USE OF FORCE ACT POLICY

For the latest version of this policy please refer to the electronic location below

Policy Number	ACG/Care & Clinical/C&C07
Version Number	02
Purpose	This policy: • Sets out responsibilities in connection with the Mental Health Units (Use of Force) Act 2018 (also known as 'Seni's Law'). This includes responsibilities according to role, training, recording and information for people using the service. • Should be read alongside Mental Health Units (Use of Force) Act 2018, the Mental Health Act Code of Practice 2015 and policies that cover practices such as physical intervention and rapid tranquillisation.
Scope	• All colleagues working in hospitals in the Active Care Group (ACG). • Sites and services in England.
Policy Owner	Julie Rowlands, Mental Health Legislation Manager
Policy Ratified	Kevin Monteith, Director of Risk and Governance on 23/02/2024
Policy Signed Off	Dr Amit Chatterjee, Chief Medical Officer on 23/02/2024
Date Issued	23/02/2024
Date for Review	22/02/2025
Electronic Location (EL)	Intranet/Sharepoint
Associated Policies	Use of Physical Interventions Policy (ACG/Care & Clinical/C&C26) Incident Management policy (ACG/Group/C&L02)

USE OF FORCE ACT POLICY

1 INTRODUCTION

1.1 Between 2000 and 2014, 46 mental health patients across the UK died following episodes of restraint.

1.2 In 2010, Olaseni (Seni) Lewis died after being restrained by 11 police officers in the Bethlem Hospital. The Act, sometimes referred to as 'Seni's law', was introduced via a Private Members Bill and was passed in November 2018.

1.3 The key provisions of the Mental Health Units (Use of Force) Act 2018 ('the Act') came in to force on 1 April 2022.

1.4 The Act aims for greater transparency and accountability around the use of restraint in mental health settings and introduces a number of requirements to support this, including publishing data on how and when physical force is used, and ensuring that any non-natural death in a mental health unit triggers an independent inquiry.

2 SCOPE

2.1 The Act imposes these requirements on 'mental health units', which for the purposes of ACG are services registered as independent hospitals (in England), registered to provide treatment to in-patients for mental disorder.

3 AIM

3.1 This policy sets out the key requirements of the Mental Health Units (Use of Force Act) 2018 and how these will be met across ACG, including:

(a) Reinforcing that the use of force is a last resort.
(b) Identifying responsibilities of different staff members in relation to the Act.
(c) Setting out data collection requirements.
(d) Identifying training needs.
(e) How information will be provided to patients.

4 DEFINITIONS

4.1 "Mental disorder" has the same meaning as in the Mental Health Act 1983, that is 'any disorder or disability of the mind'.

4.2 "Mental health unit" means–

(a) a health service hospital, or part of a health service hospital, in England, the purpose of which is to provide treatment to in-patients for mental disorder, or

(b) an independent hospital, or part of an independent hospital, in England–

(i) the purpose of which is to provide treatment to in-patients for mental disorder, and

(ii) where at least some of that treatment is provided, or is intended to be provided, for the purposes of the NHS.

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

4.4 "Use of force" means the use of physical, mechanical or chemical restraint on a patient, or the isolation of a patient (which includes seclusion and segregation).

4.5 "Negligible use of force" means force that involves 'light or gentle and proportionate pressure'. It must be the minimum necessary to carry out therapeutic or caring activities, form part of the patient's care plan, be used with valid consent. Use of force is never

negligible if it involves rapid tranquillisation, mechanical restraint or verbal or physical resistance from the patient.

4.5 "Physical restraint" means the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient's body.

4.6 "Mechanical restraint" means the use of a device which is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control.

4.7 The Company prohibits the use of mechanical restraints in non-secure services. Where, by exception, a site is considering the use of mechanical restraint for an individual, an extraordinary mechanical restraint committee (to include Chief Medical Officer, the Responsible Clinician for the individual and the Hospital Director/Registered Manager or nominated deputies of any of the above) must consider the case. See Use of Physical Interventions Policy (ACG/Care & Clinical/C&C26) for detailed guidance.

