East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
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Title	Mental Health Units (Use of Force) Act 2018
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Purpose of the report

Provide a briefing on the Mental Health Units (Use of Force) Act; the main sections of which come into effect on 31st March 2022.

Committees/meetings where this item has been considered

Date	Committee/Meeting
	n/a

Key messages

The main purpose of the Act is to make provision about the oversight and management of the appropriate use of force in relation to people in mental health units, with the objectives being to:

1) To reduce the use of force in mental health units;

2) To ensure accountability and transparency about the use of force in mental health units.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☒	Improve quality of care for service users with aimed reduction of restrictive practices
Improved staff experience	☒	Improved understanding of staff on how to monitor and address restrictive practices and approaches to reduce these.
Improved value	☐	

Implications

Equality Analysis	This will allow monitoring restrictive practices in minority groups and allow these to be addressed. Collecting the data on protected characteristics will allow indemnification of inequalities.
Risk and Assurance	This report highlights a specific new law which relates to service user care, that the Trust must comply with.

Service User/ Carer/Staff	The report sets out how Trust staff must apply a new legal framework.
Financial	The financial implications of the implementation of this legislation has not been fully evaluated.
Quality	This paper addresses patient safety within inpatient units and therefor has a direct impact on the quality of care received by service users.

1.0 Background

1.1 Olaseni "Seni" Lewis was a 23 year old black man from South London. He died as a result of prolonged restraint by police officers at the Bethlem Royal Hospital in Beckenham on 31st August 2010. Investigations following his death were critical of how the restraint was carried out. Mr Lewis' family were supported by the local Croydon MP, Steve Reid. Mr Reid in response to the case raised a private members bill in Parliament and this subsequently developed into this law. The Mental Health Units (Use of Force) Act 2018 ('the Act') was enacted on 1st November 2018. Guidance on the implementation of the Act was issued in December 2021 with an aim to start implementation from 31st March 2022.

1.2 The Act's objectives of reducing and ensuring accountability and transparency about the use of force in mental health units should be achieved by:

a) Bringing an end to the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age, and disability;
b) Providing services which meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point;
c) Services having an understanding of the negative impact of the use of force of patients with histories of trauma and abuse;
d) Services involving the individual, their families and carers in the planning and delivery of their care;
e) Ensuring that there are positive relationships between those receiving care and those providing it.

1.3 Details of he Act are given in **Appendix A**

2.0 Implementation at ELFT

2.1 At ELFT we have been working with our staff and service users for several years to reduce restrictive practices within the organisation. The implementation of this law will help support this ongoing work that is already taking place within the organisation.

2.2 Violence remains the most frequent form of clinical incident in our services. The impact and consequences of violence on our staff and service users is hard to underestimate. The Time to Think approach (using the Safety Culture Bundle) to violence reduction and the reduction of restrictive practices is now an established process across our in-patient services. As an approach it has been helpful in terms of predicting and preventing violence but where this does still occur,

restraint and seclusion remain likely consequences. Thus, the aims of reducing violence and restrictive practice are combined.

2.3 Restrictive practice is a term to describe behaviours and practices that inhibit freedoms for service users. These can be considered on a continuum from the use of blanket rules, locked doors and so on to the use of medication, restraint and seclusion. The Trust has committed to reduce the use of restrictive practices across all services

2.4 Our reducing restrictive practices plan focusses on 6 core strategies. These are :

1) Learning together and developing our workforce – the Time to Think Groups with service users are now held within each service monthly. Training on Human Rights and Trauma Informed care have been developed and introduced to services
2) Data – the data is available at ward and directorate level. Data is also created and scrutinised using the safety crosses on each ward and discussed in the ward community meeting
3) Leadership – a crucial element of any progress in this area is the constant attention of leaders to it.
4) Working with service users and families – developing strategies for keeping everyone safe has to include the active participation of service users and their families/carers.
5) Trauma Informed Care – is a way of seeing how previous experiences contribute to current behaviour and beliefs. For many we care for, there are significant issues of trauma that impact on their ability to connect with others and develop helping relationships.
6) Rigorous debriefing. This involves actively learning from incidents in order to try and prevent reoccurrence. Evidence suggests that the more this is paid attention to, the greater the reductions in restraint.

