and partners, bring about the changes that would lead to the equitable use of the Mental Health Act."

As mental health nurses, we have always had a voice in supporting the rights and civil liberties of people with mental illness.

Over the past century mental health legislation has been reviewed every 20 – 25 years, with a slow move towards increasing the rights of people subject to legal restrictions because of their illness.

Between 2006 and 2016 the number of detentions rose by 40% and England was detaining tens of thousands of people each year. The most recent Mental Health Act review reported to government in 2018. This review reported profound inequalities for people from ethnic minority groups in terms of access to treatment, experience of care and quality of outcomes. Black people were also over four times more likely to be detained under the act and over ten times more likely to be subject to a Community Treatment Order.

In June 2019, the government pledged to introduce a new Patient and Carer Race Equality Framework (PCREF), as recommended by the Mental Health Act review. The PCREF consists of three core components:

- It sets out national expectations on all mental health trusts in fulfilling their statutory duties under core pieces of legislation, such as the Health and Social Care Act, and the Equalities Act.
- It includes a competency framework to support trusts to improve patient and carer experience for ethnic minorities.
- Patient and carers feedback mechanisms should be established to embed patient and carer voice at the heart of the planning, implementation and learning cycle.

Each mental health trust will in time have its own PCREF.

Our statistics for 2020/2021 show the inequality has grown further. People from black communities are now nearly five times more likely to be subject to mental health legislation.

Across the mental health community, concern remains, particularly when seeing an increase in inequity. Over the past two years a number of additional interventions have been recommended to support the impact of PCREF.

- We need to think about mental health promotion and early interventions. There are real issues about young black people being excluded from school, beginning to experience educational and social disadvantage at a very early age and the increased likelihood of these disadvantages adversely affecting the young person's mental health. In terms of our NHS mental health services, there are concerns that many of

"People from black communities are now nearly five times more likely to be subject to mental health legislation."

these young people are not being referred to our CAMHS, EIP and IAPT services.

- We need to develop much more culturally sensitive services. On an individual basis, this is about culturally sensitive assessments and care. At the level of community, it is about knowing the characteristics of the communities we try to support, the ways we communicate with this community and enable access to advice and intervention
- There is a clear link with use of restrictive practices, particularly for young black men, and those men having a very poor experience of mental health services, and understandably disengaging when discharged from hospital and being reluctant to contact mental health services in the future
- Using Advance Statements more in mental health, a general preference about your treatment and care
- Data and intelligence is featuring highly; needing local data about the use of the Mental Health Act and tribunals.
- In terms of research, we have a long way to go in terms of delivering culturally sensitive services and there is concern about diagnosing black men with the diagnosis of psychosis.
- The idea about trusts or local areas being 'exemplars' of good practice is regarded as a very good way to show it can be done ... and the opposite.
- Knowing which areas are doing badly with the disproportionate use of the Mental Health Act was also seen as part of the solution.
- There is agreement that we need to bring together the strands of work that are happening currently regarding black and ethnic minority communities, and as a few people are saying ... create a unified movement!
- There is agreement that 'health' shouldn't be addressing this alone, and the acknowledgement that police and social work colleagues should be engaged and involved.
- Revisions to the Mental Health Act Code of Practice, particularly regarding culturally appropriate application of the act is recommended.
- Setting a national date for the equitable use of the Mental Health Act is getting some interest.

Now is the time to raise our voices again in our local communities, and, with colleagues and partners, bring about the changes that would lead to the equitable use of the Mental Health Act.

If you are interested, do contact - **Seamus.watson@nhs.net**

Seamus Watson
National Improvement Director, NHS England

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Review of therapeutic engagement and observation: a case study in leadership intervention on a quality improvement project

What we did...

A working group of RMN's from a variety of our inpatient wards signed up to six sessions to share reflections on the existing engagement and observation policy, current clinical practice, what worked well/didn't work so well, latest guidance/ research and their ideas, all important steps towards initiating a PDSA change cycle.

The work was led by the Deputy Director of Nursing and a highly experienced Senior Nurse, both of their approaches combined gave leadership, direction, facilitated engagement with staff and co-production in the development of the new policy and its implementation. Through the six sessions, ideas were shared, translated into practice language and new documentation developed that were patient focused with co-production throughout. This was an important element for the group. We wanted to explore patient experience of being on engagement and observation levels, how could we create a more collaborative approach with patients and inclusive of their carers too?

The Trust had several actions we needed to incorporate in the policy from coroner's enquiries, Root Cause Analysis recommendations and CQC action plans – the themes were similar in nature but required embedding into our revised policy, woven into clinical practice guidance with a clear expectation of staff roles in engagement and observation, standards of recording and the relational element of this important clinical practice.

How we implemented the change...

The language of observation was changed from 'levels 1,2,3' to 'low level intermittent, medium level intermittent, and high continuous/ multi-professional'. We brought patient involvement to the top of every new engagement and observation document – what was their understanding of their observation levels, any support they needed on that day etc. In terms of the actual observations we moved from timed 15,30,60 minute observations to variable and less predictable observations e.g. 6 times in one hour. We also asked staff to document each individual patient's mental wellbeing, nutrition, physical wellbeing, nature of interactions etc rather than where they were on the ward.

"The Trust had several actions we needed to incorporate in the policy from coroner's enquiries, Root Cause Analysis recommendations and CQC action plans."

We piloted the new policy on a small number of wards and used the insights to further adapt the policy and documentation. Once the final documents and policy were formed we developed a co-produced patient leaflet for each level of observation. We added a competency assessment, this required every staff member working on an inpatient ward to have either a 1;1 session with their manager or join a facilitated group session learning about the new policy, with opportunity to engage in discussion and explore scenarios.

Lastly we developed an audit tool for ward managers to use to assure embeddedness of the revised policy – the experienced Senior Nurse working on the initiative undertook this task initially for 6 months, this meant she could pick up practice issues, provide guidance and explore challenges raised by staff. The audit process was then handed over to local ward managers and practice leads for local ownership.

An evaluation of the policy will be our next step with more learning, understanding of patient experience, how we provide and assure high quality, safe clinical practice.

Clare McAdam

Deputy Director of Nursing and Allied Professions at Devon Partnership NHS Trust.

Experiences of working with self-harm by ligature: a mixed-method survey of inpatient mental health services staff

Samantha Groves (presenter), Karen Lascelles, Linda Hill, Keith Hawton

Background

Self-harm by ligature is a common and dangerous form of self-harm within inpatient mental health settings in England. Despite national concerns, there has been little research examining the experiences and impact that working with this type of self-harm has on associated staff.

Aims

To explore the experiences of staff members regarding working in inpatient settings where self-harm by ligature may occur.

Methods

A mixed-methods online survey was developed and disseminated via multiple recruitment methods, including promotion by healthcare organisations, universities, and professional networks. Content included exploration of current context of working with self-harm by ligature, barriers and facilitators to managing risk and responding, training and support needs of staff, and the impact that this work has on staff members. Quantitative data was analysed using descriptive statistics, and qualitative data using the framework approach.