4.8 "Chemical restraint" means the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body. For clarity, rapid tranquillisation (RT) is considered chemical restraint and the policy on rapid tranquillisation should be referred to alongside this policy for detailed guidance where RT is utilised.

4.9 "Isolation" means any seclusion or segregation that is imposed on a patient.

4.10 "Seclusion" is the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (MHA Code of Practice).

4.11 "Long term segregation" is a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis (MHA Code of Practice).

5 MINIMISING THE USE OF FORCE

5.1 Active Care Group (ACG) is committed to delivering a high standard of person centred care at all times, and this includes managing behaviours that may place the patient or others at risk of harm.

5.2 ACG promotes Positive Behaviour Support (PBS) programmes in all inpatient services. BILD defines PBS as 'An understanding of the behaviour of an individual. It is based on an assessment of the social and physical environment in which the behaviour happens, includes the views of the individual and everyone involved and uses this understanding to develop support that improves the quality of life for the person and others who are involved with them.'

5.3 All members of staff who support people in inpatient settings will be trained to use prevention and de-escalation as first line strategies. This means developing an understanding of potential triggers for the individual (primary prevention), in order to avoid escalation in the first place, and understanding and utilising de-escalation techniques, where primary prevention has been ineffective.

5.4 The use of force will only ever be implemented where preventative and de-escalation strategies have been unsuccessful. The implementation of restraint should be viewed as a treatment failure.

5.6 Where physical intervention is necessary, this will only ever be applied by staff trained to do so, using the approved technique for that service.

5.7 Being physically restrained, or observing someone else being physically restrained can be traumatic/distressing for the individual in care. Staff must ensure that post incident support is provided to patients to support their psychological and emotional wellbeing. Further details on this is set out within the Use of Physical Interventions Policy (and training on the same), which makes clear that any incidents that involve restrictive physical intervention should be subject to a post incident debrief/analysis where possible to allow reflective practice and lessons to be learnt and support where needed for both individuals in care and all staff involved. This must include debrief and physical health monitoring.

5.8 ACG is committed to ensuring:

(a) We protect human rights and freedoms, including specifically reducing the disproportionate use of force and discrimination against people sharing protected characteristics under the Equality Act 2010.
(b) Staff act within the law.
(c) Force is only ever used as a last resort.
(d) Only staff trained in approved techniques apply 'hands on' interventions.
(e) Mechanical restraint is only ever used by exception and its use is approved by senior members of the Executive Committee, as referenced in this policy.
(f) All uses of chemical restraint are recognised as such and are appropriately recorded.
(g) All uses of physical interventions, seclusion or segregation are recognised as such and are appropriately recorded.
(h) That services that may use force as defined in this policy have sufficient governance arrangements in place to ensure the prompt review of any such practices as is required.
(i) The use of force is documented and reported on, as is required by the Use of Force Act.
(j) Staff understand their responsibilities in relation to this policy.
(k) Patients have access to information as require by the Act.

6 TYPES OF FORCE

6.1 Staff must utilise techniques that they have been certified as competent to use, only to the extent that it is reasonable, necessary and proportionate within the circumstances.

6.2 The providers used within the group are PRICE, in children's services and MAYBO across other sites with the exception of PBM in one neurological service (Frenchay). All providers work to the RRN training standards.

6.3 The approved techniques set out above all include learning on avoiding the need for physical intervention and de-escalation as primary strategies for dealing with behaviour of concern.

6.4 Physical and chemical restraint may be used in ACG services under the direction of the relevant decision makers. However, as set out above, the Company prohibits the use of mechanical restraints in non-secure services. Where, by exception in a secure service, mechanical restraint is being considered for an individual, an extraordinary mechanical restraint committee must consider the case.

6.5 A training needs analysis will inform the technique used in any newly commissioned services, as is the case for existing services. The training need analysis is to be reviewed

and updated where there is a change to the client group, change to the service requirements and annually.

6.6 Each individual who requires some form of restraint must have a personal risk assessment in place. This must detail the approved techniques that can be used. Any techniques outside of the plan must not be used before a new risk assessment has been completed and approved.

6.7 We work with our approved providers to do an annual audit on what techniques we are approved to use, what we have used and the need for any change to this.
Reports and details from our internal reporting system help us to analyse what techniques have been used and therefore the needs going forward.

