Oxford Health
NHS Foundation Trust

## Policy control document

*This ensures good version control and effective policy management. It must be completed before a policy can be uploaded to the intranet.*

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|---|---|
| **Policy Title** | **Inpatient Mental Health Care: Use of Force** |
| **Policy Number** | **CP92** |
| **Author(s)**<br>**(Name and Title/Role)** | Kirsty Smith, PEACE Manager<br>Lynda Dix, Associate Director of Nursing, Forensic Services<br>Angie Fletcher Associate Director of Quality Improvement and Clinical Effectiveness |

| **Approval History** | |
|---|---|
| **Name of Committee** | **Date** |
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| **Committee which approved current version**<br><br>Quality and Clinical Sub Committee | **Date of approval for current version**<br><br>31st August 2023 |

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|---|---|
| **Date of next review** (Month/Year) | 31st August 2026 - Extended August 2026 to 30th November 2026 with the approval of the Chief Nurse |

Chair of Approving Committee: Marie Crofts

Signature:

Title: Chief Nurse

Date: 31st August 2023

All policies are copy controlled. When a revision is issued previous versions will be withdrawn. An electronic copy of the current policy with be posted on the Trust Intranet.

**Change control**

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| Number of pages (excluding appendices): 14 |
| Summary of Revisions:<br>New policy to replace the Reducing Restrictive Interventions and respond to the requirements of the Use of Force Act legislative requirements.<br>Separate Physical Restraint Policy developed.<br>Time out guidance moved to Seclusion Policy<br>Includes the Human rights act and how this relates to restrictive interventions. |
| Any change to code or merging with other policies.<br>Previous policy code: CP29 |
| Consultation with:<br>Associate Directors of Nursing & Matrons via Positive and Safe Committee<br>Clinical Directors<br>PEACE Trainers<br>Oxford Healthcare Improvement (QI) team<br>Positive & Safe Committee Members |

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# Policy title

**Inpatient Mental Health Care: Use of Force Policy**

# Policy code

**CP92**

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**Version 1**

**Date of approval 31st August 2023**

## 1. Purpose of policy

1.1. This policy forms part of the Oxford Health NHS Foundation Trust (OHFT) Positive and Safe Care strategy (appendix 1) which aims to advocate the use of least restrictive care and reduce the use of restrictive practice across the trust by promoting collaborative effective care between staff, patients and service users and their carers and families.

1.2. This policy also sets out the Trust's responsibilities in connection with the Mental Health Units Use of Force Act 2018, including roles and responsibilities, where and how information should be recorded and how reporting requirements are managed**.**

1.3. The policy should be read in accordance with the Mental Health Units (Use of Force) Act 2018, the Mental Health Units (Use of Force) Act 2018 Statutory guidance for NHS organisations in England, the Mental Health Act Code of Practice 2015.

## 2. Introduction

2.1. People who use our services and those who support them have a right to expect that we will engage with them in a safe and therapeutic manner at all stages of their recovery. Staff working in our services have the right to expect a safe working environment free from violence or the threat of violence whether this be verbal or physical in form.

2.2. Oxford Health NHS Foundation trust is committed to providing safe and positive care and ensuring the wellbeing of all its patients, service users, carers, and staff. In line with OHFT Positive and Safe Care strategy, we will ensure our care is the least restrictive, the most positive and takes account of human rights, choice, engagement, and collaboration. We aspire to apply the least restrictive approach and where we do use force will ensure safe and positive practice in collaboration with service users, their families/carers and are supported by best practice and sit within the framework of trauma informed care and human rights.

2.3. This policy has been renamed and includes update to comply with the Mental Health Units (Use of Force) Act 2018 ('the Act') which was enacted on 1st November 2018 having been introduced via a Private Members Bill following the death of Olaseni Lewis, who was restrained by 11 police officers in the Bethlem Hospital in 2010. As such, the Act is sometimes referred to as 'Seni's law'.