Results

Data was collected from over 250 staff members and students working within inpatient mental health services. Participants had diverse experiences of working with self-harm by ligature, with large proportions identifying specific challenges to managing risk and responding, for example, staffing

pressures, contagion and staff attitudes. Anxiety and trauma of witnessing self-harm by ligature was frequently acknowledged, including anxiety surrounding observations, worry about blame, and the possibility of being called to an inquest. Reporting of training and support received in relation to self-harm by ligature varied, but with many respondents stating these needed to be improved. Suggestions for improvement included the need for a consistent approach within and across healthcare organisations, and acknowledgement of the emotional support that staff may need.

Discussion

Results of the study highlighted the challenges faced by inpatient mental healthcare staff regarding working with self-harm by ligature, alongside the significant emotional impact, both short and long-term, that this manner of work may have on staff members. Perceptions about and suggestions to improve training and support were identified by staff members.

Conclusions

There is a need for support and training to both prepare staff members for managing the risk of and responding to self-harm by ligature and provide appropriate support for all staff members involved in responding to ligature incidents.

Professional biography

Samantha Groves is a research assistant working at Oxford Health NHS Foundation Trust on projects related to suicide and self-harm. This includes exploring suicide and self-harm among nurses and midwives, alongside exploring the experiences of staff working within inpatient mental health services who work with patients who self-harm.

Samantha Groves

Research Assistant, Oxford Health NHS Foundation Trust

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Reducing restrictive practice: 'think person, think positive practice'

Delivering person-centred care within a therapeutic environment is key to contemporary Mental Health services. As such, LSCft identified the need to focus on reducing restrictive practices (RRP) to ensure service users experienced compassionate and safe care. Therefore, a RRP Strategy and QI Collaborative was launched. Working collaboratively with service users, the Ward MDTs, RRP and QI Teams, achieved a 49% decrease in restrictive practices (restraint, seclusion and rapid tranquillisation), across all wards. Executive sponsorship and developing policy, practice and training to support RRP has been key in upskilling staff and moving to a least restrictive culture.

LSCft is a large Mental Health (MH) and Learning Disability Trust providing MH in-patient care across 42 wards. Following a CQC inspection in 2019, the Trust has had significant changes in executive and senior leadership. Through these changes, in early 2020, it was identified that there was a lack of focus on Reducing Restrictive Practices (RRP). Furthermore, NHS Benchmarking, for 2018/19, demonstrated the Trust was the 2nd highest user of restraint in Older Adults, 5th highest user for Adult Acute and 11th highest user in PICUs across 71 organisations nationally. Additionally, anecdotal benchmarking demonstrated high use of restrictive practices in general.

As a result, a RRP 3-year strategy was developed and launched in June 2020. The 'Patient Safety Team' consisted of the RRP Team, the QI Team and Ward Teams. Stakeholders included service users, Network Senior Leaders and Senior Nurse Leaders, with executive sponsorship from the Chief Nurse & Quality Officer. The RRP Strategy was implemented through various workstreams including:

- implementing Safewards
- moving to a model of positive behavioural approaches
- refreshing Positive & Safe (PaS) Training to meet Restraint Reduction Network standards
- working towards BILD accreditation for PaS
- engaging 6 wards in the AQuA Restraint Reduction 90-day QI programme
- developing and implementing a 2-year RRP QI collaborative

As expected, when NHS Benchmarking for 2019/20 was published in autumn 2020, the Trust remained an outlier in the use of restraint nationally.

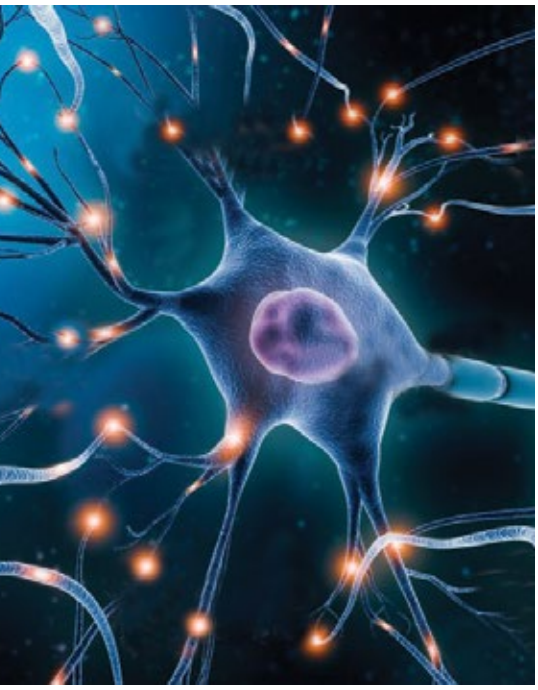
As part of the RRP strategy, a 2-year QI RRP Collaborative was launched in September 2020 with 18 wards involved. The aim of the collaborative was to reduce restrictive practices (restraint, seclusion and RT) by 33% across the Trust in 2 years.

Progress is monitored monthly at team level, with RRP and QI colleagues meeting with Ward MDTs. There

are quarterly Shared Learning Sessions and an Expert Faculty meeting to address any issues. As the collaborative has progressed staff's knowledge and skills, and use of evidence based practice in relation to RRP, has developed and evolved.

Improvement is also monitored monthly through Trust Performance and quarterly through the RRP Group, Patient Safety & Effectiveness Sub-Committee, Quality Committee, then through to Trust Board. The last published NHS Benchmarking for 2020/21, early into the RRP strategy implementation, demonstrated solid progress with moving to 18th highest user of restraint in Older Adults, 31st highest user for Adult Acute and 13th highest user in PICUs. Furthermore, RRP has reduced significantly since then.

We are
kind • a team • respectful • always learning
We are LSCft



At the end of Q4 2021/22, 18 months into the 2-year collaborative, the 18 ward teams involved have surpassed the target of achieving a 33% reduction in restrictive practices (restraint, seclusion and RT) achieving a 52% combined reduction compared to the baseline. Each ward focused one specific area of restrictive practices and the restraint reduction wards achieved a 59% reduction in restraint, the seclusion reduction wards achieved a 34% reduction in seclusion and the RT reduction wards achieved a 64% reduction in RT.

Across the Trust, through the implementation of the RRP Strategy and learning from the QI collaborative there has been a 49% combined reduction in restrictive practices, at the end of Q4 2021/22, compared to the baseline.

Restraint, Seclusion and RT are all interventions that carry a level of risk to patient safety. The Mental Health Units (Use of Force) Act (2018) states that **'The use of force always comes with risk and can be a traumatic and upsetting experience for patients when they are at their most vulnerable and in need of safe and compassionate care'**. Furthermore, restraint carries the risk of physical injury to both service users and staff and can have fatal consequences. In MINDs **'Mental health crisis care: physical restraint in crisis'** 2013 report, it was highlighted that since Rocky Bennett's death in 1998, there had been at least 13 restraint-related deaths of people detained under the Mental Health Act. The reduction in restraint across all wards has resulted in 1826 fewer physical restraints reducing the risk of injury, or death, to service users.