7 THE RESPONSIBLE PERSON

7.1 The Act requires the appointment of a 'responsible person', whose role it is to ensure that the organisation complies with the requirements of the Act.

7.2 This person must be a permanent member of staff within the organisation and must have the relevant skills and experience to undertake the responsibility of this role. They must have a relevant clinical background and experience of clinical care roles where the use of force is used, along with an understanding of the needs of the patient population being served.

7.3 Within Active Care Group, this will be the Chief Medical Officer.

7.4 The responsible person may delegate some of their functions under the Act to other suitably qualified members of staff within the organisation, including a deputy responsible person. Within Active Care Group this will be the Group Director of Risk and Governance.

7.5 The responsible person may delegate their functions under the Act to more than one relevant person within the organisation- delegated functions will include the reporting of incidents and external reporting of data. The scheme of delegation appended to this policy should be referred to for detail of delegated responsibilities.

8 ROLES AND RESPONSIBILITIES

8.1 **The Responsible Person** (subject to the delegation of authority) has an overarching responsibility to:

(a) Publish a policy regarding the use of force.
(b) Publish information for patients about their rights in relation to the use of force by staff who work in the hospital.
(c) Ensure that staff receive appropriate training in the use of force, covering all areas as set out within the national guidance and later, in this policy.
(d) Ensure records are kept of any use of force on a patient by staff who work in that unit, which includes demographic data across the protected characteristics in the Equality Act 2010.
(e) Attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in. It is important they are guided by the impact of trauma on their patients and the potentially re: traumatising impact of the use of force.

8.2 **Operational and Managing Directors** have a responsibility to ensure that the services they oversee are compliant with all parts of this Act, specifically having oversight to ensure that:

(a) Staff across their services are trained as required by this policy.

(b) Incidents of the use of force are appropriately recorded and reported.
(c) Services are providing information to patients as required by the Act.
(d) The principles of staffing for safe and effective care are met, i.e. having the right number of staff with the right knowledge, skills and experience in the right place at the right time, and the impact this can have on reducing the use of force

8.3 **Hospital Directors/Registered Managers** have responsibility for ensuring that:
(a) Staff, including agency staff, working in the hospital are trained as required by this policy.
(b) Only appropriately trained staff are involved in incidents of physical intervention.
(c) Any use of physical intervention, chemical or mechanical restraint is appropriately reporting on the incident reporting system.
(d) Any such incidents of the use of force are investigated as required and that the incident cycle is closed, i.e. risk is reassessed, care plans are updated, lessons are learnt.
(e) Any lesson learning that extends beyond the individual is shared across the service and reported through divisional governance to ensure wider learning.
(f) Patients are provided with information as required by the Act.
(g) Any concerns regarding safe staffing are raised accordingly.
(h) The emotional impact the use of force has on staff is recognised, and that they are appropriately supported.

8.4 **All staff** are responsible for ensuring that their training across all areas is up to date and that they act within the scope of their role, training and capabilities. Staff must always:
(a) Treat patients with dignity and respect at all times.
(b) Only ever use force as a last resort, having exhausted other interventions.
(c) Inform their line manager of any knowledge gaps or self-identified training needs.
(d) Ensure incidents are reported using the incident management system.
(e) Report concerns regarding unnecessary or excessive use of force.

9 TRAINING

9.1 The responsible person must ensure staff are trained in the use of force.

9.2 All staff (including temporary, bank or agency staff) involved in using force on a patient or involved in the authorisation of the use of force must undertake training which is appropriate to the role they are undertaking, throughout all levels within the business.

9.3 Staff working in sites will undertake the training relevant to them, as identified by their line manager.

9.4 Executive board members (or equivalent) who authorise the use of force in their organisation will undertake appropriate training to ensure they are fully aware of the approaches and techniques (prevention or otherwise) their staff are being trained in. (They are not expected to complete the full training programme given to staff who are directly involved in patient care, but must receive training on the overarching principles of the use of force).

9.5 Staff training must include the following elements:
(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, (this is also covered in detail within the Use of Physical Intervention Policy, which includes reference to risks such as positional asphyxiation, individual risk factors, situational and environmental risk factors, pre-existing medical conditions.
(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.