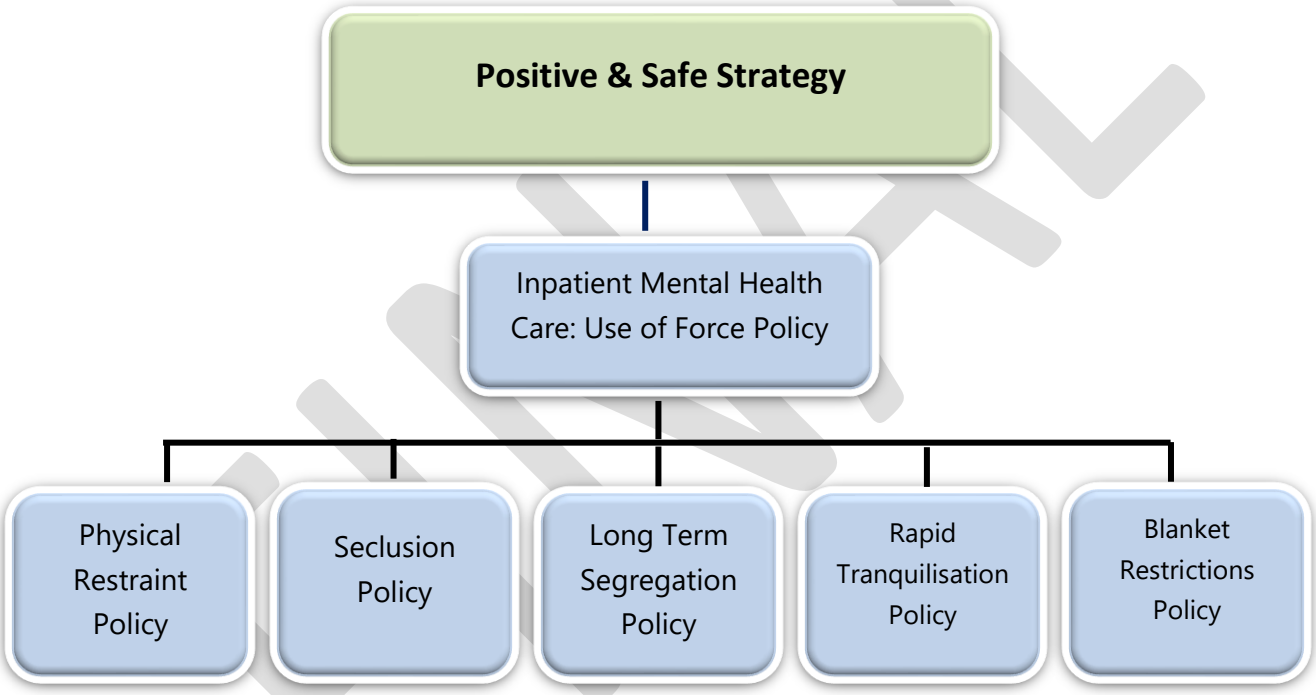
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2.1 The purpose of the Act is to make provision about the oversight and management of the appropriate use of force in relation to service users in mental health units.

2.4. The Care Quality Commission are likely to take account of the Trust's compliance with the requirements of this Act.

## 3. Context

3.1. This policy provides trust colleagues with overarching guidance in relation to the trusts Positive and Safe Care Strategy that supports colleagues to use the least restrictive approach in inpatient care. Where restriction is used this policy details how this should comply with the Use of Force Act. This policy should be read in conjunction with the relevant trust policies guiding the use of specific restrictive interventions:




3.2. The following trust policies are also relevant to the Inpatient Care Use of Force policy:

3.2.1. Medicines Management Policy MM01

3.2.2. Complaints, Concerns and Compliments Policy CORP25

3.2.3. Privacy and Dignity Policy CP51

3.2.4. Mental Capacity Act Policy CP52

3.2.5. Safe and Supportive Observations of Patients at Risk Policy CP03

3.2.6. Search of Patients and their Belongings Policy CP05

3.2.7. Safeguarding Adults Policy CP25

3.2.8. Safeguarding Children Policy CP14

3.2.9. Reporting and Learning from Incidents and Deaths Policy RMHS01

3.3. The Trust also recognises it has an obligation under the Health and Safety at Work etc. Act (1974) and the Management of Health and Safety at Work Regulations (1999), for the health, safety, and welfare at work of its staff.

## 4. Definitions

4.1. The "Use of Force" refers to**.**

4.1.1. the use of physical, mechanical, or chemical restraint; or

4.1.2. the isolation of a patient

4.1.3. 'Physical restraint' means physical contact which is intended to prevent, restrict, or subdue movement of any part of a patient's body.