A systematic review by Chieze et al (2019), found that seclusion and restraint have harmful physical or psychological consequences. This is particularly concerning for service users with past traumatic experiences. Furthermore, service users perception of seclusion was largely negative and distressful and had connotations of punishment and helplessness. Therefore, the 170 fewer seclusion episodes, achieved across the Trust by the implementation of the RRP work and QI collaborative, have reduced the risk of such harmful impacts to service users.

Also of note, people with mental ill-health are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of rapid tranquillisation (NICE Guidance, 2017). Therefore patient safety has been improved through reducing such risks by achieving 392 fewer episodes of RT across all wards.

A further 11 wards joined the RRP QI collaborative in September 2021, these and all other wards in the Trust, were already engaging with the RRP Strategy through the various workstreams. Additionally, the learning from the original 18 wards QI projects has continually been shared across the Trust throughout the QI collaborative and through the Ward Manager & Matrons Forum and other bespoke events.

As a result, across all wards, the aim to reduce restrictive practices by 33% in 2 years, has been surpassed. At the end of Q4 2021/22, there has been a 49% combined reduction in RRP across all wards compared to baseline. For the 3 separate measures, there has been a 66% reduction in restraint, 35% reduction in seclusion episodes and a 47% reduction in RT.

To implement and embed the RRP strategy, there has been a focus on policy, practice and training to ensure that staff have the right underpinning knowledge and skills to provide a solid foundation to progressing the strategy. This has supported the QI collaborative and also enabled the

learning from the QI collaborative to be shared. This has included:

- Reviewing and updating policies and procedures related to restrictive practices; including Blanket Restrictions, Mental Health Therapeutic Observations, Seclusion & Long Term Segregation, Management of Behaviour that Challenges and Searching Service Users.
- Implementing Safewards across the Trust to improve the therapeutic environment and reduce conflict.
- Reviewing and updating the PaS training programme to ensure compliance with the Restraint Reduction Network Standards and the MH Unit (Use of Force) Act (2018) and progressing towards BILD accreditation.
- Rolling out a new model of care through training in positive psychological approaches to manage behaviours that challenge. This provides multi-disciplinary teams with an evidence based framework to underpin care. This is a 3–day programme and although COVID has impacted on the pace of the roll-out, so far 14 adult acute & PICUs and 2 OA wards have completed the training; the remaining wards are scheduled to be completed by Q2 2022/23.
- Holding bespoke events to promote RRP and the QI collaborative such as a:
  - o Ward Away Day where Aji Lewis (mother of Seni Lewis) presented alongside Geoff Brennan, Safewards Clinical Supervisor
  - o Seclusion Workshop, where the CNO launched the Seclusion Best Practice Group

Executive level support and continual oversight and monitoring has supported the implementation, embedding and spreading of the RRP Strategy.

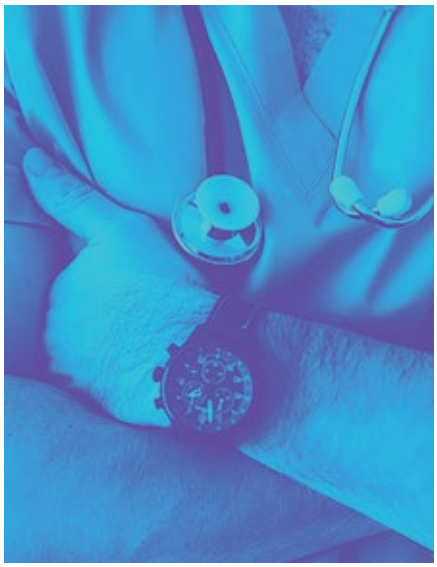
The impact the RRP Strategy has had on patient experience has been significant as restrictive practices can have harmful physical and psychological effects. Achieving a 49% reduction in RRP across the Trust has ensured a solid foundation in ensuring that service users receive compassionate person-centred care as we continue to reduce restrictive practices further. The QI collaborative has included a huge focus on meaningful activities on wards to promote a recovery-focused therapeutic environment which both service users and ward staff have enthusiastically engaged with. The feedback from our improving therapeutic environments and the impact on service users is regularly shared by wards (anonymously) on twitter with feedback including:

'Thanks to all the amazing staff here at Ribble ward. I couldn't have imagined that I could feel good again and looking forward to the future. Thank you for putting up with my moods and seeing the good in me. I feel like I have found a part of myself again.' Service User, Ribble Ward https://twitter.com/chrissy4ster/status/1396838657445748737

'Thank you for all the care and support I have received on this admission. I have felt listened to, understood and included in making decisions about my treatment. The staff have been really supportive and have been there to talk to when needed.' Service User, Edisford Ward https://twitter.com/MeganCunliffe2/status/1509872155521175612

'Over the past week the ladies on @WardShakespeare have been getting creative and working hard to create some positive and motivational recovery boards to display on the ward and they look fantastic!' Adele Barker, Shakespeare WM https://twitter.com/adelebarker_x/status/1483886552128311304

Additionally, on recent Ward Accreditation assessments, the lived experience reviewer commented that **'The personal reassurance I got from actually seeing the treatment of the patients was huge'**. Furthermore, a



"The impact the RRP Strategy has had on patient experience has been significant as restrictive practices can have harmful physical and psychological effects."

carer on another accreditation visit, gave positive feedback on the impact of the RRP work compared to their previous experience visiting a relative.

The RRP project has also had a positive impact on staff. Despite the challenges of COVID over the past 2 years, staff have been engaged and dedicated to this improvement work. Working in environments that are increasingly therapeutic and person-centred, improves staff experience as well as service user experience. Moreover, in line with evidence based practice, reducing restrictive practices has reduced physical aggression towards staff by 13%.

As the RRP Strategy implementation and QI Collaborative continue to progress, a greater focus is planned on how the therapeutic environment will reduce the need for additional staffing, thus reducing ward spend.

As staff have developed their RRP knowledge and skills, there is increasing involvement with service users, both individually and through groups. At an individual level, person-centred care has been promoted through the RRP work, below is an example of how this has positively influenced patient safety, patient experience and staff experience:

'A male service user had a significant history of MH inpatient admissions and custodial sentences. The service user has significant experience of physical restraint in these settings and his experience of these was traumatic. Working collaboratively with the service user, he identified the circumstances where, when he is becoming distressed, if male staff approach, this provokes a flight or fight response and his response is to fight. When this was explored further, he was able to identify that he responds more positively to female staff and has never assaulted female staff. Therefore, it is safer for the service user and staff to have female staff interact with him if he is becoming distressed. As a result, a person-centred care plan was written collaboratively, identifying the need for a female only response team in such circumstances. Following the implementation of this there have been no further incidents that escalated to physical restraint.' Worden Ward, WM

At a group level, service users involvement has also increased from small projects to designing the ward environment as outlined below:

'Seeing this project come to life (relaxation room) has been such a pleasure. Our ladies chose the design in our ward meetings and had so much input on the final design. I can't wait to see this room used to promote RRP.' Emily Richardson, Duxbury WM https://twitter.com/Emily_RMN/status/1514309319835148299

'Thankyou to #Wordenward for the idea. Our Mutual Expectations surrounding living with dementia which includes some of their favourite activities and day to day living.' Bronte Ward https://twitter.com/BronteWard01/status/1507004556571398156

Service Users and the MDT are involved in the QI Collaborative and RRP, both at a strategic and local level. With representatives from both on the RRP Group and wide scale involvement in designing the QI tests of change. Given the nationally reported disproportionate use of restrictive practices with service users from the BAME community, we have also developed a BAME service user and carer group.

