AIM STATEMENT PLANNING

Developing your project aim

Overall problem/area issue:	There are high levels of violence and aggression (V&A) in the Emergency Department (ED), leading to frequent use of restrictive interventions. Patients presenting with mental health (MH) issues — though not the sole source of V&A — are increasingly high-acuity. Those awaiting transfer to psychiatric facilities are especially likely to experience restrictive measures. These interventions can sometimes increase risks and are not always therapeutic.
Your purpose in wanting to improve this (WHY):	To provide better care for patients with mental health needs in the ED, in line with national best practices and CQC guidance — especially regarding the often disproportionate use of restrictive interventions on global majority populations. To enhance overall safety within the ED. To improve the experience of patients, staff, carers, and relatives
Your proposed SMART aim statement:	To review the use of restrictive practices in the Emergency Department. The aim of this is to ensure that restrictive practices are proportionate and only used where strictly necessary. The intended benefit of this is to improve patient care/experience, improve the experience for staff, to increase use of alternative therapeutic interventions, and to reduce the use of restrictive practices where possible, over the next 12 months.
What further scoping or tools will you use to understand the problem further:	Retrospective and contemporaneous data collection and analysis: both GSTT and SLaM incidents of V&A, patient self-endangerment, rapid tranquilisation and restraint; audits (#of MHA assessments/ detentions; referral/ response times; correlation with LOS; types of RI used; antecedents to RI; alternatives/ less restrictive interventions). RRN training standards. Patient/ staff experience and feedback.
What scale are you operating at within the system? (mico, meso or macro) and list the areas involved in your project	Meso; hope is that learning from this programme may lead to transferrable learning for the rest of the organisation/ ?system (macro)

PROJECT CHARTER

Project Charter

A simple one pager to help define your project

Problem Statement

(what is the current problem & why does it need to be improved?)

High levels of violence and aggression in the ED, particularly among high-acuity mental health patients—especially those awaiting psychiatric transfer—have led to frequent and sometimes harmful use of restrictive interventions. This project aims to improve safety, care quality, and experience for all, aligning practices with national guidance and addressing the disproportionate impact on global majority populations

In Scope (what will be covered by the project)	**Out of Scope** (what will not be covered by the project)
Emergency Department (ED) Environment: Interventions, protocols, and staff training focused within the ED setting. ED physical environment (to include CAU). **Mental Health (MH) Presentations:** Patients presenting to the ED with acute mental health needs, including those awaiting transfer to psychiatric units. Particular focus on patients disproportionately affected by restrictive practices (e.g., global majority populations). **Violence & Aggression (V&A):** Reducing incidents and severity of V&A in the ED. Preventative approaches (e.g., de-escalation, early identification of risk, rapid assessment and transfer to CAU). **Restrictive Interventions:** Minimising use (e.g., physical restraint, sedation). Improving decision-making and documentation processes. **Staff Support & Training:** Equipping ED staff with skills in trauma-informed care, de-escalation, and cultural competence. Embedding reflective practices post-incident. **Experience & Safety:** Improving the overall experience of patients, staff, carers, and relatives. Safety audits, surveys, and feedback mechanisms. **Data Collection & Monitoring:** Tracking outcomes such as incident reports, use of restrictive measures, and waiting times for MH beds.	**Long-Term Mental Health Treatment:** Ongoing care post-discharge or outside the ED (e.g., community mental health support). **Redesign of Psychiatric Inpatient Services:** The project does not involve changing the structure or staffing of psychiatric hospitals. **Systemic NHS-Wide Policy Change:** While aligning with national guidelines, the project won't influence broader NHS policy. **Children's or Paediatric Services:** This project likely on adult presentations. **Non-MH Related ED Attendances:** Patients presenting solely with physical health complaints or unrelated emergencies are outside the focus.

Outcomes (what do you intend to achieve from this project, what are the outcomes? What will it improve? How will things be better? Evidence your outcomes

This project aims to reduce the frequency and severity of violence and aggression (V&A) in the ED, particularly among patients presenting with mental health (MH) needs, through more therapeutic, equitable, and effective care pathways. It seeks to minimise reliance on restrictive interventions, improve staff and patient safety, and enhance the overall care experience.

Expected Outcomes:
Reduction in use of restrictive interventions (e.g., restraint, sedation) particularly for patients with MH needs.
Improved patient and staff safety, measured by a decrease in reported V&A incidents.
Better patient experiences, especially for individuals from global majority backgrounds, through culturally competent and trauma-informed care.
Enhanced ED staff confidence and capability in managing high-acuity MH presentations non-restrictively.
Faster, smoother pathways to psychiatric care, reducing the time patients spend in the ED waiting for transfer/ assessment.
Improvements:
Safer, calmer ED environment.
Fairer and more respectful treatment of patients with MH conditions.
Higher staff morale and reduced burnout.
Better compliance with national CQC standards and evidence-based guidance
More robust governance related to RI

Quality Impact

(How will the project improve patient: experience, safety, outcomes, care, services or reduce risk/harm to patients?)