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

4.1.5. 'Chemical restraint' is the use of medication which is intended to prevent, restrict, or subdue movement of any part of a patient's body. Please refer to Trust guidance on use of rapid tranquilisation

4.1.6. The Mental Health Units (Use of force) Act defines the use of force as:

4.1.7. The use of physical, mechanical, or chemical restraint on a patient, or

4.1.8. The isolation of a patient

4.2. The Act introduces the following definitions of use of force:

4.2.1. Physical restraint - The use of physical contact which is intended to prevent, restrict, or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection.

4.2.2. Mechanical restraint - 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.

4.2.3. Chemical restraint - The use of medication which is intended to prevent, restrict, or subdue movement of any part of the patient's body. This includes the use of rapid tranquilisation.

4.3. The act states that isolation is any seclusion or segregation that is imposed on a patient however the definitions for these are those provided in the Mental Health Act Code of Practice 2015:

4.3.1. Seclusion - 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. This

can include seclusion where the door to a room is open, but the patient is still prevented from leaving, for example, by a staff member either in or next to the doorway.

4.3.2. (Long term) segregation - 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 multidisciplinary 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.

4.4. Negligible (light or gentle) use of force

4.4.1. Negligible does not mean irrelevant to a person's experience of care or treatment and it is expected that negligible use of force will only apply in a very small set of circumstances.

4.4.2. The use of force can only be considered negligible where it involves light or gentle and proportionate pressure. Any negligible use of force must meet all of the following criteria:

a) is the minimum necessary to carry out therapeutic or caring activities (e.g., personal care or for reassurance)
b) it forms part of the patient's care plan.
c) valid consent to the act in connection with care and treatment has been obtained from the patient, or where appropriate a member of their family or carer has been consulted, particularly a person with parental responsibility if this is in relation to a child and the child is not Gillick competent. Where the patient lacks capacity, a Best Interest Decision would need to be made.
d) And only if they are outside of the circumstances in which the use of force can never be considered.

4.5. The use of force can never be considered negligible in any of the following circumstances:

4.5.1. Any use of rapid tranquilisation

4.5.2. Any form of mechanical restraint

4.5.3. The patient verbally or physically resists the contact of a member of staff.

4.5.4. Where the use of force involves the use of a wall, floor (or other flat surface) and the use of force is disproportionate.

4.5.5. Someone other than OHFT staff (who may be the patient, another patient, a visitor, or a carer) witnesses use of force, and has capacity to validly appraise and comment on the use of force, complains about the use of force that they witnessed.

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4.5.6. The use of force causes an injury to the patient or a member of staff (including any type of injury or other physical reaction including scratches, marks to the skin and bruising)

4.5.7. The use of force involves more members of staff than is specified in the patient's care plan.

4.5.8. During or after the use of force a patient is upset or distressed

4.5.9. The use of force has been used to remove an item of clothing or a personal possession.

## 5. A Human rights-based approach to the use of force

5.1. The use of force must be lawful and compliant with the articles of the European Convention on Human Rights as incorporated into domestic law via the Human Rights Act 1998. The Trust ensure that it has an established mechanism that enables patients to report any potential breaches of human rights through the concerns and complaints process and independent advocacy.

5.2. The Mental Health Act 1983: code of practice provides further statutory guidance in relation to the use of force which staff are under a statutory duty to have regard to in relation to patients in mental health units detained under the Mental Health Act 1983.

It defines restrictive interventions (use of force), as:

"…deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

5.2.1.1. take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and.

5.2.1.2. end or significantly reduce the danger to the patient or others.

5.2.1.3. restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation. Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

5.2.1.4. be used for no longer than necessary to prevent harm to the person or to others.

5.2.1.5. be a proportionate response to that harm, and.

5.2.1.6. be the least restrictive option.

## 6. Trauma Informed Approaches

6.1. Trauma, personal and/or caused by the system, whether historical or current is a

real issue will work to deliver care that is trauma aware and sensitive to the impact of actual, potential, and vicarious trauma on the lives of everyone who encounters services, including those who work within it.

6.2. As part of our Positive and Safe Care strategy we will work to ensure that our processes and pathways do not re-enact peoples' experiences of trauma but promote safety and recovery. We will build and maintain cultures and atmospheres where both services users and staff feel supported, validated, and included.