Finally, over the past 2 years, the RRP and QI work has enabled staff to raise concerns with regards to restrictive practices as knowledge and understanding in this area has been increased.

Laura Holt (was Holdcroft)
Head of Nursing & Professional Practice (MH & LD)

Safer staffing data: Nottinghamshire Healthcare NHS Foundation Trust

Matthew Hammond (BSc, RMN)
Trust Lead – Safer Staffing
Corporate Nursing
Nottinghamshire Healthcare
Foundation Trust

Within Nottinghamshire Healthcare NHS Foundation Trust, our ambition is to deliver staffing within our services which are Safe, Effective and Sustainable. A key area identified following a Gap Analysis of our governance frameworks was the lack of useful data associated with Staffing and the inability to triangulate such data with other safety and quality measures. As such, a programme of work was developed within the trust to identify ways in which data could be collated and used to support Safe Staffing within the inpatient areas.

The Heads of Nursing, Associate Directors of Nursing and Trust Lead of Safer Staffing began this work within the Trust Wide Safer Staffing Group. Some of the challenges identified early on were the difficulty in quantifying the relational aspects of Safety within mental health wards, such as the skill mix, patient mix and the feel of a ward. Similarly, it was identified that there was very little evidence base to support 'Nurse Sensitive Indicators' within mental health wards, as most research associated with Safe Staffing is Acute Hospital based and the mental health specific research providing being sparce. Additional challenges were identified within the Trust itself, due to the wide verity of services covering, acute mental health, older people's mental health, CAMHS, Perinatal, Low Secure, Medium Secure and High Secure and the onset of the COVID Pandemic (and the redeployment of some corporate staff).

The group, none the less, developed a longitudinal dashboard using data which was already in existence (so no new data was needed to be collected from the wards), supported by the performance and applied informatics department, looking at monthly overviews of Staffing Information, Safety Data, Quality Data, E-Roster Data and Workforce Data. This work has since progressed to allow a day-by-day view of staffing and safety data to allow a greater level of triangulation.

This data is now being reviewed monthly within the trust-wide safer staffing group. Areas to note or 'Hot Spot' wards identified are reviewed in detail alongside a ward level narrative around how the ward has been and how it has felt, to provide effective oversight, assurance, and escalation processes around Safe Staffing within the inpatient areas. Moving forward, additional work is being undertaken to provide a greater sense of the patient's voice within this process outside of using complaints information. Alongside this work, the greater challenge is to support the use of the data effectively from Ward to Board.

Changing culture across MH: developing inclusivity and civility in teams across Somerset Foundation Trust

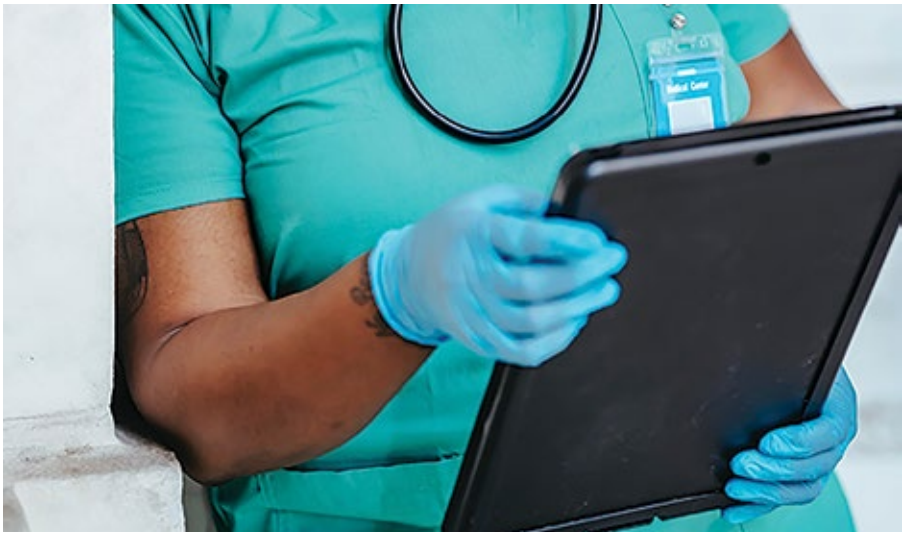
Somerset Foundation Trust have been extremely successful in recruiting international nurses to our Mental Health wards, but following on from data received from the staff survey of 2021, as well as concerns from staff including the freedom to speak up guardian, we decided to bring these issues to the top of our agenda and created a new 'Culture, Civility and Inclusion' group where these areas can be discussed openly, to try to develop a culture where uncivil behaviour can be challenged, and where our staff can feel safe and supported in their work and lives in our community.

Our area has been historically less multi-cultural and diverse than other areas, and our new colleagues are contributing to changes in demographics across the whole community, and we welcome this. However, some of this group faced, and still face, challenges from others in accepting and understanding that we are now a more diverse workforce.

The group has taken some time to focus; one important aspect of the group is that we are keen to learn from our mistakes, and that we can challenge each other in our behaviours to ensure that we model to others a civil and inclusive leadership team, and we recognise the importance of creating a safe place for reflection, questioning and discussion to look in detail at topic areas. We will shortly be conducting listening events across our teams so we can look in more detail about what really matters to colleagues, and involve them from the start in developing actions to ensure that change, when needed, is made.

Cultural influencers across the directorate were identified, and the group consists of senior nurses, psychologists, recovery partners, our head of inclusion and our HR people partner, all of whom have committed to making changes, being informed by what we are told by our colleagues, and by introducing support to all, regardless of job title or background. The group is further supported by an extensive OD team who are able to offer rapid bespoke training to our teams when needed.

The group hopes that by openly discussing and responding to the new changes, we may develop a culture across the directorate which continues to cherish each individual staff member and patient and to make discrimination of any kind a never event. By doing this, we will become the exemplar across the wider merged Trust for others to use our experiences, so that we all can learn together to continue make Somerset Foundation Trust a dynamic, respectful, kind and safe place to work and be cared for.



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LeadingMinds

Improving the experience of therapeutic engagement and observations

ELFT has focused on improving supportive observations over recent years and have continued to see a significant number of incidents where observations have been implicated. We have had a cluster that showed that observation practice was not constant and on these occasions practice fell below expected standards impacting on patient safety.

As part of understanding the challenges and hoping to engage staff and service users in making this therapeutic, we have tasked local services to review their current systems of work to include environmental and human factors that impact on observations being successfully undertaken. We have also acknowledged that the focus of observations has shifted to visibility rather than engagement.

