IN THE MATTER OF THE LAMPARD INQUIRY

STATEMENT OF DR ADRIAN CREE IN RESPONSE TO THE RULE 9(7) REQUEST

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1. I Dr Adrian Cree whose address for the purpose of this statement is c/o Priory, 80 Hammersmith Road, London W14 8UD will say as follows:

2. My role at Priory is Chief Medical Officer, a position I have held since 2020. In this role amongst other responsibilities, I chair the Central Clinical Network meetings and am involved in the development of Priory inpatient clinical pathways.

3. I have prepared this statement in response to a request for evidence from Priory pursuant to Rule 9 of the Inquiries Act, referred to by the Lampard Inquiry as request 'Rule 9(7)' dated 31 January 2025. The focus of the Rule (7) request is, in summary, information concerning the patient pathway for NHS-funded mental health patients from admission to discharge in Priory's care in Essex over the 24-year period that the Inquiry is investigating.

Background

4. In preparing this statement, I have accessed all available relevant Priory policies and these cover the period 2004 to the current time. During the period relevant to the Lampard Inquiry, there were both Partnerships in Care (PiC) and Priory Sites in the Essex Region. The Priory site was Priory Chelmsford and the PiC sites were Suttons Manor, Elm Park, and Oaktree Manor. Following the merger between PiC and Priory on 1st November 2016, the Priory Polices will have covered all these sites.

5. Priory holds electronic Microsoft Word copies of Policies, within a central drive folder. Priory also has a live Microsoft Excel working document, which tracks the journey of a policy. When searching the folders for policies, archived policies were not always saved following a consistent approach and prior to 2004 the majority of policies could not be located. In the event that a previous version of a policy could not be located, this has been documented in the policies exhibit list R9(7). In relation to the time period being considered by the Inquiry, Priory has carried out a review of all folders, both current and archived and checked against the working document for void policies, to ascertain where a policy was replaced/merged.

6. Prior to 2009, Policies were divided up in to Clinical Policies, Detained patients and IPC (Infection Prevention and Control). There were sub folders within the central drive for these separate domains, which the relevant policies were saved in, alongside an index for the policies. In 2009, policies underwent a change from an overarching list of clinical policies to a more defined approach, of grouping policies under specific domains, for example Healthcare, HR, Legal, Operational, IPC, H&S. Sub folders were created for each of the domains, with the policies saved in the relevant folder. An overarching index was created listing all policies and their specific domains. The pre-2009 policies and associated indices were archived within the Healthcare sub folder. Within each domain folder, every policy has its own folder, where previous versions of the policy are kept. There is also a folder for policies, which are made void.

7. Prior to 2012, Priory did not have a system in place to capture any changes made to a policy, or the reason behind this change. Therefore, information regarding specific word change to policies, was not available during the 2000-2012 time period being reviewed, which is highlighted in the policies exhibit list R9(7). In 2012, Priory began documenting the ratification and sign off process of policies and the significant changes the policy had undergone during its review. For the purpose of this Inquiry, each separate policy folder was reviewed, to find historical policies and ratification forms. There were some instances where policies and/or ratification forms were not available i.e. a version of the policy, or ratification form, was not saved in the folder. In the event that a previous version could not be located, this has been documented in the policies exhibit list R9(7).

8. In 2016 following the merger with PiC, a task was undertaken, at that time, to merge the current PiC policies with the Priory policies, using a policy mapping exercise. Once this was completed, the PiC policies were archived in the policy central drive folder. Only PiC policies in place at the time of the merger were saved in the archive folder, with no historical record of changes that had been made to the PiC policies prior to the merger. The PiC policies did not indicate a version number, so it was also not possible to ascertain the number of revisions they had undergone.

9. Priory has identified all relevant policies within the period and scope of the Inquiry. We have only been able to include policies, which have been saved in the central drive and report on the reasons significant changes were historically made, where this information has been made accessible. I confirm that I understand my ongoing duty to the Inquiry to provide further disclosure of any such data arising from ongoing searches which is relevant to this Rule 9 request.

10. Priory Chelmsford provides three services for NHS patients: Acute, Eating Disorders, Child and Adolescent services. Suttons Manor has a low secure service for male patients. Oaktree Manor had a

low secure male and female service for patients with learning disability and closed in September 2019. Elm Park provides a service for patients with an Acquired Brain Injury (ABI).

