NHS Providers response to Department for Health and Social Care's proposed guidance for the Mental Health Units (Use of Force) Act 2018

Key messages

- We welcome the focus the Mental Health Units (Use of Force) Act 2018 (the Act) brings to ensuring high quality care for those with mental health conditions. In particular, we fully agree that restraint should only be used as a last resort and welcome further support for trusts and other providers to reduce the use of force in mental health services.

- We are pleased to see the proposed guidance for the Act set out more clearly the requirements of trusts under the Act. This aligns with practice that trusts agree should be in place, have established or are working towards implementing as soon as possible. Trust leaders are clear about the importance of an organisation-wide commitment to good practice and the right training, with staff having time for supervision and reflective practice in order to reduce the use of restraint and other restrictive practices.

- There are some areas of the guidance where more clarity would be helpful, such as the settings the Act applies to and the circumstances under which use of force can be considered as negligible. Clarity and guidance on any intentions to use this guidance more broadly in future, for example to inform regulatory approaches or training accreditation processes, would be welcome.

- In pursuing reductions in restraint and force, it is important to take account of the context in which mental health services are operating. As in other parts of the NHS, mental health trusts are facing growing demand, often with increased acuity and complexity (with the pandemic having a clear and significant impact), at the same time as deep-seated financial pressures and staffing shortages persist. Despite the substantial progress that has been made in recent years, with new services and higher levels of investment in mental health, the Act needs to be implemented alongside improved resourcing. This is necessary to ensure adequate training and sufficient staffing to enable alternative approaches to be pursued and embedded and to support the delivery of a safe service.

- There are also significant, systemic challenges to consistently providing the right level and nature of mental health support that need to be addressed. We agree with the Care Quality Commission's assessment of mental health wards for children and young people that, while the day-to-day responsibility for quality of care sits with hospital managers and staff, shared learning and effort is needed across the health and care system in order to tackle the inappropriate use of restrictive practices. How mental health services and their partners in the wider system are

resourced, commissioned and funded needs to be addressed to improve the current quality and system of care for individuals across the country.

- There are examples of good practice by mental health trusts already making progress on these issues, but there is still room for improvement. The trusts that are getting this right demonstrate a strong organisational commitment to working within a least restrictive model in all settings, and have robust governance processes to monitor use of restrictive practices, policy, training and incident reviews. We would encourage supporting the wider adoption of such approaches and sharing where progress is being made.

NHS Providers response to consultation questions

Key definitions

Trusts have made some suggestions as to how to clarify some of the terms used in the Act. These include defining chemical and mechanical restraint in greater detail to better illustrate all the forms these take – for example, rapid tranquilisation, night-time sedation, and hypnotic medication. Some have suggested it might also be helpful to add 'short-term' segregation to this section of the guidance, and that the definition of 'seclusion' can include 'open-door' seclusion.

Applicable settings

The guidance could be clearer about what settings the Act applies to. The guidance states that the Act's definition of a 'mental health unit' includes any part of a hospital which has the purpose of 'provid[ing] treatment to in-patients for mental disorder' and 'mental disorder' is defined in the same way as in the Mental Health Act 1983 (the MHA). Acute trust leaders are uncertain which, if any, of their wards will be covered in light of this – for example, acute and rehabilitation wards that exist to treat patients with brain injuries. While these individuals would not be detained under the MHA, they do appear to fall into the broad definition of 'disorder'. The MHA code of practice includes 'personality and behavioural changes caused by brain injury or damage' in the list of clinically recognised conditions which could fall within the MHA's definition of mental disorder. We would ask for this to be clarified as soon as possible.

Acute trusts have also observed that there are other wards, for example acute medical admission wards, where use of force is often more likely. Improved resourcing is needed across the sector, and beyond the settings within which the guidance applies, to enable alternative approaches to be pursued and embedded and to support the delivery of a safe service in all settings.

We would also welcome the guidance clarifying that the Act is applicable to the entire patient population in services where NHS-funded care is provided.

Policy on use of force

Trusts have fed back to us that this section of the guidance would benefit from reinforcing that the policy applies to all staff whether NHS employed, agency or contractor. They would also welcome this section reinforcing how data collected through digital or other devices should or could be used in reporting, as well as in local and national benchmarking, to identify specific areas where practice requires examination or explanation for assurance about 'least restrictive' interventions. Transparency of communication here will also be important.