2.5 We will also continue to work with Police through our Health and Safety Officer, Richard Harwin, to minimise Police intervention on units and create a culture and climate in which the use of force is minimised.

2.6 A communication plan is being developed to inform staff and service users of the implementation of this Act and give details of how data will require to be recorded when force is used. A leaflet is being coproduced for services users who are admitted to our units in the future.

2.7 The Trust has organised an Implementation Group consisting of:

a) The Chief Medical Officer and Chief Nurse;
b) Senior stakeholders such as clinicians, service managers, MAPA trainer, People Participation, Risk & Governance, Informatics;
c) Associate Director of Mental Health Law as a senior advisor.

2.8 This is a task and finish group that will meet fortnightly to ensure that staff, service users and carers are all aware of the implementation of the Act and its consequences.

2.9 The Chief Medical Officer and Chief Nurse will publish a joint statement to launch the legislation in the Trust and will work with People Participation regarding how to launch it through Working Together Groups.

3.0 Action Being Requested

3.1 The Board is asked to:

a. **RECEIVE** and **NOTE** the report
b. **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required

Appendix A

Mental Health Units (Use of Force) Act 2018

1.0 Definitions - section 1

1.1 References to ‘mental disorder’ are the same as in the Mental Health Act 1983; “any disorder or disability of the mind”.

1.2 Mental Health Unit (for the purposes of the Trust) means a hospital or part of a hospital which provides treatment to in-patients for mental disorder.

1.3 Patient means a person who is in a mental health unit for the purpose of assessment or treatment of mental disorder.

1.4 References to ‘use of force’ are to:

- the use of physical, mechanical or chemical restraint; or
- the isolation of a patient

a) Physical restraint means physical contact which is intended to prevent, restrict or subdue movement of any part of a patient’s body.
b) Mechanical restraint means the use of a device which is intended to prevent, restrict or subdue movement of any part of a patient’s body and which has the primary purpose of behavioural control.
c) Chemical restraint is the use of medication which is intended to prevent, restrict or subdue movement of any part of a patient’s body.
d) Isolation is seclusion or segregation that is imposed on a patient.

2.0 The Responsible Person - sections 2 and 10

2.1 The Trust must appoint a single responsible person who is employed by the Trust and is “of an appropriate level of seniority” in relation to all of our hospitals which are mental health units. The Chief Medical Officer is the Responsible Person but will be supported in the implementation of the Act by the Chief Nurse.

2.2 Whilst retaining responsibility, the responsible person may delegate their functions to a “relevant person” in each hospital. Again, this person must be “of an appropriate level of seniority” and so they will be the local clinical directors.

3.0 Duty of Responsible Person re Policy - section 3

3.1 The Responsible Person must consult on, publish and keep under review, a policy in relation to all of our hospitals which must include what steps will be taken to reduce the use of force in those hospitals. A skeleton policy has been drafted to be completed with all agreed Trust processes and a decision will be made about having this as a stand-alone policy or incorporating it within existing policy i.e. restrictive practice. The policy will require Board approval.

4.0 Duty of Responsible Person re information about use of force - section 4

4.1 The Responsible Person must consult on, publish and keep under review, information for patients about the use of force by staff who work in the hospital. This must be provided to (unless refused) each patient and any other person to whom the responsible person considers it appropriate to provide that information.

4.2 The information must be provided as soon as practicable after the patient is admitted to the hospital. As with for instance, information provided under section 132 of the Mental Health Act 1983, the responsible person must take reasonable practicable steps to ensure that the patient is aware of the information and understands it.

4.3 In ensuring that patients get access to the information, the Trust will make use of existing information packs, website and noticeboards in relevant clinical areas. The information given will require Board approval.