11. Chelmsford Acute services would provide a general adult acute setting for diagnosis, initial treatment with medication or review of current treatment, Occupational services and nursing support. The length of stay would be usually short, around 4-6 weeks on average. Eating disorders services would follow national guidance on provision of treatment and would include group and individual psychology based on need, nursing support around dietary intake and occupational therapy. The length of stay could be variable depending on presentation of the patient and available community services for post discharge care and support.

12. Child and adolescent services at Chelmsford provide both for the patients educational as well as mental health needs. Length of stay can be variable depending on the patient's presentation and the core of treatment will be provided by nursing support and psychiatric diagnosis and treatment with medication and psychology options being available.

13. The Acquired Brain Injury services tend to have long stay patients and the focus is on rehabilitation as well as mental health support. Occupational health, nursing support, psychology and psychiatric input would be a focus here.

14. For secure services at Oaktree Manor and Suttons Manor, the patients would tend to be long stay, sometimes detained under forensic sections imposed by the court system. As well as managing the patients underlying mental health needs there would also be a focus on their behaviour and forensic needs. This would require nursing, occupational health, psychology and psychiatry input. There were no Priory admission or assessment units in this time period in the Essex Region.

15. In 2022, Priory developed a stated philosophy of care called Live your Life. The philosophy is the goal of enabling each patient to achieve a mental and physical state that would let them live their best life. The focus is not just on treating symptoms but enabling recovery.

Bed Managers and Access to Treatment

16. Policy H114 (AC/01) has four versions between 2016 and 2022. Prior to this there is no Priory policy outlining the admission decision-making process. Throughout the four versions the role of the bed manager does not change. The Bed Manager role is responsible for managing NHS inpatient enquiries and referrals to site that come from the Customer Service Centre. The Bed Manager is any person

appointed to the role. They can be clinical or non-clinical but if not clinical they need to consult with a clinical professional, such as a senior nurse or doctor at site. They ensure the required clinical information is received by site, reviewed by the relevant clinicians and feedback provided to the centre within the agreed time frames for each service. The role covers the following service lines: Acute (including High Dependency Units and Psychiatric Intensive Care Units, Child and Adolescent Mental Health Services and Eating disorders. On being advised of a referral the Bed Managers role is to access the referral information and if clinically able to review it themselves and make a decision based on the sites respective admission criteria. If the Bed Manager is not clinical then they remain responsible for ensuring a decision is made by an appropriate clinician and fed back within the agreed time frame. In terms of what factors determine the specific bed type the patient is assessed for it will be influenced primarily by what the referrer is requesting. Reasons for declining NHS patients referred from NHS would be network specific and sometimes site specific based on acuity of the ward, or environmental reasons such as availability of seclusion or suitable safe room. The clinical presentation and having suitable treatment options, acuity of the patient and other risks are patient specific reasons. Where possible a suitable alternative option would be offered as close to the patients local area as possible. The reasons for decline will be stated on the relevant individual record but we do not hold consolidated data on reasons for declining.

Admission and treatment of Voluntary and involuntary patients

17. Priory sites can admit patients whether they are voluntary or involuntary and during the admission a patient's status can change moving in either direction depending on their capacity and whether they meet the criteria laid out for detention by the Mental Health Act.

Admission Process to an inpatient unit

18. There are 18 versions of the policy covering admission that range from 2004 to the current time and called C02 or H02 (AC/02). In 2004 the policy details that a patient would be provided with a user guide for the hospital detailing philosophy of care, aims and objectives, services and facilities and key members of staff. The admission would be led by the primary nurse, introduced on arrival and responsible for the assessment, planning and implementation of care in collaboration with the patient and key staff in the treatment team including consultant psychiatrist.

19. In 2009, there is the addition of the CPA assessment and reference to local procedures relating to gathering of pre-admission information, liaison with keyworkers, appropriateness of admission including risk assessment and ensuring appropriate funding is in place. In 2011, the only addition to admission is that for any patient who has had previous treatment a copy of the medical record must be obtained.

20. H02 Version 6 2014 makes a number of changes to the admission process. It delineates a pre-admission process that predates the policy H114 detailed above. It details that a referring responsible clinician must initiate the referral and discuss with the Central enquiries team. It also describes a comprehensive pre-admission assessment will be completed if required to determine suitability of placement.