6.3. Where the behavior of an individual indicates their level of risk cannot be managed safely using the Trust standard approved PEACE techniques staff should refer to the PEACE Team for advice of a more bespoke risk management plan. In circumstances where techniques have had to be adapted by the PEACE Team, these must be approved by the "responsible person" under the Mental Health Units (Use of Force) Act. The responsible person for the trust is the Medical Director.

6.4. Care Plans and Positive Behavioral Support Plans should, with the patient's consent consider how patients, their families and carers are involved in care planning which should set out the preventative strategies to the use of force. However, it is important to remember that there may be circumstances where it could be harmful to a patient to involve their family or carers (i.e., survivors of domestic abuse or violence so the patient's wishes and preferences must be considered.

## 7. Duties

7.1. All staff working in Mental health settings will have due regard of this policy and its procedural arrangements.

7.2. Both the 'responsible person' and staff working in mental health units 'must have regard' to the specific guidance related to the Use of Force Act (2018). It is important that, the responsible person ensures that they and other staff are familiar with its requirements, as departures from the guidance could give rise to legal challenge.

7.3. Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective.

7.4. The Responsible Person is the Chief Medical Officer.

7.5. Functions delegated by the Responsible Person to officers of the Trust in accordance with section 10 of the Act.

7.5.1. Deputy Responsible Person for each Mental Health Unit is the local clinical director.

7.5.2. Clinical Directors are responsible for ensuring that all managers in their areas are aware of this policy and linked policies where the implementation of the use of force Act is outlined. Support its implementation and ongoing leadership and co-ordination. The Director of Patient Safety must to ensure that the Trust complies with the requirements of the Act.

7.6. The Chief Medical officer will ensure that staff groups with responsibility will have the knowledge and skills required of the roles, the support of the executive team.

7.7. PEACE team trainers are responsible for delivering training (as appropriate to job

role requirements) within OHFT.

7.8. The PEACE training manager will keep the training provision under on-going review in order to be consistent with current national policy, new developments, best practice guidance and evidence.

7.9. Ward/Team/Department Managers are responsible for:

7.9.1. Ensuring that this policy (and linked policies) is fully implemented within the ward environment/the team/the department that they manage.

7.9.2. Ensuring that this policy is always readily available to all staff.

7.9.3. Ensuring that the recording and auditing of incidents of physical intervention is completed in line with this policy.

7.9.4. Responding appropriately to any concerns regarding the attitude of staff members around issues of the use of force, aggression, violence, or restrictive practice.

7.9.5. Ensuring that there is a regular and comprehensive general risk assessment to ensure the safety of the environment.

7.9.6. Maintaining training compliance levels and equipment in their ward/team/department. This will include ensuring that staff are appropriately trained to monitor physical health.

7.9.7. The trust Learning and Development Department will maintain a database of all staff who have undergone Positive Engagement and Caring Environments (PEACE) Training. This will specify via risk assessment the level of training different groups of staff require and the frequency of training and updates (NICE 2005) and current levels of compliance.

7.9.8. NHSP bank staff are required to undertake PEACE training with the trust. Compliance with this training requirement is monitored through NHSP training framework monitoring. Agency staff are required to have undertaken accredited physical intervention training equivalent to PEACE. This is monitored via the agency training framework.

7.9.9. All Staff members are responsible for ensuring that their practice is safe. Clinical staff have a Duty of Care to ensure that they act in ways that are consistent with any codes of practice relevant to their profession. The Trust also has a Duty of Care towards its employees and towards service users, which is fulfilled by the implementation of this policy.

## 8. Training

8.1. Staff who work for Oxford Health are trained in preventative rather than just reactive approaches. All training in the use of restrictive interventions must meet the requirements of the Mental Health Units (Use of Force) Act and be certified by an accredited organisation (BILD ACT). Information on the types of force and specific techniques which staff are trained to use and the risk assessments that must be undertaken prior to use are detailed in the Physical Restraint Policy.

