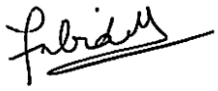
Birmingham and Solihull Mental Health NHS Foundation Trust

SAFE USE OF FORCE
(Use of Force Act 2018,Seni's Law)

Policy number and category	**C 26**	**Clinical**
Version number and date	**2**	**March 2023**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**March 2023**	
Next anticipated review	**March 2026**	
Executive director	**Medical Director (Responsible Person for the Use of force Act)**	
Policy lead	**Chief Mental health legislation Officer**	
Policy author *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

The use of force includes physical, mechanical or chemical restraint of a patient, the isolation of a patient, including seclusion and segregation.

Such use of force has to comply with the trusts values of compassion and inclusion and :

1.The Human Rights Act 1998 (freedom from torture, inhuman and degrading treatment)

2.The Mental Health Units (Use of Force) Act 2018.

3. The Mental health act 1983 amended 2017

The Use of force act and the statutory guidance issued by the Department of Health and Social Care 2021 clearly set out the measures that are needed to both prevent the inappropriate use of force and ensure accountability and transparency about the use of force in mental health units.

This policy will provide the overarching framework information needed by BSMHFT staff on how they should meet the legal obligations placed on them by the act, in addition to best practice advice.

Policy requirement (see Section 2)

- The Policy sets out to achieve the aims of the Mental Health Units (Use of Force) Act 2018 section 3 and the statutory guidance for NHS units 2021.
- Section 3 – requires that the responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.
- The policy sets out the measures which are being undertaken to both reduce the use of force and set out the accountability and transparency about the use of force
- How we record and reports data on the use of force, the quality of staff training, and the way in which investigations are carried out when things go wrong
- Use of a human rights-based approach to the use of force, working with patients in a trauma-informed, person-centred way, and developing therapeutic environments which ensure that force is used proportionately and only ever used as a last resort.

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1: Introduction

1.1 Rationale

Birmingham and Solihull Mental health Foundation trust (BSMHFT) has a commitment to minimising the use of force, through the promotion of positive cultures, relationships and approaches which will prevent escalation and any need to use force**.**

The Trust is committed to its values of compassion and inclusion and all use of force in the Trust and Policies and procedures governing it will reflect this .

Section 3 of the Use of Force Act 2018 and Department of Health Guidance on use of force Act 2021 requires that the:

1. *Responsible person for BSMHFT (The Medical Director) must publish and keep under review a policy regarding the use of force on patients by staff who work in BSMHFT.*
2. *One single organisation wide policy should be produced and shared across the organisation ensuring there is a consistent approach across the organisation*
3. *This single overarching policy on the use of force sets out to bring together the different policies and procedures currently in place governing the use of force in BSMHFT including physical, mechanical or chemical restraint of a patient the isolation of a patient, including seclusion and segregation*.

1.2 Scope

This policy will apply in all instances where force is used in BSMHFT inpatient wards against patients.

This policy serves as an overarching policy covering all use of force including physical (physical restraint and mechanical restraint), chemical and isolation (seclusion/segregation) of a patient.

1.3 Principles

All uses of force must be rights-respecting, lawful and compliant with the Human Rights Act 1998. Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away – but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment are absolute and can never be restricted.

The Human Rights Act 1998 incorporates into domestic law the rights enshrined in the European Convention on Human Rights (ECHR). Articles 3 (freedom from torture, inhuman and degrading treatment), 8 (respect for private and family life) and 14 (protection from discrimination) of the ECHR are those which relate to the use of restraint in mental health settings. It means all public authorities and organizations such as BSMHFT carrying out public functions (including the provision of mental health units) are legally obliged to respect patient's rights and take reasonable steps to protect those rights.

Alongside the Human Rights Act 1998, the UK government has signed and ratified other United Nations (UN) human rights treaties which are relevant to the use of force. Organisations such as BSMHFT are required to ensure that all staff are aware of and understand their duties under the Human Rights Act 1998 and other relevant UN human rights treaties.

This includes:

- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- International Covenant on Civil and Political Rights (ICCPR
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)

Further detailed guidance on human rights is provided via:

- Chapter 26: Safe and therapeutic responses to disturbed behaviour – Mental Health Act 1983: Code of Practice
- Equality and Human Rights Commission; Human rights framework for restraint
- Human rights framework for people in detention – Equality and Human Rights Commission
- Mental Health, Mental Capacity and Human Rights: A practitioner's guide – the British Institute of Human Rights

BSMHFT aims to ensure that the legislative framework is applied in a way which is compatible with ECHR rights and freedoms. The Human Rights Act 1998 is the foundation on which other laws and duties are implemented.

There are legal frameworks including those under the Mental Health Act 1983 and the Mental Capacity Act 2005 that are designed to ensure that any use of force is applied only after a proper process has been followed. Such legal frameworks require any force used to be necessary and proportionate, and the least restrictive option.

BSMHFT will only authorize its staff to use force in line with legislation relevant to the use of force:

- Human Rights Act 1998
- The Mental Health Act 1983 (as amended 2007)
- Mental Capacity Act 2005
- Equality Act 2010
- The Children Act 1989
- The Children Act 2004
- The Children and Families Act 2014
- The Care Act 2014

'*The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this*.'

2: **The policy**

The Policy sets out to achieve the aims of the Mental Health Units (Use of Force) Act 2018 section 3 and the statutory guidance for NHS units 2021.

The act, which received royal assent in November 2018, is better known as Seni's Law and is named after Olaseni Lewis, who died as a result of being disproportionately restrained while a voluntary inpatient in a mental health unit in south London.[1]

The policy sets out the measures which are being undertaken to both reduce the use of force and set out the accountability and transparency about the use of force.