9.6 To ensure these principles are embedded into practice, these elements have been confirmed as included in existing training, or additional slides have been developed and inserted as necessary. They will be covered in existing training on approved physical intervention techniques (at the time of writing this policy, these approved techniques within the group are PRICE, MAYBO and PBM). Training will only be delivered by certified training providers, or staff certified by these providers as competence competent to do so.

9.7 To ensure staff have an awareness of the Use of Force Act itself, additional information will be provided to staff attending the training set out above.

9.8 Staff will receive training on appointment and subsequently through refresher training, as dictated by training cycles.

10 RECORDING REQUIREMENTS

10.1 The Act requires the responsible person to ensure the reporting of any non-negligible use of force.

10.2 Reportable incidences of the use of force must be recorded on the incident recording system and the service manager must ensure that staff have the training, knowledge and skills to do so correctly.

10.3 This data will be reported for external monitoring via the Mental Health Services Data Set (MHSDS).

10.4 Information recorded must include:
(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.
(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).
(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 (subject to the patient's consent).

10.5 The 'relevant characteristics' of the patient referred to above are (as set out in the Equality Act 2010):
(a) The patient's age.
(b) Whether the patient has a disability, and if so, the nature of that disability.
(c) The patient's status regarding marriage or civil partnership.
(d) Whether the patient is pregnant.
(e) The patient's race.
(f) The patient's religion or belief.
(g) The patient's sex.
(h) The patient's sexual orientation.

11 NEGLIGIBLE USE OF FORCE

11.1 The Act differentiates between the use of force, and 'negligible' use of force.

11.2 Only acts that amount to a use of force fall within the scope of the Act, guidance and this policy.

11.3 Negligible does not mean irrelevant to a person's experience of care or treatment. Whenever a member of staff makes a patient do something against their will, the use of force must always be recorded.

11.4 If a member of staffs' contact with a patient goes beyond the minimum necessary in order to carry out therapeutic or caring activities, then it is not a negligible use of force and must be recorded.

11.5 The Act defines negligible use of force as involving 'light or gentle and proportionate pressure'.

11.6 Negligible use of force, for the purpose of this policy, must also meet all of the following criteria. It must:
(a) Be the minimum necessary to carry out therapeutic or caring activities.
(b) Form part of the patient's care plan.
(c) Used with valid consent given in connection with care and treatment as part of the delivery of care and treatment, as obtained from the patient.

11.7 The use of force can never be considered negligible in any of the following circumstances:
(a) Any use of rapid tranquillisation.
(b) Any form of mechanical restraint.
(c) Where there is verbal or physical resistance from the patient.
(d) Where the use of force involves the use of a wall, floor, (or other flat surface) and the use of force is disproportionate.
(e) Where a patient complains about the use of force either during or following the use of force.
(f) Someone else complains about the use of force. (This need not be a formal complaint and can include another patient telling a member of staff they are hurting a patient.
(g) Where the use of force causes an injury to the patient or a member of staff, including scratches, marks to the skin and bruising.
(h) Where the use of force involves more members of staff than is specified in the patient's care plan.

(i) If during or after the use of force, a patient is upset or distressed.

11.8 Any intervention that meets the above criteria is negligible and is therefore not considered a use of force. However, hands on interactions with patients must be included in the patient's care plan and be recorded, monitored and reviewed weekly.

12 CONCERNS REGARDING THE USE OF FORCE

12.1 Where any member of staff observes or has concerns regarding the use of force they have a duty to report this accordingly.

12.2 ACG actively encourage the reporting of suspected wrongdoing as soon as possible, and staff can be assured that their concerns will be taken seriously and investigated as appropriate, and that their confidentiality will be respected wherever possible.

12.3 Staff should escalate any concerns to their line manager in the first instance. Where they feel unable to do this or, it would be inappropriate to, or would prefer not to, they can raise their concerns through a number of alternative routes, including direct to the CEO, via the Freedom to Speak Up guardian speakup@activecaregroup.co.uk or using Safecall, an independent whistleblowing service provider (0800 915 1571 or report online at www.safecall.co.uk/report).