Over a number of years alongside other inpatient safety agendas, we looked at and had a number of initiatives in this area and joined national initiatives with other organisations to try to solve this knotty problem, despite which this practice remained stubbly unchanged.

We have again adopted a QI approach to improving observations with the main aim of the work focusing on **Therapeutic Engagement and Observations**.

In September our CNO/ Deputy CEO facilitated a workshop for staff across all directorates to acknowledge the challenge and complexity of this issue. Teams were invited to share their experiences and proposed solutions, with each directorate formulating their own Fishbone Diagrams to feed into their QI Driver Diagrams to progress work locally. The session had representation from all disciplines and service user representation. We engaged colleagues from City University to share current research on therapeutic engagement and observations.

"The review has engaged staff on the wards to identify themes in their experience of factors inhibiting their ability to carry out observations."

The difference in this initiative is the investment in understanding local challenges, engaging wider MDT in thinking about challenges and solutions and gaining the service user experience and expectations of observations. Our focus as part of the improvement is resurrecting the therapeutic engagement element that comes with observations.

The process each team has already undertaken has included a review of the existing systems, environments and experiences of people to inform the change ideas. We have looked at the adherence to Policy on Observations and introduced daily online audit tools to enable spot checks, audits of observation records and annotations for reasons when observations are not completed. The review has engaged staff on the wards to identify themes in their experience of factors inhibiting their ability to carry out observations. This has allowed for 'live' systems that support early learning that will lead to a refined group of change ideas to be tested and promoting spread and evaluation.

There is a real focus on safety discussions and local areas have adopted safety huddles that include staff across the MDT and offer protected time to talk about safety incidents, observation audit findings and generate discussion. Our presentation on the day will demonstrate how some of this foundation work has been interpreted and implemented by one locality team (Newham journey) to understand their challenges around therapeutic engagement observations and informed their QI process.

" The difference in this initiative is the investment in understanding local challenges, engaging wider MDT in thinking about challenges and solutions and gaining the service user experience and expectations of observations."

Claire McKenna
Director of Nursing

Sasha Singh
Director of Nursing (MH London)

George Chingosho
Lead Nurse, Newham Centre for Mental Health, East London NHS Foundation Trust

Shifting beyond suicide risk prediction to safer care of mental health service users

Suicide risk assessment is part of all mental health nurses' daily routine. However, the myriad approaches to assessment across services, e.g. different risk assessment tools and varied electronic notes packages, mean that practice can be inconsistent and in cases driven by systems rather than evidence and best practice. Whilst stratification of risk into low, medium or high for purposes of prediction and use of risk algorithms to determine care delivery was advised against in the 2011 NICE guidance for the assessment and management of self-harm, the reinforcement of this message in the revised 2022 version has stimulated national dialogue across the country regarding the best approach to this fundamental and complex aspect of care.

We published a multidisciplinary article, which included service user involvement, to urge a shift from static and predictive approaches to suicide risk assessment towards individualised and therapeutic assessment, formulation and management, with an emphasis on safety. In this article we highlight the evidence that risk prediction does not work, and research illuminating pitfalls we can unwittingly experience as clinicians, such as framing questions to elicit a negative response to avoid disclosure of suicidal thoughts or intent. We note that service users do not mind being asked difficult questions providing they are asked with thoughtful curiosity and tailored to the individual rather than recited from a proforma.

We argue that all mental health service users should be recognised as vulnerable. We believe we should gather information from all patients about factors which might lead

to emotional and psychological distress, and therefore potentially suicidal thoughts and behaviours. By exploring and assimilating predisposing, modifiable, future and protective factors in collaboration with the patient, and ideally a family

Reference to paper:

Hawton K, Lascelles K, Pitman A, Gilbert S, Silverman M (2022).

Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management.

Lancet Psychiatry, August 8 doi: https://doi.org/10.1016/S2215-0366(22)00232-2

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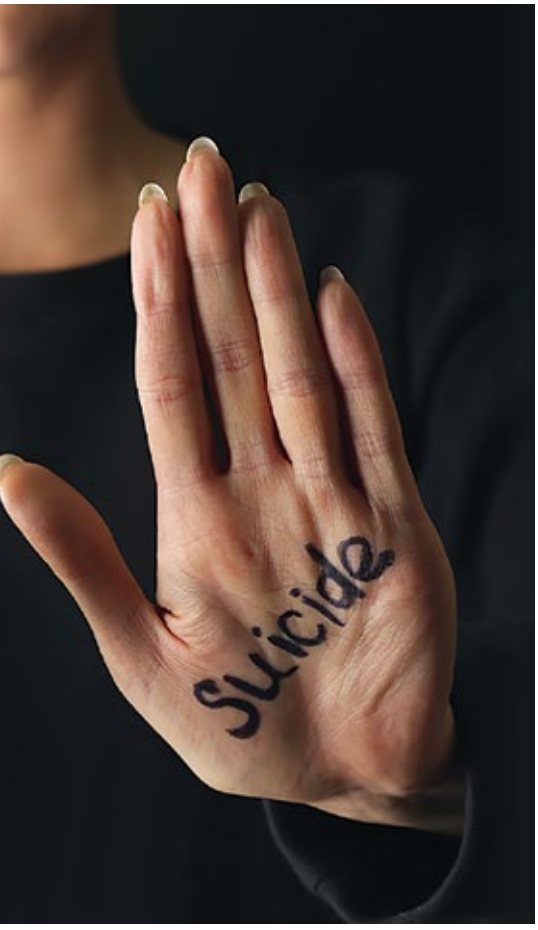
member or carer, we can achieve an individualised formulation and a greater understanding of the persons' needs and what might help them. Thus, risk management and safety plans will be more comprehensive and useful to the service user.



What we haven't done is eliminate the word 'risk assessment', which some may argue should be the case. There should certainly be a shift from 'risk attitude' to 'safety attitude', but are we ready for the colossal change in lexicon abandonment that 'risk assessment' might bring?

My own reasoning is that patients and clinicians will not be helped by simply replacing the work 'risk' with the word 'safety', but we can work towards a meaningful transition from risk to safety by ensuring our practice and clinical dialogue around risk assessment is focused on what will benefit the patient and has safety at its core.

NHSE is leading on a review of the 2007 DoH Best Practice in Managing Risk document, which will address all aspects of risk and offer guidance to mental health services. We hope we have produced a helpful and practical paper and that it can inform the much needed work NHSE is leading. The paper is not open access but if you would like a copy please email: karen.lascelles@oxfordhealth.nhs.uk

A role that was not directly clinical could help their development as a more insightful nurse. The ability to look wider than oneself and to work collaboratively was an asset to the experience.

The placement was delivered over eight weeks and involved traditional practice assessor oversight within a placement hub. 'Spoke' opportunities were offered with various teams within the corporate infrastructure, and this was determined jointly with the student to address their specific learning needs. A student's placement hub could be with the safeguarding team, for example, but they could get 'spoke' experience shadowing/working alongside the Deputy Director of Nursing.

This venture was not without challenge, as the students initially found it hard to grasp how a corporate placement would benefit them. In addition, they were working at home much of the time and so needed a lot of support orientating to their online meetings.