21. Emergency admissions, applies to both informal and detained patients. This relates to out of hours referrals. A referral form is required detailing historical and current risks and recent serious incidents. A doctor-to-doctor discussion and exchange of clinical information is strongly recommended. For NHS Specialised Commissioned service users, a retrospective gatekeeping assessment at earliest opportunity is required. A retrospective gatekeeping assessment is one that occurs after the admission due to the emergency nature of the admission. It would still be a robust assessment similar to a non-retrospective one. This Policy version describes a process of assessment of the patient at admission. It states the service user will be escorted at all times on arrival until assessment commences and a formal level of observations is agreed.

22. Each service user should receive a comprehensive joint assessment by nursing and medical staff that includes: a mental state examination, a nursing assessment, an assessment of risk and establishment of observation levels and a physical examination, completing the relevant form in care notes (electronic patient records) if available and a physical health care plan as appropriate. The joint assessment should be initiated within an hour of arrival on the Unit (though this timeline was not audited in the period relevant to the Inquiry). The admitting doctor should have read all available prior information on the patient from the referring doctor and service user's family. Information should be collected from those involved in the admission including family, police or ambulance staff. If family are present during admission they would be consulted by staff for further information. Following confidentiality guidelines, if the patient does not want their family to receive information about their admission this must be respected, but the family can still be asked for information about the patient if present. Any information from the family would be documented in a clinical entry to the notes. There is no target time for obtaining information from family: details are gathered at and during admission if the opportunity arises including through conversations with staff during visits or calls to the ward and via MDT meetings attended by family. An initial joint risk assessment and risk management plan must be completed prescribing the agreed level of observation necessary and when this plan should be reviewed. The admitting nurse and doctor are responsible for ensuring that the immediate short-term management plan (24/48 hour plan) has been agreed, recorded and communicated. Information should be gathered from family/carers and they should have the opportunity to express any concerns they have.

23. In relation to the admission process in addition to previous policy there is a focus on needs of any dependents of the admitted patient who may be vulnerable including children and the use of the local safeguarding team where necessary. Service users admitted under the Mental Health Act are only deemed formally admitted when the appropriate forms are complete. Service users and their family are to be informed of advocacy services. Every effort will be made to support service users or family members if any specific communication and information needs. There are currently 22 interpreting services listed by our procurement department. Throughout the period of the Inquiry sites would use their own local services to support communication. An added part of the process is now that a member of the nursing team checks and lists details of the patient's property and must give a clear explanation of the clinical need to remove items considered dangerous and these must be stored safely. A personal search will be undertaken if the risk assessment indicates that it is necessary.

24. H02 version 7, 2015 expands on the support for patients during the admission process. It highlights the need for patients to be provided with a clear explanation of the care to be provided for them during their admission. It states they should be fully involved in all aspects of care, being allowed choice and opinion within this care and aware of all relevant information which may influence decision making process. It gives more detailed guidance on types of support for any communication difficulties including face to face interpretation, use of sign language and translated written information if requested. These supports are to be used as often as the service user requests or Multi-Disciplinary Team (MDT) feel is necessary. Examples include mental state or physical health examination, CPA or MDT meetings and Mental Health Review Tribunals (MHRT) tribunals. The policy also states that admission to a Mental Health inpatient ward can be a distressing experience and staff should ensure they provide a warm welcome to the service user and their family.

25. H02 version 8, 2018 lists in more detail the type of information that may be requested for emergency admissions: Pre-admission risk assessment, previous discharge summaries, clinical history detailing historical and current risk, detailed criminal history, psychiatric history and reasons for admission. In relation to admission it adds to the previous policy that if a patient is not detained under the Mental Health Act, they must consent to the admission and treatment programme. If the Mental Capacity assessment shows their capacity is in doubt, a best interest decision must be recorded. Arranging a Mental Health Act Assessment should also be considered. In relation to the admission process this policy version adds that a CareNotes record should be opened and that relevant information contained in documentation received at admission must be recorded appropriately in care notes during the admission process. The initial care plan is now called the Keeping Safe or Stopping My Problem Behaviour care plan.