12.4 Any inappropriate or disproportionate use of force must be escalated and reported in accordance with the incident management reporting process and documented on Datix, with a flag for a safeguarding concern. Any incidents that meet the threshold for a safeguarding referral must be referred in line with local safeguarding procedures along with a notification to the regulator. Any such incidents will be investigated.

12.5 Where a patient, family member or any other person raises a concern regarding the use of force, this must be reported on the incident management system and escalated accordingly for investigation/response. Such concerns should never be dismissed or downplayed, and staff must recognise the impact and potential trauma of witnessing physical interventions on others.

13 CARE PLANNING AND INVOLVING PEOPLE WHO USE OUR SERVICES

13.1 The co-production of care plans, risk plans and positive behaviour support plans is integral to supporting recovery in patients and forms part of the model of care in ACG hospitals. Families, carers and independent advocates will be involved in accordance with the patient's wishes.

13.2 Care plans and Positive Behaviour Support plans must include preventative strategies to the use of force, as identified with the patient.

13.3 Care and risk plans will be reviewed and updated collaboratively as part of the incident cycle.

13.4 Patient post-incident support must be provided in line with the person's care plan and My Support Plan in order to ensure the support provided is in line with their wishes. There is extensive debrief guidance contained within the Incident Management policy (ACG/Group/C&L02).

13.5 Risk and care plan plans must be reviewed following the incident cycle and ensuring that these take full account of the patient's views and those of any family members subject to the patient's consent.

13.6 An expert consultant was engaged with the initial development of this policy to obtain input from people who use our services in relation to what information they felt was important to people and in the development of the patient information leaflet. This was limited to one adult service due to the short timeframe for implementation.

13.7 At first review, people across different services were consulted by an independent user involvement specialist. Findings are reflected throughout this policy and a summary is appended.

14 CONSENT AND CAPACITY

14.1 Matters of consent arise in this policy specifically in relation to:

(a) The sharing of information with those named for notification in a care plan following the use of force.

(b) When consenting to the use of negligible force.

14.2 Where the Act and this policy refers to the patient giving consent, this assumes the definition provided within the Code of Practice to the Mental Health Act:

"Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent."

14.3 Where the patient's ability to give valid consent is called into question, this should be formally assessed under the Mental Capacity Act (those aged 16 and over) or using the Gillick principles to assessment competence (in those under 16).

15 ADDITIONAL CONSIDERATIONS FOR CHILDREN AND YOUNG PEOPLE

15.1 Additional considerations apply in the care and treatment of children and young people, and professionals working with this particularly vulnerable group of people must be familiar with the relevant legislation (e.g. The Children's Act).

15.2 The restraint or isolation of a child or young person may be particularly traumatic for both them and for other patient who witness such incidents.

15.3 Services providing care in a CAMHS setting must ensure the rights of the child are protected at all times, specifically in situations where they are separated or isolated from others within the unit. Suitable engagement, activities, education and support must be provided.

15.4 The environment should be the least restrictive possible and should be as homely and personalised as practicable given any risk associated with the individual.

15.5 Those with parental responsibility will be notified of any episodes of restraint or isolation or other restrictive intervention, subject to the consent of the child or young person in accordance with Gillick principles/Mental Capacity Act.

16 ADDITIONAL CONSIDERATIONS FOR SPECIFIC GROUPS

16.1 Active Care Group provides a range of services in various settings to people with a broad spectrum of individual needs. Some services provide care and treatment to those who have specific needs, such as autism. All services serve the general population and staff are expected to recognise the differences in approach required to ensure services recognise and are respectful and responsive to the cultural differences, beliefs and practices of the population being served.

16.2 This includes recognising the individual needs of the wider patient population including children and young people, adults, women and girls, patients with autism or a learning disability, people from black and minority ethnic backgrounds and people who share protected characteristics under the Equality Act 2010."

16.3 People from particularly vulnerable groups may be more likely to experience multiple overlapping risk factors and poor health (such as poverty, violence and complex trauma), experience stigma and discrimination.

16.4 Services must ensure that specific needs are identified prior to, or as soon as possible following admission and care plans are co-produced that address any such needs e.g. religious or spiritual, staff gender preference, specific health vulnerabilities, accessible information, communication needs etc.