As a corporate nursing and quality team, we are committed to providing the future workforce with opportunity and challenge. Typically, students would not be involved at this level and are often not privy to the tremendous amount of work that goes on 'behind the scenes' when delivering high quality patient-centred care. We wanted them to be immersed in the governance support systems that provide guidance to the frontline services with which they were familiar.

We feel this placement was an exciting first step in bridging the gap between delivering care on the frontline and delivering care at a strategic level. This placement provided a positive example of rising to the challenge of student facilitation during COVID-19 and provided an opportunity for involvement in a dynamic and tactical environment. Students gained first-hand knowledge of how services pull together and function in a crisis and, in addition, the purpose of the corporate nursing and quality team. The students evaluated the placement well, and it is hoped that this experience will motivate and enable those students to become the nursing leaders of tomorrow.

Practice example: National Mental Health and Learning Disability Nurse Directors Forum

Subject: Developing an Independent Health Providers Safeguarding Forum.

Body:

Independent health provider Safeguarding Leads are typically not encouraged to share experiences with their peers across the sector; colleagues can often feel isolated and under pressures that NHS counterparts do not experience where an entire architecture of support networks exist. Getting the safeguarding response right improves patient safety both in preventative safeguarding work and in the response to patient safety incidents where further actions are required to minimise future risk.

Typically, providers are considered to be in competition with each other - it is rare that providers come together to share learning and explore these challenges. The Head of Safeguarding for Cygnet Healthcare, Phil Winterbottom, who is an active member of the NHSE Safeguarding Adults Network, found himself positioned by NHSE as the representative for the independent sector in a number of meetings including the national NHS Liberty Protection Safeguards Clinical Reference Group. Phil introduced the Head of Safeguarding for HCRG to these forums to provide a wider representation of the sector. However, to represent the sector, you need to be able to communicate with the sector and escalate their needs upwards in addition to sharing the NHS messages.

Phil began working for Cygnet Health Care in January 2022 where he was supported to progress this idea. Having faced challenges due to anxieties regarding potential commercial sensitivity in previous roles when suggesting setting up a network or forum, Cygnet's Director of Nursing (who has similarly commenced the new Mental Health Patient Safety Network with Pennine Care NHS Foundation Trust and the NMHLD Nurse Directors Forum) role modelled and supported the idea.

Phil worked with members of the NHSE National Safeguarding team to develop the Terms of Reference, ensuring that (whilst not formally part of the NHS safeguarding architecture) the new forum feeds up to the Safeguarding Adults National Network on quarterly basis and has direct access to the national team. These were jointly signed off by NHSE and Forum members in the first meeting which was successfully convened on October 5th 2022.

New members represented the four biggest independent mental health providers in the UK, physical health and social care providers, 3rd sector organisations and specialist services, all commissioned by the NHS. The National Head of Safeguarding for NHSE and the National Safeguarding Advisor for the CQC joined to provide valuable input and reflections alongside provider representatives. Feedback from attendees has been fantastic, the future work streams and agendas are developing quickly.

The culmination of months of planning and development, the first Independent Health Providers Safeguarding Forum was an example of where providers can be brought together, suspend any sense of competition to reflect, learn and challenge in the interest of the safety of those we support. National Safeguarding Leads for Independent Health Providers working providing services under the NHS standard contract interested in joining can contact: **philipwinterbottom@cygnethealth.co.uk** for more information.

Philip Winterbottom
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Use of a communication and interaction training (CAIT) video on Dementia wards to reduce restrictive practices

Staffing levels on inpatient units (e.g., qualified staff, care staff), have been under pressure for a considerable time. The shortfall is usually made up with agency staff to ensure the appropriate care can be provided. However, agency staff are frequently not specialists in the area in which they are being deployed, and they need to pick up the skills quickly to support patients and the established team.

We are presenting the case for an older adult dementia inpatient ward in Cumbria. Commonly, many patients on such wards display Behaviours that Challenge, which untrained staff can find difficult to deal with. By not knowing what to say or how to support such patients, temporary staff may contribute to the presentation escalating, and this may lead to restrictive practices being required and increase use of PRN medication. CAIT (Communication and Interaction Training, James et al 2022) focuses on improving care-giver skills in communicating with people living with dementia and can help reduce behaviours that challenge as it gives staff the skills to de-escalate situations. However, a gap has been identified regarding the training agency staff are given on interacting with people living with dementia to help reduce the use of restrictive practices on such wards (PMVA holds, use of restraint and PRN medication) yet care-giver interactions are an important element of reducing incidents and de-escalating situations on dementia wards.

In order to equip 'novice' (to the area) agency staff with knowledge on basic communication skills with a person living with dementia we are piloting the use of a short CAIT video specifically tailored to agency staff on how to interact with people living with dementia to help reduce use of restrictive practices. We aim to show the video to novice staff prior to working with patients on the ward. Feedback on the usefulness of the video will be collated from the agency staff, as well as feedback from permanent staff, as to whether this has been a useful addition to the induction and if it has successfully reduced incidents on the shift in terms of use of PMVA holds and use of PRN medication.

Dr Paula Maisey
Consultant Clinical Psychologist
Dr Katharina Reichelt
Consultant Clinical Psychologist
Professor Ian James
Consultant Clinical Psychologist
North Cumbria,
Northumberland, Tyne and Wear
NHS Foundation Trust

LeadingMinds

Open culture, open door

Context

Historically, our acute inpatient ward doors have been open, meaning that our patients, whether informal or detained, could have the opportunity to leave without the knowledge or agreement of the staff team. In 2006, following a year of public consultation, high profile national critical enquiry reports, and a number of national distressing incidents which had impacted on the confidence of families, carers and the public, a decision was taken to implement a system that allows staff to control both access and egress to our wards. Whilst the safety of our patients is our highest priority, we did not feel we could simply lock the ward doors. The Code of Practice gives guidance in relation to informal patients in hospital;

'Informal patients must be allowed to leave if they wish, unless they are to be detained under the Act' (4.51)

Our system was designed to improve safety whilst upholding people's human rights and civil liberties. It also allowed us to ensure that

'Informal patients must be allowed to leave if they wish, unless they are to be detained under the Act' (4.51)

people could not gain inappropriate entry to the wards, contributing to an environment where our patients felt safe.

What We Did

We introduced a system whereby our wards were locked using a swipe card mechanism that could be monitored. All staff were issued with a swipe card that allowed them access to all areas of our inpatient units. In recognition of the differences in care and treatment that individuals may need, all our patients were risk assessed as to whether they would receive an access card. Patients, who agreed to informal admission, would as standard procedure be given an access card. There may be occasions when an informal patient is asked to give up their right to a swipe card for a period in order that staff can undertake an effective assessment which could only happen with their capacitous consent. Patients who are detained would not usually have a swipe card programmed to allow them to exit the ward but could have a card to allow immediate entry if appropriate. Before patients are issued with a swipe card a discussion takes place with staff to ensure that they understand and accept responsibility for its use. The importance of this conversation is paramount.