How we record and reports data on the use of force, the quality of staff training, and the way in which investigations are carried out when things go wrong

Use of a human rights-based approach to the use of force, working with patients in a trauma-informed, person-centred way, and developing therapeutic environments which ensure that force is used proportionately and only ever used as a last resort.

BSMHFT provides different types of services across several units the policy this policy set out the different needs or considerations that may be relevant for particular patient groups, including children and young people, adults, women and girls, elderly and patients who share protected characteristics under the Equality Act 2010.

This Trust recognises that there are differences in approach required to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the patient population being served.

We recognise the differences in approach required to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the patient population being served. This includes understanding of cultural identity and heritage, and the discrimination faced by many people from black and minority ethnic backgrounds, in particular by black men. Eg: the over-representation of black men being restrained.

Our Policy and practice recognises the specific needs of the socially excluded, including people who experience homelessness, people with drug and alcohol dependence, or victims of modern slavery. They typically experience multiple overlapping risk factors and poor health (such as poverty, violence and complex trauma), experience stigma and discrimination.

The policy sets out the plan / approach the organisation is taking to reduce the use of force within BSMHFT inpatient units.

[1] https://www.gov.uk/government/news/new-law-to-prevent-use-of-force-in-mental-health-settings

The policy includes the following:

a) the organisation's commitment to protect human rights and freedoms
b) the organisation's commitment to minimising the use of force, recognising the potentially traumatising impact the use of force can have
c) information about how the organisation will monitor the use of force on people who share protected characteristics
d) what action the organisation will take if the inappropriate use of force is identified
e) details of the types of force and specific techniques which the BSMHFT may use, which may be different in services for children and young people, adults or older people; including information about the risk assessments undertaken prior to the techniques being approved by the trust board, and an assessment of the training needs of staff in using these techniques. All types of use of force in BSMHFT will be in line with Both the Mental Health Act 1983: Code of Practice and Positive and Proactive Care: reducing the need for restrictive interventions guidance set out in relation to physical restraint
f) circumstances in which the use of force may or may not be used, and when a use of force is considered negligible (in accordance with Department of Health guidance 2021)
g) information on how the risks associated with the use of force will be managed
h) details of relevant staff training programmes and how learning and knowledge will be transferred into the workplace. This includes the importance of all training complying with Restraint Reduction Network National Training Standards
i) details of how patients, their families, carers, and independent advocates will be involved in care planning which sets out the preventative strategies to the use of force, through for example advance statements
j) information about how staff will use and follow individualised patient plans
k) details of how patients, their families, carers, and independent advocates will be involved in post incident reviews following the use of force, and how the impact (physical or emotional) will be reflected in the patients' follow up care. The NICE Quality Standard, Quality Statement 5 provides further information on post incident debrief
l) clear information on the expectations for recording and reporting of the use of force within the organisation
m) detail on how local management information will be used to inform development and review of the policy (see below)
n) details on how BSMHFT will work to co-produce policies with their local patient populations to reflect their needs and experiences
o) details of how the policy will be communicated to patients, families, carers and independent advocates
p) Details of how often the policy will be reviewed and by whom

3: The procedure:

The Trust has individual polices covering different areas of use of force these include:

1. Clinical Risk Assessment Policy (appendix2)
2. Prevention and Management of Violence Policy (appendix3) (physical restraint)
3. Duty of Candour (appendix 4)
4. Learning from Deaths Policy (appendix 5) (investigation of use of force)

5. Rapid Tranquilisation Policy (appendix 6) (chemical restraint)
6. Seclusion and Segregation policy (appendix 7) (use of isolation)
7. Trauma Risk Incident Management Policy (appendix 8)
8. Care Programme Approach and Care Support Policy/ dialogue plus (appendix 9) (How use of force will be incorporated into care planning)
9. Police Interventions Policy (appendix 10) (use of body worn cameras in BSMHFT hospitals by the police)
10. Handcuff Policy/Use of Mechanical restraints (Appendix 11) (use of mechanical restraint)
11. Emergency Response Belt (appendix 12) (use of Mechanical restraint)
12. The Reporting, Management & Learning from Incidents Policy (appendix13)

All the above polices should be read in line with and the Use of Force Act 2018 and Mental Health Units Use of Force Department of Health guidance 2021.

Key definitions and areas

"Mental disorder" has the same meaning as in the Mental Health Act 1983.

"Mental health unit" means—
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,

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

References to "use of force" are to the use of physical, mechanical, or chemical restraint on a patient, or the isolation of a patient.

Responsible person

It is essential that there is accountability and responsibility for the use of force at the highest level within an organisation. BSMHFT has a legal, professional and ethical obligation to minimise harm to service users, staff and others, and therefore must be accountable for the use of force within it.

As per the Mental Health Units Use of Force Act 2018, relevant health organisation (NHS Foundation Trust) operating a mental health unit must appoint a 'responsible person' whose role it is to ensure that the organisation complies with the requirements of the Act.

For the purposes of the Act the executive Medical Director of BSMHFT will be the responsible person.

The responsible person should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in. The Responsible person will be guided by the impact of trauma on patients and the potentially re-traumatising impact of the use of force.

The Responsible person will ensure a consistency of approach to the use of force across the organisation. The Medical director will be the responsible person for all Mental health units within BSMHFT.

The responsible person may delegate some of their functions under the Act to other suitably qualified members of staff within the organisation. Whether the responsible person delegates any of the Act's duties or not, they retain overall accountability for these duties being carried out.

When responsible person has delegated a duty to a relevant person, they can still perform this duty themselves. Whether the responsible person delegates any of the Act's duties or not, they retain overall accountability for the duties being carried out on their behalf.