16.5 In accordance with the Restraint Reduction Network training Standards, staff must ensure that no individual is exposed to any restrictive practice because of their age, mental health status, mental capacity, physical impairment, race/ethnicity, religion and belief, gender (including transgender), HIV/AIDS status, sexual orientation, political opinion, socio-economic background, spent convictions, or on any other grounds which are irrelevant to a decision-making process leading up to any application, and that any interventions are necessary and proportionate.

16.6 Non-discriminatory practice forms part of training for all staff.

17 INFORMATION ABOUT THE USE OF FORCE

17.1 The responsible person is required to consult on, publish and keep under review information, for patients about the use of force.

17.2 This is to be provided to patients on admission (and to any existing inpatients at the time the Act is enacted).

17.3 This information should also be provided to families.

17.4 The information required is listed below:

(a) A statement that the use of force is only ever used proportionately and as a last resort and that it can never be used to cause pain, suffering, humiliation or as a punishment.
(b) Which staff may use force and in what circumstances, and what approaches and steps will be taken to avoid using it.
(c) Details of the types of force (techniques and approaches used) which staff may use with a distinction between children and young people, adults and older people and sex.
(d) Details of how stakeholders must be involved in care planning which sets out the preventative strategies to the use of force.
(e) Details of how stakeholders must be involved in post incident reviews following the use of force.
(f) What action the organisation will take if the inappropriate or disproportionate use of force is identified.
(g) The patient's rights in relation to the use of force.
(h) The patient's legal rights to independent advocacy and how to access it, the role of the IMHA and IMCA.
(i) The organisation's complaints procedure and the process for raising concerns about abuse and breaches of human rights, and the help available from independent advocates.
(j) Information on what will be recorded and reported on the use of force.

(k) Details on how the organisation will work to co-produce policies and information with their local patient populations.
(l) A glossary of the terms used by staff and the organisation in relation to the use of force.
(m) Details on where the policy on the use of force can be found.
(n) Details of how often the information about use of force will be reviewed and by whom.

17.5 This is a significant amount of information to provide and for patients to take on board and staff must be mindful that information about the use of force must be given in a way that is open and honest, but which also does not appear as a threat or to ensure compliance.

17.6 ACG have worked with service user representatives on how best this information can be made available, and patient feedback indicated that:
(a) Patients should be given information about use of force in written form as a leaflet or ideally as a poster kept on the ward or in their rooms safely.
(b) Information on use of force should be given gently but proactively before a restraint is necessary (i.e. process should be explained beforehand).
(c) Staff should explain to patients "I don't want to put you in a hold, but will keep you safe when you are in one".
(d) Staff should reassure patients that they are safe when in holds and reassurance should be given.
(e) Staff need to be aware that there is an imbalance of power between staff and service users, this is particularly noticeable during use of force.
(f) Staff should be aware that any use of force – hands on or off (restrictive practice) – can be distressing for some.

17.7 Information leaflets and posters are available for sites and will reference this policy.

17.8 Service managers must implement a system locally to ensure that all patients are provided with this information and that there is documented evidence of this.

18 INVESTIGATION OF DEATH OR SERIOUS INJURY

18.1 When a patient dies or suffers a serious injury in a mental health unit, the responsible person for the mental health unit must have regard to any guidance relating to the investigation of deaths or serious injuries that is published by:
(a) The Care Quality Commission (see Part 1 of the Health and Social Care Act 2008).
(b) Monitor (see section 61 of the Health and Social Care Act 2012).
(c) The National Health Service Commissioning Board (see section 1H of the National Health Service Act 2006).
(d) The National Health Service Trust Development Authority (which is a Special Health Authority established under section 28 of the National Health Service Act 2006).
(e) A person prescribed by regulations made by the Secretary of State.

18.2 Internal ACG reporting and investigation processes should be followed in addition to the above.

19 POLICE ATTENDANCE ON SITE

19.1 Where police attend a mental health unit to assist staff, attending officers must wear and keep operational, a body camera if reasonably practicable.