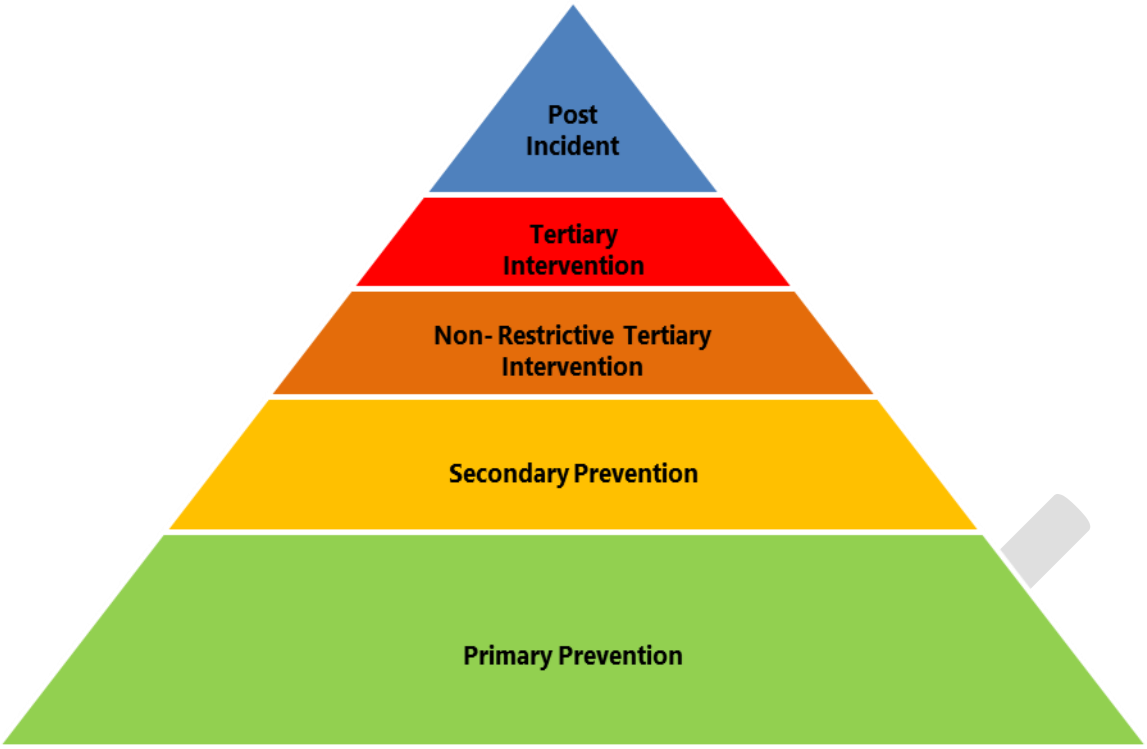
8.2. PEACE Training is the certified model of training used in Oxford Health and all staff



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who are required to use any type of force are expected to achieve and maintain competence in PEACE training.

8.3. The PEACE approach is founded on two basic principles of Positive Engagement and




Caring Environments. All staff regardless of experience or role are expected to uphold these principles and implement activities at each level (please see Physical Restraint Policy for further details)

8.3.1. PEACE training model.

- **Primary Prevention Level** – This level describes all the activities and approaches that will help to prevent an incident of restrictive intervention from ever occurring.
- **Secondary Prevention Level** – This level describes activities that if applied effectively will calm a tense situation and upset or aroused person.
- **Non-Restrictive Tertiary Level** (bridge between Secondary and Tertiary)– This level describes controlling, containing or limit setting activities and approaches that could be used to bring to an end any behaviours of concern that are already happening or are imminent but do not involve restraint, segregation, seclusion, or rapid tranquilisation.
- **Tertiary intervention Level** – This describes all the activities and approaches that could be used when the danger to the person or others is serious, imminent and cannot be prevented or reduced by any other means and may include physical restraint, seclusion, rapid tranquilisation.

- **Post Incident Leve**l – This level requires all staff implementing strategies at any other tier to engage in activities which will restore wellbeing, report effectively and learn from incidents to prevent re occurrence.

- **Staff Competence**
- All staff who are involved in the use of restrictive interventions are required to refresh annually unless extensions to this are approved by the Positive and Safe Committee (for example during peak covid transmission) and suitable risk mitigations are in place.

8.3.2. Alongside PEACE training Oxford Health provides continuous professional development to ensure that staff are enhancing key skills to prevent the need to use restrictive interventions.

## 9. Use of Force by 3rd Party

9.1. All units have a memorandum of understanding in place for all police services linked to their area. This outlines the agreed actions to be taken when force is applied within our organisation. This includes use of minimum force and body worn cameras to be in operation whilst using restrictive practices.