If the responsible person delegates any of their functions to others within the organisation, they should keep a record of what they have delegated and to whom.

The Mental health legislation compliance aspects of the Responsible person's duties will be delegated by the Executive medical director to the chief Mental health legislation officer.

The measures which are being undertaken to reduce the use of force and investigations surrounding use of force will be delegated to the chair of the restrictive practices reduction group for the trust and local areas .

Day to day implementation, monitoring and reporting of the use of force will be delegated to the Clinical lead (clinical director for areas without suitable clinical lead) for the Area and Clinical Nurse Managers for each mental health unit (Hospital) within BSMHFT.

Information about Use of Force

It is important that patients, and where appropriate their families and carers, are provided with information about the use of force and their rights in relation to any use of force which may be used by staff in BSMHFT. The information will help patients and their families and carers understand what might happen to them while they are an inpatient in a mental health unit, what their rights are, and what help and support is available to them should they need it.

As with the policy on use of force, the responsible person must publish and keep under review information about the rights of patients as it relates to the use of force. It is important the information being provided reflects the age and needs of the patient population using the service and is tailored to the specific service being provided. Where an organisation is providing different types of services across several units the information should be specific to the type of service being provided.

In line with the DOH guidance 2021 BSMHFT has published a coproduced leaflet and video on the use of force (annex13) which covers the following:

- A clear 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

- Which staff may use force and in what limited circumstances, and what approaches and steps will be taken to avoid using it
- 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

- Details of how patients, their families, carers, and independent advocates must be involved in care planning which sets out the preventative strategies to the use of force, through for example advance decisions
- Details of how patients, their families, carers, and independent advocates must be involved in post incident reviews following the use of force
- What action the organisation will take if the inappropriate use of force is identified
- The patient's rights in relation to the use of force; this includes rights protected by the Human Rights Act 1998, the Mental Health Act 1983, Mental Capacity Act 2005, and the Equality Act 2010 (including the duty to make reasonable adjustments)
- The patient's legal rights to independent advocacy and how to access organisations who can provide this service, and the role of the Independent Mental Health Advocate and Independent Mental Capacity Advocate (if applicable)
- The organisation's complaints procedure and the help available from an independent advocate to pursue a complaint in relation to the use of force
- The process for raising concerns about abuse and breaches of human rights, and the help available from independent advocates
- Clear information on what will be recorded and reported on the use of force
- Details on how organisations will work to co-produce policies and information with their local patient populations
- A glossary of the terms used by staff and the organisation or trust in relation to the use of force
- Contact details of independent advocacy services and other relevant local and national organisations
- Details on where the policy on the use of force can be found
- Details of how often the information will be reviewed and by whom
- Before publishing the information leaflet, consultation with both current and former patients, their families and carers, bereaved families, staff representatives, and any relevant local third-party sector organisations will take place. This will be carried out through existing networks, user groups and forums.

Recording of Use of Force

BSMHFT seeks to promote openness and transparency within its hospitals about how often use of force occurs , and the reasons why. Robust data collection has many organisational advantages, such as informing restraint reduction plans and identifying issues at an individual patient level.

Recording use of force also helps public authorities such as BSMHFT to meet its obligations under the Public Sector Equality Duty, by demonstrating an understanding of use of force on different groups. This will enable action to reduce any disproportionate use of force identified.

BSMHFT will have the necessary systems in place to record any use of force and that staff have the training, knowledge and skills to do so correctly.

The responsible person (or members of staff to whom the responsibility for keeping a record has been delegated to) will ensure that all staff involved in the use of force understand the relevant definitions and terminology, and guidance about what must be recorded.
It is already mandatory for NHS trusts, to submit data on the use of force to the NHS Digital Mental Health Services Data Set.

4: Responsibilities

This summarises defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All Staff	1. To read and understand this policy and its annexes and act in line with this policy. 2. Undertake appropriate training in the use of force as offered by BSMHFT based on their job role. 3. Report the use of force accurately and in a timely manner through the eclipse system.	
Service, Clinical and Corporate Directors	1. To ensure that use of force is reported in line with this policy within their service areas. 2. Staff within their service areas are offered training in line with this policy on the use of force. 3. Use of force is appropriately reviewed and incidents investigated in line with this policy.	
Policy Lead	1. This policy is reviewed annually and updated based on current good practise and consulted on appropriately. 2. Takes on delegated roles from the responsible person.	
Executive Director	Fulfils the role of responsible person and delegate appropriately	
Policy leads for Below Policies: **1. Clinical Risk Assessment Policy** **2. Prevention and Management of Violence Policy** **3. Duty of Candour** **4. Learning From Deaths Policy** **5. Rapid Tranquilisation Policy (chemical restraint)** **6. Seclusion and Segregation policy (use of isolation)**	Ensure that their policies are annually updated in line with the Use of force Act and learning from investigations on the use of force	

7. Trauma Risk Incident Management Policy **8. Care Programme Approach and Care Support Policy (How use of force will be incorporated into care planning)** **9. Police Interventions Policy (use of body worn cameras in BSMHFT hospitals by the police)** **10. Handcuff Policy (use of mechanical restraint)** **11. Emergency Response Belt (use of Mechanical restraint)** **12. The Reporting, Management & Learning from Incidents Policy**		

5: Development and Consultation Process Consisting of:

Before publishing this policy, the responsible person is required to consult, as per the use of force Act 2018 guidance for NHS Mental health units 2021, "*with whoever they consider it appropriate to consult.* This should include both current and former patients, their families and carers, bereaved families, and any relevant local third sector organisations. This may be carried out through existing networks, user groups and forums. The policy should also include details of who or which groups were consulted.