19.2 All staff should be aware that police attendance on site will likely be alarming for staff and patients alike. The Protocol for Police and Mental Health staff in (rcem.ac.uk)

provides clarity on the role of the police service in responding to incidents within mental health and learning disability settings and identifies its over-arching ethos as follows:

(a) Each situation should be properly judged on its individual merits.

(b) Police officers should NOT be called to undertake restrictive practices, connected to purely clinical interventions (e.g. taking of fluid samples, injections, etc.) unless exceptional factors apply.

19.3 These exceptional factors could include (but are not restricted to):

(a) An effort by healthcare staff to undertake a restrictive intervention (restraint, manual handling, threatened or actual use of force or other therapeutic intervention that involves the threatened or actual use of force) without police support has led to injury to staff which compromises their ability to continue safely; OR

(b) No other support from healthcare staff is available or appropriate in a sufficiently timely manner to ensure safety of all those affected.

19.4 The police service should ensure an appropriate response to allegations of crime and to requests for immediate support in connection with risks of serious injury or damage, where healthcare providers' internal mechanisms have been unsuccessful and safety is then compromised.

20 IMPLEMENTATION

20.1 A Use of Force working group was established to support the implementation of this Act and policy across relevant services. The Use of Force Act now sits within the Reducing Restrictive Practice and Human Rights Committee, which reports to the Quality Assurance Committee.

20.2 Although staff receive the necessary training as part of their physical intervention training on appointment and refresher, there is a need to ensure all staff are aware of requirements in the interim period.

20.3 This was achieved, in the period prior to implementation by the provision of information to sites, which should be shared at local clinical governance and cascaded throughout the service via handovers and other routes as identified by the service manager.

20.4 Information was provided to all current inpatients through the publishing of posters and the sharing of information leaflets to those in services as soon as is reasonably practicable after 31 March 2022. Patients are now given this information routinely.

20.5 A copy of this policy is published on the company website.

20.6 The delegation of tasks is set out in Appendix A.

21 MONITORING

21.1 This policy will be reviewed annually.

21.2 Data and activity on the use of force across services will be reviewed in the Reducing Restrictive Practice and Human Rights Committee.

21.3 This data, and feedback from services, will be used to inform future policy reviews.

21.4 The Group is committed to working with the professional Expert by Experience to review and co-produce policies.

22 EQUALITY IMPACT STATEMENT

22.1 This policy has been equality impact assessed and we believe that it is in line with the Equality Act 2010 as it is fair, it does not prioritise or disadvantage any employee or applicant and it helps to promote equality in our services.

23 DOCUMENT VERSION HISTORY

Version	Description of Revision	Date of Revision
1	New document	30/03/2022
2	Reviewed in response to CQC feedback and in alignment with guidance. Policy reference changed from ACG/Hospital/01	23/02/2024

Appendix A

USE OF FORCE ACT- DELEGATION OF TASKS SCHEDULE

	Requirement	**Statutory Reference[1]**	**Statutory Guidance Reference[2]**	**Delegated Person(s)**
1	Policy on Use of Force Including producing, consulting, publishing, and keeping under review.	Section 3	Chapter 2	Group Mental Health Law Manager, Policy Manager
2.	Information about the Use of Force Publishing, Consulting, keeping under review Giving information to patients (and others) and ensuring they understand	Section 4 Section 4 (1)(2)(6)(7)(8) Section 4 (3)(4)(5)	Chapter 2	Group Mental Health Law Manager, Policy Manager As above Patient-facing staff
3.	Training in appropriate Use of Force Including providing training, ensuring the content meets requirements, refreshing and keeping under review	Section 5	Chapter 2	Chief People Officer, Operational PBS Lead in collaboration with training providers Hospital Directors responsible for ensuring all staff training attendance
4.	Reporting Use of Force- including internal recording and reporting and external reporting via MHMDS	Section 6	Chapter 2	Hospital Directors responsible for ensuring incidents are reported on incident reporting system. Intelligence & Insights Team
5.	Investigation of Deaths or Serious Incidents	Section 9	Chapter 2	Group Director of Risk and Governance

[1]Mental Health Units (Use of Force) Act 2018
[2]Mental Health Units (Use of Force) Act 2018 Statutory guidance for NHS organisations in England, and police forces in England and Wales (published 7th December 2021)