Information about use of force

The guidance does explain what information should be given to patients on the use of force. However, in the list of information that should be provided as a minimum, it might be beneficial to add a reference to whistleblowing processes and Freedom to Speak Up Guardians. This would be in addition to an organisation's complaints procedure in order to be more robust and help to mitigate cultures of poor practice in isolated services.

Trusts would find it helpful to have a national template for information that will be provided to patients, akin to leaflets produced by the Department for Health and Social Care in other areas, to avoid variability in what information is provided and how.

Trusts have also highlighted that the guidance could benefit from strengthening other means by which information may be provided to patients and carers, such as via digital means, and in British Sign Language and Makaton.

Training in appropriate use of force

The guidance sets out the requirements for training on the use of force. Trusts have suggested the section could be strengthened to include training in the safe use of handcuffs and other mechanical restraints, as well as debriefing witnesses, other patients and carers about any form of restraint used.

An online national training module for staff, perhaps facilitated by Health Education England, has been identified by trusts as something that would help them significantly in preparation for implementation. We are keen to emphasise training is important for all staff.
Workforce shortages mean staff are moved between wards, where the likelihood of force being used may differ. We would also welcome training for security staff being considered.

Trust leaders are clear about the importance of the right training, but also staff having time for supervision and reflective practice in order to reduce the use of restraint and other restrictive practices. Additionally, the importance of having a sufficient and stable workforce to implement and sustain change cannot be overstated.

Recording use of force

The guidance does explain what information should be recorded when force is used on a patient. Trusts are supportive of the requirements on recording of use force and welcome a move to clearer, more systematic reporting.

Negligible use of force

We recognise the difficulty in setting out any and all circumstances where use of force is proportionate. The list in the guidance of circumstances in which the use of force can never be considered negligible is quite comprehensive. Trusts now report all serious incidents and these include those that cause no harm, so they should also be able to record all use of force incidents, including those considered negligible, subject to reporting systems fully supporting this. If it remains the case in the final guidance that the duty to keep a record should not apply if the use of force is negligible, as currently defined, this must be subject to appropriate safeguards.

Investigation of deaths or serious injuries

The guidance does explain what should happen following a serious injury or death in a mental health unit. We welcome the guidance highlighting existing guidance and processes in place for trusts to follow when investigating such incidents. We think the intention to extend the medical examiner's role should be considered in this section also. As we have said previously, in introducing investigatory powers, it is important to recognise and preserve the role of the independent coronial system, and avoid driving unwarranted bureaucracy and cost into the system.

Further areas for comment

Applying the legislation in practice

It is important to emphasise that, as we said during the Act's passage through Parliament, many of the requirements set out are already in place through existing laws which protect against assault or use of force. A focus on ensuring that pre-existing legislation is successfully applied in practice – alongside ensuing the requirements from this new Act are properly aligned and resourced to ensure clarity, avoid confusion and unintended consequences – remains crucial.

Implementation and ongoing compliance

The timescale for implementation appears to be feasible, provided there is a reasonable period from November to adjust and bed-in any required changes to local policies and training programmes. Trust leaders are clear the requirements of the Act will require additional resource and funding, for example, around IT developments and training, to ensure ongoing compliance.

Embedding just and effective safety cultures

Trusts have a vital role to play in ensuring the right culture on wards. It takes a whole-board and whole-organisation approach to fully embed a just and effective safety culture. We would note that, despite progress and commitment from providers, a blame culture arguably still exists within the NHS. Compassionate and inclusive leadership from provider boards remains fundamental in addressing this, but positive behaviours must also be modelled at all levels of the system including by national and regional bodies.

Guidance for police

We note that the Home Office and the College of Policing will consider whether current guidance on the police use of body cameras requires further updating to ensure it is in line with the requirements of the Act, and that a link to the relevant College of Policing guidance (and any other relevant guidance) will be published in the final version of this guidance. Further consideration of the positioning of cameras would be welcome. We have previously said there is a need for clarity on how the police will be brought into the proposed requirements for mental health unit policies, and more detail on requirements for additional training for police officers. We would welcome both aspects being made clear and clearly signposted in the final version of the guidance.

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