It is important that staff working in mental health units recognise the valuable contribution people with lived experience can have in the design and improvement of services. Mental health units should ensure that the policy on use of force is co-produced with people with lived experience of mental health services, along with their families and carers."

In line with the above, the policy has been consulted on with current and ex service users, carer representatives.

The Act requires the responsible person to keep the policy on use of force under regular review. This should be done on an annual basis to ensure it is up to date with current practice and evidence, and to allow for local management information to inform the review. If the review suggests changes to the policy which are considered to be a substantial change, the Act requires that the responsible person must again consult on the changes and re-publish the policy.

Consultation summary	
Date policy issued for consultation	March 2022
Number of versions produced for consultation	2
Committees / meetings where policy formally discussed	**Date(s)**

CGC	March 2022
Secure Care CGC	
Tamarind CGC	First Wednesday, January, Feb, March 2022 , April 2022
Focus Groups Incl Service Users & Carers **PDMG**	June 2021 to April 2021 April 2022

Where received	Summary of feedback	Actions / Response

*(*Add rows as necessary)*

6: Reference Documents:

1.**https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales**

7: Bibliography:

- Use of Force Act 2018
- Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales
- Mental Health Act 1983: Code of Practice
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- International Covenant on Civil and Political Rights (ICCPR
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)
- Human Rights Act 1998
- The Mental Health Act 1983 (as amended 2007)
- Mental Capacity Act 2005
- Equality Act 2010
- The Children Act 1989
- The Children Act 2004
- The Children and Families Act 2014
- The Care Act 2014

8: Glossary:

Mental Disorder has the same meaning as in the Mental Health Act 1983 which is “any disorder or disability of the mind”.

- Mental Health Unit is described as a health service hospital or independent hospital in England (or part thereof) that provides treatment to in-patients for a mental disorder. An independent hospital (or part thereof) will only be a “mental health unit” if its purpose is “to provide treatment to in-patients for mental disorder”, and “at least some of that treatment is provided, or is intended to be provided, for the purposes of the NHS.”
- The types of in-patient service which would be considered within the definition of a mental health unit (this is not an exhaustive list) include:
- acute mental health wards for adults of working age and psychiatric intensive care units
- long-stay or rehabilitation mental health wards for working age adults
- forensic inpatient or secure wards (low/medium and high)
- child and adolescent mental health wards
- wards for older people with mental health problems
- wards for people with a learning disability or autism
- specialist mental health eating disorder services
- acute hospital wards where patients are “detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder”

The following services are considered to be outside of the definition of a mental health unit (this is not an exhaustive list) and therefore not covered by the requirements of the Act:

- accident and emergency departments of emergency departments
- section 135 and 136 suites

9: Audit and Assurance:

The policy will be published in line with the requirement of the DOH guidance. This will be on the trust’s website and intra net and in hard copy format. The policy should be made available in different formats (such as easy read) and languages as appropriate to the type of service being provided and the population being served in line with the duty to make reasonable adjustments. all available formats will be published on the trust’s website

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Data publication Annual report	responsible person /policy author supported by Governance Intelligence team and restrictive practices reduction committee	Data as set out in the policy	Quarterly	Local clinical governance Committees MHL subgroup/committee Trust clinical governance and QPES

10. Appendices

Appendix 1 - Equality Impact Assessment

Appendix 2 - Addendums to existing Policies

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**Mental health units use of force Act 2018**		
Person Completing this proposal	Dr.Dinesh Maganty	**Role or title**	Chief Mental Health legislation officer
Division	Medical directorate	**Service Area**	Medical directorate
Date Started	0ct 2022	**Date completed**	Dec 2022

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

Improving the practise of use of force , minimising use of force

This policy recognises as required by the statutory guidance under the use of force act that It is important that the differences in approach required to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the patient population being served becomes part of practise . This should include understanding of cultural identity and heritage, and the discrimination faced by many people from black and minority ethnic backgrounds, in particular by black men. In the context of use of force one needs to consider the needs of inclusion health groups i.e people who are socially excluded, this includes people who experience homelessness, people with drug and alcohol 19 dependence, or victims of modern slavery. They typically experience multiple overlapping risk factors and poor health (such as poverty, violence and complex trauma), experience stigma and discrimination which leads to use of force having a particularly disproportionate effect on them ..

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Who will benefit from the proposal?

The use of force policy reduces the adverse impact of use of force by

1. Increasing recording and transparency of use of force

Promoting culture change and encouraging consideration of the disproportionate adverse effect of use of force on different groups especially those who are socially and culturally marginalised

Do the proposals affect service users, employees or the wider community?
Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward

NHS digital data (2017) shows Girls and young women under the age of 20 were the most likely to be restrained, each being subjected 30 times a year on average to techniques involving use of force .

Black people were three times more likely to be restrained than white people, according to the first comprehensive NHS National data on the use in England published by NHS Digital 2017

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There were 3591 physical restraints in 2019 in BSMHFT

Female 1980

Male 1611

- British - White 2395 B - Irish - White 14 C - Other White - White 91 D - White & Black Caribbean - Mixed 81 E - White & Black African - Mixed 12 F - White & Asian - Mixed 167 G - Other Mixed - Mixed 41 H - Indian - Asian Or Asian British 30 J - Pakistani - Asian Or Asian British 208 K -Bangladeshi - Asian Or Asian British 19 L - Other Asian - Asian Or Asian British 35 M - Black Caribbean - Black Or Black British 200 N - Black African - Black Or Black British 99 P - Other Black - Black Or Black British 29 R - Chinese - Other Ethnic 6 S - Other Ethnic Category - Other Ethnic 81 U - Arab 18 Z - Not Stated 65

Summary of Seclusion Data Collected for the Use of Force Act 2022

1. The reason for use of force with regard to seclusion is recorded as it is collected on RiO but currently not coded and directly reported and there is ongoing work to collect and report this data in all cases . The current quarter data is available in over 95% of cases.