## 10. Reporting

10.1. All uses of force must be recorded in an incident form. OHFT have set up the incident reporting system to ensure that we adhere to the formal reporting systems that satisfy the legal requirements but also contractual reporting requirements with NHSEI. Some of the below information can be obtained by cross referencing with the electronic notes system and is not directly recorded in the incident report, such as diagnosis.

10.2. **Staff must complete the incident report in full, further guidance can be** found in the Reporting and Learning from Incidents and Deaths Policy

10.3. **Below are some of the key requirements that must be detailed into the incident form, and this will be pulled through to their care record.**

10.3.1 the reason and type of the use of force

10.3.2 the place, date, and duration of the use of force

10.3.3 whether the type or types of force used on the patient formed part of the patient's care plan and if notifiable persons (if any) were contacted following use of force as described in the care plan.

10.3.4 a description of how force was used.

10.3.5 the name and job title of any member of staff who used force on the patient.

10.3.6 whether the patient has a learning disability or autistic spectrum disorder.

10.3.7 a description of the outcome of the use of force

10.3.8 whether the patient died or suffered any serious injury due to the use of force.

10.3.9 any efforts made to avoid the need for use of force on the patient.

10.4. Incident data is utilized to develop anonymised data for each ward via TOBI (The Online Business Intelligence) application to ensure staff are able to analyze and consider their use of force/restrictive practices and measure improvement in reduction of use. Trust wide reporting will take place through reports that include high level data that has been reviewed and analysed to assure and inform the Quality and Clinical Sub Committee of current practice and any associate potential or actual risks that should be escalated to Quality Committee.

10.5. The Use of Force Act includes the requirement to investigate all deaths and serious injuries in a mental health unit. OHFT will utilise the *"Learning Today for a Safer Tomorrow"* Patient Safety Incident Response Framework (PSIRF) approach to review inpatient deaths and adhere to the principles of Section 9 of the Use of Force Act.

10.6. Section 12 of the act relates to police use of body cameras. Whenever the police are called to assist a mental health unit they are required to wear and operate a body camera at all times when reasonably practicable. If the police officer has a body camera they must wear and keep it operating (recording) at all times. However, there may be special circumstances that justify not wearing or operating a camera, it is for the police officers to determine in line with current College of Policing guidance on the use of body cameras whether special circumstances apply**.**

## 11. Communication

11.1. The trust has developed information leaflets and posters about the Use of Force (appendix 2) these are accessible at the point of care. Staff will take reasonable practicable steps to ensure that the patient and/or carer is aware of the information and understands it.

## 12. Complaints

12.1. Complaints made against staff as a result of a violent incident including what the service user feels was an inappropriate use of force or where too much force was applied will be investigated through the appropriate OHFT procedure including

complaints, safeguarding, performance and disciplinary procedures.

12.2. Service Users and Carers will be supported through this process by a member of the clinical team.

12.3. Data around complaints related to use of force will be evaluated for themes and be reviewed within directorate governance processes and report into the Trust positive & Safe committee which reports into the Trust Quality and Governance sub-committee.

## 13. Compliance, Monitoring and Review

13.1. Compliance with the requirements under the Use of force Act 2018 will be reviewed via local directorate based Positive and Safe groups and the rust wide Positive and Safe Committee and monitored through the Mental health Act committee which reports into the Quality and Clinical Governance Sub Committee chaired by the Chief Nurse and Chief Medical Officer where it reports to the board through Quality committee. See appendix 3 for Positive and Safe Committee delegated responsibilities.

## 14. Monitoring and evaluation

| Measure | Lead (Name and Title) | Group/ Committee that measures will be reported to by lead | Frequency of Reporting |
|---|---|---|---|
| Systems in place to monitor the number of incidents of restrictive practice and incidents of harm in relation to violence and aggression. | Deputy Chief Nurse | Positive & Safe Committee | Quarterly |
| | Chief Nurse | Quality & governance Sub-Committee | Quarterly |
| | Associate Directors of Nursing | Directorate governance meetings | Monthly |
| | Deputy Chief Nurse and Associate Directors of Nursing | Weekly Review Meeting | Weekly |
| Staff involved in the practice of restrictive interventions to undertake PEACE teamwork training. | Director of Education and Development | Learning Advisory Committee reporting to the Quality & Clinical Governance sub-Committee | Quarterly |