5.0 Duty of Responsible Person re training in appropriate use of force - section 5

5.1 The Responsible Person must ensure provision of training for staff that relates to the use of force which must include the following topics:

(a) how to involve patients in the planning, development and delivery of care and treatment in the mental health unit,
(b) showing respect for patients' past and present wishes and feelings,
(c) showing respect for diversity generally,
(d) avoiding unlawful discrimination, harassment and victimisation,
(e) the use of techniques for avoiding or reducing the use of force,
(f) the risks associated with the use of force,
(g) the impact of trauma (whether historic or otherwise) on a patient's mental and physical health,
(h) the impact of any use of force on a patient's mental and physical health,
(i) the impact of any use of force on a patient's development,
(j) how to ensure the safety of patients and the public, and
(k) the principal legal or ethical issues associated with the use of force.

5.2 The training must be provided as soon as practicable after the Act comes into force and subsequently, when new members of staff are appointed. Refresher training must also be provided. The lead for Management of Actual or Potential Aggression in partnership with the Crisis Prevention Institute, will determine the elements of the Act that will need to be introduced to existing training provision.

6.0 Duty of Responsible Person re the recording of use of force - section 6

6.1 The Responsible Person must ensure that records are kept of any use of force by staff that is not negligible. Use of force that is negligible is set out in guidance published by the Secretary of State wherein it states that use of force can only be considered negligible where it involves light or gentle and proportionate pressure. Any negligible use of force for the purpose of this section must also meet all of the following criteria:

a) it is the minimum necessary to carry out therapeutic or caring activities (for example, personal care or for reassurance);
b) it forms part of the patient's care plan;
c) valid consent (or agreement in the case of children) to the act in connection with care and treatment (which may include the use of force) as part of the delivery of

care and treatment has been obtained from the patient and where appropriate a member of their family or carer has been consulted.

6.2 The guidance states that use of force can never be considered negligible in a number of situations, such as any use of rapid tranquillisation, any use of mechanical restraint, any verbal or physical resistance by the patient, the disproportionate use of a wall, floor or other flat surface, a patient complains about the use of force either during or following the use of force, someone else complains about the use of force, the use of force causes an injury to the patient or a member of staff, the use of force involves more members of staff than is specified in the patient's care plan, during or after the use of force a patient is upset or distressed, and use of force has been used to remove an item of clothing or a personal possession.

6.3 The record (which must be kept for 3 years) must include the following information:

a) the reason for the use of force;
b) the place, date and duration of the use of force;
c) the type or types of force used on the patient;
d) whether the type or types of force used on the patient formed part of the patient's care plan;
e) name of the patient on whom force was used;
f) a description of how force was used;
g) the patient's consistent identifier (in accordance with data protection legislation);
h) the name and job title of any member of staff who used force on the patient;
i) the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient;
j) the patient's mental disorder, if known;
k) the relevant characteristics of the patient, if known (age, nature of any disability, marital/civil partnership status, pregnancy, race, religion/belief, sex, sexual orientation);
l) whether the patient has a learning disability or autistic spectrum disorders;
m) a description of the outcome of the use of force;
n) whether the patient died or suffered any serious injury as a result of the use of force;
o) any efforts made to avoid the need to use force on the patient;
p) whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan.

6.4 The above records will form the basis of a report published by the secretary of state each year.

6.5 Where such information will be recorded is to be finalised; the datix incident reporting tool is one option and a gap anlaysis has been carried out to determine if it is fit for the Act's purposes.

7.0 Duty of Responsible Person re investigation of deaths/serious injuries - section 9

7.1 When a patient dies or suffers a serious injury in a hospital, the responsible person must have regard to any guidance relating to the investigation of deaths or serious injuries that is published by the Care Quality Commission, NHS England/Improvement and anyone prescribed by regulations made by the Secretary of State (not applicable at the moment).

8.0 Police body cameras - section 12 (not commencing 31st March 2022; commencement date to be confirmed)

8.1 If the police attend a hospital to assist staff, they must if practicable, take and wear a body camera and keep it operating.

9.0 References

- The Act: https://www.legislation.gov.uk/ukpga/2018/27/contents
- Secretary of State Guidance: https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018