2. The Number and duration of use of force. In year 2020 there were 582 seclusion, in 2021 640 and in 2022 until the end of September there have been 500 seclusion episodes in BSMHFT.

The longest duration of seclusion in year 2020 was 85.9 days, the median being 1.5 days and mean being 3.4.

For 2021 the longest duration is 119.1 days, median 1.6 days and mean 4 days.

For the year 2022 the longest seclusion being 168.3 days, the median being 1.8 days and mean being 4 days.

There is gradual year on year increase in median and mean duration of seclusion and longest seclusion duration over the last 3 yrs .

Nationally there has been increase in duration of seclusions lasting more than 2 weeks. This is also reflected in BSMHFT. In 2020 there were 17 seclusion lasting more then 15.5 days. In 2021 there were 23 and 2022 until end of September there are 16 seclusions lasting more than 15.5 days.

3.The Use of Force Act requires that whether seclusion is used as part of the patient's care plan is recorded. This is currently not coded for collection on the report but the ICT team is currently working on including this in the reporting.

4.The name of the patient on whom the use of force is used is available in 100% of cases.

5.The name and job title of every member of staff who used force on the patient is available in 100% of cases and virtually on all cases of recorded use of force by BSMHFT members of the nursing team with other professionals involved in a very small minority of cases (OT and psychology).

6.The reason and if any member of staff who is not a staff member of the mental health unit was involved in the use of force on the patient is not recorded currently within BSMHFT within any of the record keeping systems. There is lack of recognition within BSMHFT staff currently that use of Restraint , handcuffs etc when employing external contractors such as secure care or Prometheus should be recorded under the Use of Force Act .It is recognised that BSMHFT does employ staff from other providers, such as Secure Care and Prometheus to use force on BSMHFT patients whilst transporting them between hospitals or during what it terms as bed watches. This needs to be recorded by the Eclipse system so that it can be reported on.

7.The patient's mental disorder. This is known and recorded in 100% of cases. The vast majority of patients have a diagnosis of either schizophrenia, schizoaffective disorder or bipolar affective disorder or depression with a secondary diagnosis in some cases of personality disorder.

8.The relevant characteristics of the patient are recorded and are available.

Year	BAME	Non-BAME	Unknown	Total
2020	288	276	18	582
2021	318	305	17	640

2022 (until Sept)	246	227	27	500

Over the last 3 years in every year where ethnicity is recorded a majority of patients in whom seclusion is used are from a BAME background. Year 2020 49.5%, 2021 49.7%, 2022 49.2%. (with at least 4%not known)

It is clear that there is disproportionality in the use of seclusion as the majority of patients detained under the Mental Health Act or the majority of admissions to BSMHFT services are not BAME but the majority of known seclusions are used in the case of BAME patients.

9.The recording of learning disability or autistic spectrum. This has been recorded 100% of the time.

Year	Learning Disability or Autism Yes	Learning Disability or Autism No	Total
2020	110	472	582
2021	72	568	640
2022	32	468	500

It is clear that a vast majority of patients who were secluded in BSMHFT do not have autism or learning disability. This is to be expected considering that BSMHFT does not provide services to patients who have an exclusive diagnosis of autism or learning disability as an inpatient setting.

10.Currently a reporting system is being built, though data is available on RiO whether physical injuries or death occurred in a patient's case during seclusion.

11.Recording of any efforts made to avoid the need of use of force on the patient. : This is currently not coded for seclusion but as seclusion inevitably and in virtually all cases is preceded by physical restraint and in the case of physical restraint 99% of cases there is evidence of de-escalation being used. Not Recording separate de-escalation for seclusion is an artifact of recording and an act of not double recording rather than a true reflection of the position.

12.**Recording of notification regarding use of force was sent to a person or persons to be notified under a patient's care plan**, i.e., to family, friends and advocate. This is not currently coded for collection on the report for use of force and work is in progress to secure this data. There is also clear anecdotical evidence that this is not occurring, i.e., family/friends are not being

notified when there is seclusion and are not part of the debrief and currently do not routinely contribute to the care plan to reduce this use of force practice of seclusion in the future. Data gathered over the last 3 months for the Tamarind Centre by the matron shows that this did not occur in the first month in 3 out of 6 cases of use of seclusion and this was reduced to 1 in the following month but required a concerted effort.

13. **The patient's age**.

YEAR	0-20	21-30	31-40	41-50	51-60	61+	Grand Total
2020	45	176	127	123	95	16	**582**
2021	50	233	158	111	80	8	**640**
2022	37	151	144	99	59	10	**500**
Grand Total	**132**	**560**	**429**	**333**	**234**	**34**	**1722**

14.Whether the patient has a disability, and if so, the nature of that disability.

YEARS	N	Y	Grand Total			YEARS	N	Y
2020	358	224	582			**2020**	62%	38%
2021	401	239	640			**2021**	63%	37%
2022	315	185	500			**2022**	63%	37%
Grand Total	**1074**	**648**	**1722**			**Grand Total**	62%	38%

15.The status regarding marriage or civil partnership

Marital Status	2020	2021	2022	TOTAL
Single	390	386	295	**1071**
Unknown	107	156	132	**395**
Married / Civil Partner	32	26	41	**99**

Not asked	22	7	9	**38**
Co-Habitee	2	19	6	**27**
Divorced / Civil Partnership dissolved	9	15		**24**
Not recorded	9	9	1	**19**
Not Disclosed	4	6	7	**17**
Other/Unknown	3	12	1	**16**
Separated	4	2	8	**14**
Not Known		1		**1**
Common Law/Cohabit		1		**1**
	582	**640**	**500**	**1722**

16.The patient's sex

YEAR	Female	Male	Grand Total
2020	244	338	**582**
2021	249	391	**640**
2022	157	343	**500**
Grand Total	**650**	**1072**	**1722**

Use of Force Act Data – Physical Restraint, Chemical Restraint, Mechanical Restraint

1.Percentage of cases where the reason for the use of force is recorded (physical, chemical, mechanical)
99.98%

2.Median duration of force.