Outcomes

A reduction in the use of enhanced observations that were implemented specifically to prevent people from leaving the unit and a reduction in the number of people absconding from the ward.

Incidents of patients using their cards inappropriately were low and did not result in harm.

Feedback from patients in an evaluation following the implementation was mixed with responses varying from frustration to a feeling of freedom which was dependant on whether a swipe card had been issued or not.

Summary

This system does not function in isolation, but alongside comprehensive risk assessments and open conversations with our patients. It has helped us to achieve the balance of safety alongside mental health law and human rights legislation.

In response to Covid infection Control Guidance, we had to temporarily suspend the operation of this system for the first time since its implementation. However, we will be reintroducing this within the next few months when we have done the necessary preparatory work with our staff, patients, and carers.

Gail Galvin
Clinical Lead Acute Care Services

Hannah Wilkinson and Fred Besa
Matrons for Acute Inpatient Service and PICU

Alison Quarry
Professional Lead for Nursing
Leeds and York Partnership NHS Foundation Trust

"Our system was designed to improve safety whilst upholding people's human rights and civil liberties."

" Safeguarding adults and children from abuse and neglect is everyone's business and is a core duty of the Trust and all staff have a responsibility to report concerns."

The fundamental standards of care

The Trust aspire to provide exceptional care which is personalised and always considers the individual needs and preferences of our service users. Our mission is to provide clear guidance to all clinical staff and teams to ensure consistent high quality care delivery across all services. A dashboard has been developed to monitor performance on each of the 11 standards and to provide assurance to teams and senior leaders that the care provided is of the expected standard.

1. Care Planning

Care Planning is about involving patients in how their care is planned and delivered, ensuring it meets their recovery goals and addresses both their mental and physical health care needs. Care plans should be co-produced and reviewed regularly with the patient's named clinician and where appropriate their family, friends, or carers.

2. Physical Health Assessment

The Physical Health Assessment standard is about ensuring the physical health needs of our patients are being met and addressed as part of their care planning. People with SMI (severe mental illness) are at a greater risk of poor physical health and have a higher premature mortality than the general population.

3. Risk Assessment

The aim of the Risk Assessment standard is to ensure that staff are equipped with the necessary skills to identify and manage clinical risk so they can act appropriately to either prevent or safely manage risk, and to implement all necessary follow-up procedures and interventions.

4. Safe and Supportive Engagement and Observation

All patients admitted to inpatient units require a level of engagement and observation. Engagement and observation should be safe and therapeutic. Enhanced observation involves the use of activity, discussion and distraction processes, but recognition should also be made of the need for periods of silence and as much privacy as is safely achievable.

5. Safeguarding Adults and Children

Safeguarding adults and children from abuse and neglect is everyone's business and is a core duty of the Trust and all staff have a responsibility to report concerns. With Children's safeguarding we use a 'Think Family' approach because 'it takes a village to raise a child'. Looking at the whole family: services working with both adults and children to consider family circumstances and responsibilities.

6. Infection Prevention and Control

Infection prevention and control (IPC) is fundamental to service user safety and all staff of all disciplines have a responsibility to ensure effective IPC procedures are incorporated into their daily practice.

7. Medication Review and Optimisation

Medicines optimisation is about supporting patients to obtain the best possible outcomes from their medicines by providing a patient-centred approach. Ensuring patients receive the right evidence-based medicine which works for them and their lifestyle, and their individual needs, preferences and values are considered.

8. Mental Health Act Compliance

This standard is to ensure compliance with the Mental Health Act in everyday practice. Our patients and their carers rely on us to provide care and support when we either have valid consent (informed and voluntary) or have taken a best interest decision for a person who lacks capacity to consent on the specific issue in question. This is a legal responsibility of all staff.

9. Restrictive Practice and Use of Force Act

Restrictive practice covers a range of interventions used by staff to protect patients and manage safety in line with our patients' needs. This standard outlines Trust requirements on the use of seclusion, segregation or time out as restrictive interventions within inpatient units, in line with the Mental Health Units (Use of Force) Act 2018 and national guidance from the Mental Health Act Code of Practice 2015.

10. Incident Management

Understanding when things could go wrong is the key to preventing them or helping prevent a reoccurrence. This is achieved through effective management of risk and incident management, measurement, analysis and organisational learning across all the Trust's functions and activities.

11. Safer Staffing

Safe staffing is about ensuring we have enough suitably qualified, competent, skilled and experienced staff to meet the needs of the people who use our services.

We have information boards on each ward, indicating planned and actual staffing levels for every shift. We also publish a month-by-month, cross-site summary on our website.

Michael Hever

Deputy Director of Nursing
South West London and StGeorge's Mental Health NHS Trust

Multi professional approved clinicians

The Trust has been supporting staff from various professions to train as Approved Clinicians, a role reserved to the implementation of the Mental Health Act.

The Approved Clinician role was first developed as part of the review and refresh of the Mental Health Act in 2008. This role was introduced in order to widen the range of mental health professionals who could lead the care for people subject to the Mental Health Act 1983, and ensure better patient care experience, increased patient choice and that there are Approved Clinicians available with the appropriate experience to oversee their care and treatment needs.

This opportunity offers mental health nurses, learning disability nurses, clinical psychologists, Occupational Therapists and Social Workers the option to progress into a senior clinical role, encouraging the retention of some of our most skilled clinicians in the workforce. Other professions bring a unique skill set to this role which directly benefits patient care, promoting person-centredness and holistic approaches for person-centred care.

What is an Approved Clinician (AC)?

An Approved Clinician (AC) is **"a person approved by the appropriate national authority to act as an Approved Clinician for the purposes of the Mental Health Act 1983"**

The Mental Health Act 2007 identifies the following as eligible to act as Approved Clinicians in England:

- practitioner psychologists listed on the register maintained by the Health and Care Professions Council (HCPC)
- first level nurses with a field of practice in mental health or learning disability
- occupational therapists registered by the HCPC
- social workers registered by Social Work England.

To obtain approval, a portfolio of evidence would need to be submitted to the relevant Department of Health regional panel.

Approved Clinician competencies develop the clinician to consultant level practice, extending their approach and perception of a case which can greatly assist with an expert understanding of clinical risk, clinical formulation; considering a range of assessments and interventions both non pharmacological and pharmacological; dealing with differences of opinion and advising senior clinical staff and legal bodies such as Tribunals and Court of Protection.

The role of Approved Clinician has benefits across mental health, learning disability and autism practice even outside of the auspices of the Mental Health Act 1983 and can support where areas of human rights, mental health, mental capacity and other health and social care law overlaps.

What is a Responsible Clinician (RC)?

A Responsible Clinician is the **"Approved Clinician who has been given overall responsibility for a patient's case"** where they are detained under a section of the Mental Health Act or on a Community order of the Mental Health Act such as Guardianship, Community Treatment Order or Conditional Discharge.

Once approved, the AC can take on the role of Responsible Clinician taking clinical responsibility for people of any age who are subject to the Mental Health Act 1983 working within the scope of their practice. This means that each Approved Clinician brings something different depending on the clinician's prior knowledge skills and experience.