As above

Measurements (What data both qualitative and quantitative can you collect to show an improvement has been made?)

Description of Measure	Baselines (what are they currently at prior to the project?)	Target (Where do you want them to be?)

Team (Who is your project team involved in the project?)

See slide 11

What are your key milestones

Project start; baseline data collection/ analysis; stakeholder engagement; process mapping; intervention design; pilot implementation and evaluation

BUILDING RELATIONSHIPS

Relationship building

How will you keep connected and learn from others?

Communication methods How will you talk to each other – on what format? Teams? Emails? WhatsApp?		**Understanding** How will you create an understanding of each other's roles, experiences and views? Meetings? Shadowing? Observe?
Listening How will you make the space and time to truly listen to each other to understand? Coffee chat? Off-site meet? Protected time?		**Challenge your biases** How will you reflect on your own thoughts and assumptions? Reflective journal? Speak to a mentor?
Personal connections How will you make personal connections, build trust and connect? Talk about personal interests? Life outside of work? What matters to you?		**What else?** What other ideas do you have on how you can build good engagement with other team members across the interface?

Your chosen approaches on building relationships:
Multiple modalities for communicating; facilitated reflective practice sessions, 'team' away days (ambitious), joint learning/ education (e.g. SIM), PDSA reviews, fortnightly project groups

STAKEHOLDER MAPPING

Stakeholder mapping

High Power	**Satisfied** People who have a high power of influence over the project, but they just need to be kept satisfied with what is happening	**Manage** People who have a high power of influence over the project who should be fully engaged through communication and consultation
Low Power	**Monitor** People who have low power that could be ignored if time and resources are stretched	**Inform** People who have a low level of influence, but it is helpful to keep them informed
	Low interest/impact	High interest/impact

Stakeholder Name	Job role details	Impact (High or low?)	Influence (High or low power?)	How could they contribute to the project?	How could they block the project?
Joe Atkin	MH Head of Nursing	High	High	Leadership, decision-making, resource allocation	
Dr Cormac Fenton	Psychiatry Medical Lead (Liaison)	High	High	Leadership, decision-making, integration of MH teams	
Nyasha Kajawu	Psychiatry Clinical Service Lead	High	High	Leadership, decision-making, integration of MH teams	
Dr Katherine Henderson	Clinical Director	High	High	Leadership, decision-making, resource allocation	
Sonia Lane	General Manager	High	High	Leadership, decision-making, resource allocation	
James Hill	Head of Nursing	Low	High	Engagement of ED, leadership	
Margaret Dawodu	Matron	High	Low	Education, governance/ quality	
Sarah/ Diane	QIPS Senior Nurse	High	Low	Governance and data	
Doug Kalisa	Security	High	High	Implementation of RI, reporting	
Anne/ Nic/ Dee	Site Operations	Low	High	Redesign of trust and departmental policy	
Jackie Waghorn	Trust MH Lead	Low	High	Expert guidance, oversight, comms	
Jane Briscoe	Clinical Psychologist	Low	Low	Education, reflective practice	
Vivian Ezeanozie	PICU Lead Nurse	Low	Low	Education, expert advice	
Mercedes Esprit	Violence Reduction Lead	High	Low	Implementation of RI, engagement	
Sadie Thomson-Ashworth	Clinical Team Leader	High	Low		

MEASUREMENT TEMPLATE

Measurement Template

Being clear on who will collect what, when and how

Measure Definition What is the data you want to collect – define it	Type of measure Outcome Process Balancing Which one is it?	Concept Why Measure it?	Frequency How often will it be collected? Will it be all occurrences, a sample or snapshot?	Data Collection How will the data be collected? Is there a system? Will it be done manually?	Person Who will be the person responsible for collecting it?
Incidents: type, location/ time/ date, demographics, whether repeated?				Radar (dashboard; code 10, restraint, RT, self-harm, absconding) Datix (restraint; informal but on enhanced obs)	Acute Med QIPS Nyasha/ Lambeth Gov?
Patient experience feedback/ complaints				Civica ?Deming (SLaM)	Nyasha
Legal frameworks/ # MHA detentions and/ or assessments				Thalamos? E-MHA? SNPs (136) MHLT proforma?	Acute Med QIPS MHA Office SLaM
Enhanced observations; reason, length, level, review				EPIC (flowsheets) MHECT referral data (EPIC)	
MHLT referral data (patient hospital number; date/ time of arrival and referral)				EPJS	Mahir
Casenote audit				EPIC	