Please see chart below. The average length of time a patient was restrained by way of physical and mechanical restraint decreased from 2007 gradually to March 2022 but gradually increased from March 2022 over the next several months.

3.Details of the patient's care plan

There is lack of recording of information of physical restraint being given to carers and advocates or family and friends and them being involved in debriefing of the patient and this informing the care plan of patient. This is a requirement of the Mental Health Act Code of Practice, NICE guidelines on the management of violence and also the Use of Force Act. Despite this, there is currently no recording on RiO nor Eclipse system of information being conveyed to carers or families or advocate when their loved one or patient is restrained or given rapid tranquilisation/chemical restraint or mechanical restraint is imposed on them. This is not a data collection issue but appears to be a practice issue, based on discussions held with various clinicians involved. There needs to be a significant change in practice, i.e., informing carers and family members and having an advocate involved when use of force i.e physical or chemical or mechanical restraint occurs in a patient's case.

a) Percentage of cases where the patient name is recorded
   99.9%

b) Percentage of cases listing staff involved
   75.2%

c) Details of non trust employees involved in a restraint
   Not currently recorded. When staff of Secure Care or Prometheus are involved in restraint processes or transportation of a patient using handcuffs, this is not recorded within the Eclipse system or anywhere else which is reportable.

d) Patients mental disorder
   Is recorded in virtually all cases on RiO.

There is evidence based on previous analysis of black Caribbean patients are at least 2 times more likely to be restrained in prone position and black African at least 4 times more likely to be held in prone restraint. There is ongoing analysis of breakdown of physical, chemical and mechanical restraint based on ethnicities, The raw data is available.

Recording of learning disability and autism. This is recorded on RiO and this is reportable and extractable and would be reported for the next quarter. Injury to patient during physical or chemical restraint. Patients were injured in .1% of cases involving a restraint. De-escalation used occurred in 99.2% of cases of physical and chemical restraint. This can also be extrapolated to seclusion as seclusion is preceded in virtually all cases by physical restraint and/or mechanical restraint. Notification percentage regarding restraint to relevant parties. Notifications are rarely sent to family and carers and the advocate post physical restraint and this is an area of improvement that needs to be targeted.
Do the proposals significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***
Reduce inequality in the use of force by increasing **1. transparency in the use of force** **2. Providing the statutory frame work necessary to reduce the use of force**
Does it involve a significant commitment of resources? ***How will these reduce inequality?***
Respecting a Patients human rights is part of core work of a health care provider , the policy requires resources which form part of business as usual to be deployed in a lawfull manner
Do the proposals relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)
Yes
Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			x	By improving transparency by publication of data online And establishing named individuals as accountable
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			x	By improving transparency by publication of data online And establishing named individuals as accountable
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			x	By improving transparency by publication of data online And establishing named individuals as accountable
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships			x	By improving transparency by publication of data online And establishing named individuals as accountable
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				

Pregnancy or Maternity			x	By improving transparency by publication of data online And establishing named individuals as accountable
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			x	By improving transparency by publication of data online And establishing named individuals as accountable
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			x	By improving transparency by publication of data online And establishing named individuals as accountable
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			x	By improving transparency by publication of data online And establishing named individuals as accountable
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			x	By improving transparency by publication of data online And establishing named individuals as accountable
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			x	By improving transparency by publication of data online And establishing named individuals as accountable
Affecting someone's right to Life, Dignity and Respect?				

Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				x
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
n/a				
How will any impact or planned actions be monitored and reviewed?				
By publication of annual data report , locally at every mental health unit, regionally and ultimately by the secretary of state publishing a annual report to be presented to parliament				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				
By publishing data on line as a dashboard available to every one				
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis				

Appendix 2 - Addendums to existing Policies

To be added to existing policies to comply with the Use of Force Act:

1) **Prevention and Management of Violence Policy**

Patients must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen.

There must be no planned or intentional restraint of a person in a prone or face down position on any surface, not just the floor.

Exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.

Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation.

Updated Definitions

"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;
"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;

Guidance on the Negligible Use of Force

The duty to keep a record of the use of force does not apply if the use of force is negligible.

Only activities which are considered to be part of daily therapeutic or caring activities could possibly be considered as a negligible use of force, and only if they are outside of the circumstances in which the use of force can never be considered negligible as set out below.

If a member of staff's contact or touch with a patient goes beyond the minimum necessary in order to carry out daily therapeutic or caring activities then it is not a negligible use of force and must be recorded. Whenever a member of staff makes a patient do something against their will, the use of force must always be recorded.

One example of a negligible use of force is: the use of a flat (not gripping) guiding hand by one member of staff to provide redirection or support to prevent potential harm to a person. Using this example, it is important to note that the contact is so slight that the person can at any time over-ride or reject the direction of the guiding hand and exercise their autonomy. It is essential that the guiding hand does not cause distress to the person.