Health Education England Support

With the support of funding from Health Education England the Trust is currently supporting eight staff to train as Approved Clinicians and has committed to identifying an additional three staff to start in 2023. The funding covers staffing replacement costs; a University preparation course and Mentorship from an experienced Approved Clinician.

The Trust also hosts the HEE funded co-ordinator role held by Chris Hutchinson, a Consultant Nurse and Approved Clinician. The co-ordinator supports all trainee Multi Professional Approved Clinicians in the North West across Pennine Care;

Greater Manchester Mental Health; Cheshire and Wirral Partnership and Mersey Care Trusts.

In the North West the co-ordinator leads a community of practice that meets monthly and action learning sets in each Trust which allows for peer development, further education and training. The Co-ordinator also undertakes work to address system matters working closely with senior staff in each Trust and with the Approval's Panel.

Interested in knowing more?

Considering Approved Clinician as part of your career journey?

We have an open event on 18th January 2023 at 13.00.

Contact sarah.richards@lscft.nhs.uk

Christine Hutchinson

Consultant Nurse - Approved Clinician
Associate Director of Nursing and Clinical Lead
Lancashire and South Cumbria NHS Foundation Trust

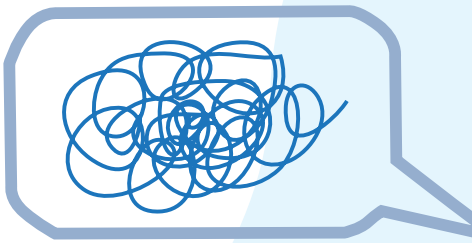
Body worn cameras as the antithesis of therapeutic engagement and quality mental health nursing: cause for concern

Use of body worn cameras has been given recent prominence as a method to keep service users and staff safe in the acute inpatient mental health setting. Creating a safe environment that ensures service user (SU) safety is at the heart of mental health nursing. Yet, whilst the use of body worn cameras has been reported to improve subjective feelings of safety, there is no sound evidence that it increases objective security or decreases violence[1].

Ensuring SU safety is an essential aspect of quality mental health nursing care. The bedrock for feeling safe is having good therapeutic relationships with healthcare professionals, in particular nursing staff, as the group that spends most time with service users. A therapeutic relationship built on mutual respect, openness and honesty forms the basis of a partnership enabling SUs to speak about their thoughts, feelings and anxieties without fear of rejection or dismissal[2]. The quality of therapeutic relationships between nurse and SU is strongly associated with positive care quality outcomes[3]. This relationship enables the SU to embark on a journey of self-discovery to express their needs and aspirations while feeling connected, protected and in control[4] Service users value therapeutic engagement, perceiving it to be an essential component of recovery-focused care, and a contributor to feelings of trust and safety[4].Despite evidence that SUs desire improved therapeutic engagement, and mental health nurses recognise the benefits of therapeutic relationships, such interactions remain sub-optimal[5]. Use of body-worn cameras arguably intercedes negatively in these relationships, weakening their capacity to generate feelings of care and safety.

Mental health inpatient environments are challenging places experiencing limited resources, rapid discharge, risk-adverse ward cultures together with high potential for disruption through violence and aggression[4]. However, these demanding elements do not necessarily justify the use of body worn cameras, which of themselves could be considered a form of control and coercion on the part of staff, especially nursing staff.

There also appears to be limited justification for the major financial and staff resources required to implement and monitor the use of body worn cameras in the absence of sound methodological studies including those of an ethnographic nature, which could determine the antecedents and consequences of any untoward incidents. Lack of 'scientific' evidence makes it difficult for the use of body worn cameras to inform practice and policy. Building and sustaining good nurse-SU therapeutic relationships offers a better way to support and care for those experiencing mental health issues and reduce incidence of violence and aggression with better utilisation of our limited financial resources than the use of body worn cameras.



"Ensuring service user safety is an essential aspect of quality mental health nursing care."

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Peter Hasler, Forum Development Officer

Our Autumn conference this year has a particular focus on the work of our in-patient services. This seems very appropriate as we know these services have been under great pressure over the last few years. We have heard from many Trusts that workforce challenges have created real concerns; experienced staff moving to community roles; and a shortage of applicants to advertised jobs.

Despite this, we know there is still great practice and innovation. We were delighted to have received so many submissions for publication. I am also fortunate to help run the national ward manager and team leader programme which was set up by Professor Hilary McCallion. We are always delighted by the high standard of our ward managers and team leaders. They are without doubt the key positions in our services, overseeing the quality of care and leading complex multidisciplinary teams. The conference is truly an opportunity to reflect on where we are post-Covid but very much to celebrate the great work that is happening across the country.

In October we commenced this year's Aspiring Director programme jointly with the NHS Confederation. This is the fourth year of running the programme and it has helped many people over that time to move into more senior leadership roles including Chief Nurses. This year's participants are all invited to attend our conference, so I hope there is an opportunity to network with them.

Finally, many of you will be aware that every two years the Forum conducts a census of nurse consultants in mental health and learning disability. 2023 will be the next census and this time we are asking to expand the parameters to include Advanced Clinical Practitioners (ACPs) and those with Approval Clinician (AC) status. Please contact me directly if you require further information on this, the census will begin in January 2023.

"The conference is truly an opportunity to reflect on where we are post-Covid but very much to celebrate the great work that is happening across the country."

Peter Hasler
Forum Development Officer
Peter.hasler1@nhs.net

Leadership in Care

NATIONAL LEADERSHIP PROGRAMME FOR WARD MANAGERS AND TEAM LEADERS, 2023 DATES

We are currently taking bookings for our 2023 Leadership in Care - National Leadership Development Programmes for Ward Managers and Team Leaders. These are 6-day residential programmes, delivered over 3 modules, one in spring and one in autumn. Both take place at Missenden Abbey, Missenden, Bucks - please see dates below.

PROGRAMMES FOR 2023

Spring 2023
24 - 25 April 23
22 - 23 May 23
19 - 20 June 23
Venue - Missenden Abbey, Bucks

Autumn 2023
18 - 19 Sept 23
30 - 31 Oct 23
27 - 28 Nov 23
Venue - Missenden Abbey, Bucks

For more information and prices visit:
www.hilarymccallionconsultancy.co.uk/national

For booking enquiries or more information please email Emma:
leadershipincare@gmail.com

Peter Hasler - 07777 661716 • Hilary McCallion - 07879 995538

www.hilarymccallionconsultancy.co.uk

National Mental Health and Learning Disability Nurse Directors Forum

Influencing and advancing care in mental health and learning disabilities

The Conference is kindly sponsored by

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Making Room for Dignity

Patchwork

Patchwork was founded in 2016 by clinicians Dr Anas Nader and Dr Jing Ouyang. They are on a mission to make healthcare staffing more sustainable, building modern workforce systems that promote flexibility and achieve optimal outcomes for organisations, managers, staff and patients.

Named Staffing Solution of the Year by the HSJ in 2022, Patchwork's fully integrated workforce management solution has been co-created with the NHS, and over 70 NHS sites have already embraced their technology and services.

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