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## Appendix 1 Positive and Safe Care Trust Strategy

*To be included once ratified via Positive and Safe Committee*

## Appendix 2 Mental Health Units Use of Force Patient/ Service User information

### 2.1 Patient/ Service User Information Leaflet

*To add current version*

### 2.2 Ward Information Poster

*To add current version*

## Appendix 3 Positive and Safe Committee duties in relation to the Use of Force Act

The Positive and Safe Committee will;

- Oversee development, dissemination, and implementation of the Trust-wide strategy on Positive and Safe Care.
- To oversee the development, implementation and regular review of policies and procedures related to restrictive practices and de-escalation to support the delivery of the Trust's strategy on Positive and Safe Care
- To ensure the Trust discharges its duties in the use of restrictive practices in line with legislation as articulated within Human Rights, Mental Health Act, The Mental Capacity Act and The Mental Health Units (Use of Force) Act 2018 and Trauma informed care.
- To oversee and critically reflect on the use restrictive practice across all care pathways within the Trust, including oversight of evaluation of embedding the clinical model application.
- To enable the voice of lived experience to influence the policy and development of practice within the Trust through appropriate representation.
- To receive reports from the local directorate based Positive and Safe Care groups including analysis of restrictive practice data across the Trust, considering themes, and ensuring shared learning from incidents.
- Ensure data is being used effectively at patient, team, and strategic level.
- A quarterly Positive and Safe Care report will be presented to the Quality Committee to;
- Scrutinize output from local Positive and Safe Care practices group, and feedback from patient safety and safeguarding committee.
- Review incident trends, Areas for improvement and learning, Analysis of information via Trust, Directorate, and team data available via TOBI in order to support learning, identify themes and any areas for address or improvement.

- Safer staffing information is reported through E-roster and can be triangulated with incident reporting data and Clinical Establishment Reviews as part of the Directorate Performance Reviews.
- An audit programme is available to support audit and review of the standards related to restrictive practice and the Use of force, specifically to seclusion, restraint, and rapid tranquilisation. Audits will be performed as per schedule agreed and reports are available to establish if standards are being met.
- OHFT have a responsibility to consider the detail behind the data to evaluate if our 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.
- Data and its analysis will be vital in informing the OHFT plan to reduce the use of restrictive interventions.

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# Equality Analysis (EqA) Screening Form

**Name of Policy/Procedure/Practice/Project/Programme/Plan: Use of Force Policy CP92**

Equality Analysis (formerly known as Equality Impact Assessment) is a thorough and systematic analysis of a policy, practice or procedure to ensure it is not unlawfully discriminating against any group with a protected characteristic.

An equality analysis is:

- A tool for delivering equality
- A key way of demonstrating that you have given 'due regard' to equality considerations as prescribed by the public sector equality duties in the Equality Act 2010
- Part of good policy and service delivery governance
- A positive activity which should identify improvements

Please use this EqA Screening Form to examine and identify any differential impact for any of the protected characteristics and to prompt mitigation of the adverse/negative impact before it is approved by the relevant committee.

This Screening Form can be used at the beginning of the equality analysis process to gather initial feedback, thoughts and ideas, or at quarterly intervals to monitor implementation of a project/programme, or at the end on completion to assess impact or outcome.

If this Screening Form reveals any adverse/negative impact for any of the protected characteristics listed below, you may need to complete a full Equality Analysis (Form EqA1). For further details (including a copy of the EqA1 Form), please see Equality Analysis Procedure and Guidance which can be found on the Polices Site.

For advice, information and guidance, please contact the Head of Inclusion at: EqualityandInclusion@oxfordhealth.nhs.uk

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| Protected Characteristic | Positive Impact | Neutral Impact | Negative Impact | Comments/Evidence |
|---|---|---|---|---|
| | √ | √ | √ | |
| **Age** | √ | | | |
| **Disability** | √ | | | |
| **Sex/Gender** | √ | | | |
| **Race/Ethnicity** | √ | | | |
| **All Faiths & None** | √ | | | |
| **Sexual Orientation** | | √ | | |
| **Transgender** | √ | | | |
| **Pregnancy & Maternity** | √ | | | |
| **Marriage & Civil Partnership** | | √ | | |

**Completed by:-**
**Name: Lynda Dix**
**Title: Associate Director of Nursing, Forensic Services**
**Date: 1st August 2023**

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