It follows that the use of force can never be considered as negligible in the following circumstances:

- Any form of chemical or mechanical restraint is used
- The patient verbally or physically resists the contact of a member of staff
- 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
- More than one member of staff carried out the use of force
- Negligible use of force is excluded only from the duty to record. Other parts of the Act and guidance apply to all uses of force.

Use of Force information to be Recorded

The Act requires that the record of the use of force used on a patient by a member of staff must include the following:

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 disorder
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 for use of 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

For (k) in the above list the patient's relevant characteristics are:

a) the patient's age
b) whether the patient has a disability, and if so, the nature of that disability
c) the 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

i) gender reassignment – whether the patient is proposing to reassign their gender, is undergoing a process to do so, or has completed that process

- Gender reassignment is a protected characteristic under the Equality Act 2010 and information about whether a patient has transitioned from one gender to another should also be collected.

For (d) and (p) in the list above references to care plans may also include Positive Behavioural Support Plans (or equivalent).

For (k) in the list above proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.

For (m) in the above list of recording requirements (a description of the outcome of the use of force) the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

For (n) in the above list (whether the patient died or suffered any serious injury as a result of the use of force) there is no specific definition of what constitutes a serious injury in NHS settings. Current guidance in the NHS England and Improvement Serious Incident Framework 2015 should be followed to identify a serious incident. What injuries the patient suffered should also be recorded.

Serious injuries to a patient should also be reported to the Care Quality Commission if the patient was seriously injured while a regulated activity was being provided or their injury may have been a result of the regulated activity or how it was provided. The notification form provides detail of what might be considered a serious injury for the purposes of recording under this Act's requirements.

NHS and independent organisations (where providing NHS-funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. The death must also be reported to the local Coroner (including voluntary or informal patients). It is for the Coroner to determine the cause of death. The requirement to record whether the patient died as a result of the use of force will need to be recorded once the Coroner has provided their conclusion. The responsible person must ensure that this is added into the record of the incident. It would also be good practice to notify the Care Quality Commission of the Coroner's conclusion.

For (o) in the above list (any efforts made to avoid the need for use of force on the patient) this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.

For (p) in the list above (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) this must be with the patient's consent,

in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

A notification should be sent to the person or persons (families, carers or independent advocates) identified in the patients care plan or positive behavioural support plan (or equivalent) following every use of force. This should occur inline with the guidance in Chapter 26 – 'Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice on notifications following the use of force.

The Act requires that the responsible person must keep the record of any use of force for 3 years from the date it was made. It is not permitted to record anything which would otherwise breach data protection legislation [footnote 2] or the common law duty of confidence. This is intended to preserve the patient's rights in relation to their information.

BSMHFT records the use of force within its internal incident reporting system Eclipse. It is current good practice to include the record of the use of force within the patient's electronic record. This is satisfied by the eclipse recording system being linked to RIO.

Openness and transparency about the use of force within an organisation is essential, but it is also important to recognise that the data only tells us part of the story. There are many factors which can impact the number of incidents reported such as staff reporting behaviours or the mix of patients which can impact the ward environment and relationships.

Organisations have a responsibility to consider the detail behind the data to evaluate if their wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone.

BSMHFT will also consider the following:

- when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force

This data and its analysis will be vital in informing the BSMHFT's plan to reduce the use of force.

2) Rapid Tranquilisation Policy

Updated Definition

"Chemical restraint" means the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body;

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

Use of Force information to be Recorded

The Act requires that the record of the use of force used on a patient by a member of staff must include the following:

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 disorder
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 for use of 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

For (k) in the above list the patient's relevant characteristics are:

a) the patient's age
b) whether the patient has a disability, and if so, the nature of that disability
c) the 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
i) gender reassignment – whether the patient is proposing to reassign their gender, is undergoing a process to do so, or has completed that process

- Gender reassignment is a protected characteristic under the Equality Act 2010 and information about whether a patient has transitioned from one gender to another should also be collected.

For (d) and (p) in the list above references to care plans may also include Positive Behavioural Support Plans (or equivalent).

For (k) in the list above proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.

For (m) in the above list of recording requirements (a description of the outcome of the use of force) the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

For (n) in the above list (whether the patient died or suffered any serious injury as a result of the use of force) there is no specific definition of what constitutes a serious injury in NHS settings. Current guidance in the NHS England and Improvement Serious Incident Framework 2015 should be followed to identify a serious incident. What injuries the patient suffered should also be recorded.

Serious injuries to a patient should also be reported to the Care Quality Commission if the patient was seriously injured while a regulated activity was being provided or their injury may have been a result of the regulated activity or how it was provided. The notification form provides detail of what might be considered a serious injury for the purposes of recording under this Act's requirements.

NHS and independent organisations (where providing NHS-funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. The death must also be reported to the local Coroner (including voluntary or informal patients). It is for the Coroner to determine the cause of death. The requirement to record whether the patient died as a result of the use of force will need to be recorded once the Coroner has provided their conclusion. The responsible person must ensure that this is added into the record of the incident. It would also be good practice to notify the Care Quality Commission of the Coroner's conclusion.

For (o) in the above list (any efforts made to avoid the need for use of force on the patient) this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.

For (p) in the list above (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) this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

A notification should be sent to the person or persons (families, carers or independent advocates) identified in the patients care plan or positive behavioural support plan (or equivalent) following every use of force. This should occur inline with the guidance in Chapter 26 – 'Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice on notifications following the use of force.

The Act requires that the responsible person must keep the record of any use of force for 3 years from the date it was made. It is not permitted to record anything which would otherwise breach data protection legislation [footnote 2] or the common law duty of confidence. This is intended to preserve the patient's rights in relation to their information.

BSMHFT records the use of force within its internal incident reporting system Eclipse. It is current good practice to include the record of the use of force within the patient's electronic record. This is satisfied by the eclipse recording system being linked to RIO.

Openness and transparency about the use of force within an organisation is essential, but it is also important to recognise that the data only tells us part of the story. There are many factors which can impact the number of incidents reported such as staff reporting behaviours or the mix of patients which can impact the ward environment and relationships.

Organisations have a responsibility to consider the detail behind the data to evaluate if their wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone.

BSMHFT will also consider the following:

- when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force

This data and its analysis will be vital in informing the BSMHFT's plan to reduce the use of force.

3) Seclusion Policy

Updated Definition

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

Use of Force information to be Recorded

The Act requires that the record of the use of force used on a patient by a member of staff must include the following:

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 disorder
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 for use of 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

For (k) in the above list the patient's relevant characteristics are:

a) the patient's age
b) whether the patient has a disability, and if so, the nature of that disability
c) the 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
i) gender reassignment – whether the patient is proposing to reassign their gender, is undergoing a process to do so, or has completed that process

- Gender reassignment is a protected characteristic under the Equality Act 2010 and information about whether a patient has transitioned from one gender to another should also be collected.

For (d) and (p) in the list above references to care plans may also include Positive Behavioural Support Plans (or equivalent).

For (k) in the list above proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.

For (m) in the above list of recording requirements (a description of the outcome of the use of force) the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

For (n) in the above list (whether the patient died or suffered any serious injury as a result of the use of force) there is no specific definition of what constitutes a serious injury in NHS settings. Current guidance in the NHS England and Improvement Serious Incident Framework 2015 should be followed to identify a serious incident. What injuries the patient suffered should also be recorded.

Serious injuries to a patient should also be reported to the Care Quality Commission if the patient was seriously injured while a regulated activity was being provided or their injury may have been a result of the regulated activity or how it was provided. The notification form provides detail of what might be considered a serious injury for the purposes of recording under this Act's requirements.

NHS and independent organisations (where providing NHS-funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. The death must also be reported to the local Coroner (including voluntary or informal patients). It is for the Coroner to determine the cause of death. The requirement to record whether the patient died as a result of the use of force will need to be recorded once the Coroner has provided their conclusion. The responsible person must ensure that this is added into the record of the incident. It would also be good practice to notify the Care Quality Commission of the Coroner's conclusion.

For (o) in the above list (any efforts made to avoid the need for use of force on the patient) this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.

For (p) in the list above (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) this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

A notification should be sent to the person or persons (families, carers or independent advocates) identified in the patients care plan or positive behavioural support plan (or equivalent) following every use of force. This should occur inline with the guidance in Chapter 26 – 'Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice on notifications following the use of force.

The Act requires that the responsible person must keep the record of any use of force for 3 years from the date it was made. It is not permitted to record anything which would otherwise breach data protection legislation [footnote 2] or the common law duty of confidence. This is intended to preserve the patient's rights in relation to their information.

BSMHFT records the use of force within its internal incident reporting system Eclipse. It is current good practice to include the record of the use of force within the patient's electronic record. This is satisfied by the eclipse recording system being linked to RIO.

Openness and transparency about the use of force within an organisation is essential, but it is also important to recognise that the data only tells us part of the story. There are many factors which can impact the number of incidents reported such as staff reporting behaviours or the mix of patients which can impact the ward environment and relationships.

Organisations have a responsibility to consider the detail behind the data to evaluate if their wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone.

BSMHFT will also consider the following:

- when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force

This data and its analysis will be vital in informing the BSMHFT's plan to reduce the use of force.

4) Reporting, Management and Learning from Incidents Policy

Investigation of Deaths or Serious Injuries

Section 9 places a duty on the responsible person to investigate deaths and serious injuries in the mental health unit for which they are responsible. This duty relates to all deaths and serious injuries in a mental health unit, not just those which were as a result of the use of force.

When death or serious injury occurs within a mental health unit, it can indicate that something has gone wrong in the care and treatment provided to an individual. Where there is evidence that problems in care and treatment have occurred and those problems may have led to the death or serious injury then it is important that organisations understand why things may have gone wrong and how to reduce the risk in the future. Where a full investigation is required by relevant guidance (see below), that process must involve those affected, including the family members or carers of the patients. Any investigation should be conducted by people who are independent of those involved in the incident, be timely and of good quality and ensure that lessons are learned to drive continuous improvements in patient safety and reduce the risk of similar incidents from happening again.

When a patient dies or suffers a serious injury in a mental health unit the responsible person must, under the Act, have regard to guidance relating to the investigation of deaths and serious injuries that is published by the following organisations:

- Care Quality Commission
- Monitor
- NHS Commissioning Board
- NHS Trust Development Authority
- a person prescribed by regulations made by the Secretary of State

Monitor and the NHS Trust Development Authority merged to become NHS Improvement in April 2016, and the NHS Commissioning Board was renamed NHS England in 2013. NHS England and NHS Improvement have now merged to become NHS England and NHS Improvement.

At the time of publication, the existing guidance on the investigations of such incidents are listed below (this is not an exhaustive list):

- National Guidance on Learning from Deaths; National Quality Board – March 2017
- Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers; NHS Improvement – July 2018
- Serious Incident Framework; NHS England, updated March 2015
- Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services – November 2015

Current NHS guidance sets out clear guidelines on the timescales for investigations and the skills and experience investigation team members will need or require access to. All investigators must have expertise in systems-based investigation methods.

Following any death or serious injury the patient themselves, or patient's family or carer should be communicated with in an open, honest and compassionate manner. They should be informed of how they can be involved in any investigation process and kept informed of progress at every stage. It is fundamental that they are involved from the very beginning of the process and that their needs are assessed to ensure they are appropriately supported