26. H02 Version 9 2018 expands on when the patient will meet with key staff. It states that on or soon after admission the patient will be introduced to their named nurse who will lead on assessment, planning and implementation of care along with other key team members. The patient's family and carers should as far as possible be involved in the decision-making process and planning. The patients Responsible Consultant psychiatrist should meet with the patient as soon as possible. For planned acute admissions, this should be within 48 hours. For emergency NHS admissions, this must be on the next working day. A request for medical records for any patient who has had previous inpatient treatment should be made, especially seeking details of potential risks and serious incidents. In this policy version during the admission process for patients admitted into learning disability and/or autism services the collection of Assuring Transforming (AT) data on behalf of NHS England should be collected if the patient consents. If they do not consent then it details a process of informing NHS England for next steps.

27. H02 version 11 2019 details that a pre-admission risk screen will be completed for all referrals and where the risk indicates that there are specific complexities, particularly of young people for Learning Disability (LD) or Autism with challenging and high levels of need, this must be fully risk assessed and escalated to a senior clinician for further discussion. This policy also adds that if a patient is admitted for a medically assisted alcohol or drug withdrawal the responsible consultant psychiatrist should either assess the patient prior to or at the point of admission . Where this is not possible the admitting doctor must agree the plan of care, including medication for supporting withdrawal with the responsible consultant. In the admission process, this policy adds that during the joint assessment matters that need to be addressed in respect of the patient's privacy and dignity should be explored and addressed. At this point the name of the 24/48-hour plan is now the Keeping Safe plan.

28. H02 version 12, 2020) adds a section on supporting transgender service users stating care must be patient-centred, respectful and flexible towards all transgender service users, whether they live continuously or temporarily in a gender role that does not conform to their natal sex. Priory did not have a specific transgender policy prior to 2024. In the admission process, it adds that it is the responsibility of colleagues to ensure that any available background information, particularly in respect of risk and current prescription (assisting medication reconciliation) is available and reviewed prior to the admission assessment.

29. H02 version 13 2022 for the section on emergency admissions states that Colleagues at the individual unit must be confident that they have sufficient information to make a balanced decision to admit. This may include: Pre-admission risk assessment, psychiatric history, previous discharge summaries, clinical

history detailing historical and current risk, details of any offending history and reasons for admission. It also details that the patient should be subject to level 3 within eyesight observations on arrival to the hospital until the assessment commences and a formal level of observations has been agreed. As this is policy the aim would be to achieve this in all cases (though this process was not formally audited in the time period of the Inquiry). In the admission process, the policy states the patient's consultant psychiatrist should meet with them as soon as possible but within 2 working days unless admitted for a medically assisted withdrawal from alcohol or drugs. In addition, there is guidance on patients admitted in the perinatal period where in line with NICE guidance consideration must be given to whether a referral to NHS services (and in particular a mother and baby unit) should be made. Decisions to refer to a specialist perinatal service would have been made by the Commissioners and NHS England rather than by Priory as it should be an initial known need. If for any reason, this was not known prior to admission, it would be discussed with Commissioners or NHS England depending on who is commissioning the admission.

30. H02 version 14 2023 states that for those patients who have not been assessed just prior to admission they should be seen within 24 hours of admission to hospital. It also states that there should always be a discussion between the admitting doctor and the responsible clinician shortly after patients have been admitted to hospital to clarify their initial treatment plan (including observation levels and prescription). For medically assisted withdrawal from drugs or alcohol it states the responsible clinician should either assess prior to or within 24 hours of admission. For patients who are admitted and are subjected to a Mental Health Act section then the admitting Approved Mental Health Professional should provide an outline report to colleagues on the ward and a full report within 24 hours. For patients who do not arrive for their admission, the ward/unit must contact the referrer as soon as possible to inform and agree a plan.

Clinical Networks

31. In November 2011 Priory established Service Line Networks (AC/03). These were created to close the gap between operations, sales and marketing and compliance. The idea was the networks would focus on how we manage consistencies, levels of continuous observations and staffing ratios. The aim was to provide the networks with quality data around benchmarking rates, complaints and incidents. This would enable the networks to identify the sites that might need more support. The original concept was that the networks would inform Priory of what works, what doesn't and what we can do about it.

32. The Networks relaunched in July 2018 (AC/04). They were called clinical networks and they were structured around improving clinical effectiveness. The networks relevant to the Essex services were

Forensic including Forensic learning disability, Acquired Brain Injury, Child and Adolescent services, Acute and Eating disorders. Each network would be co-chaired by a clinical director and a network lead, both experienced in the relative speciality of the network. Networks met quarterly and developed their own Clinical Network Operating Framework. Each network developed its own clinical pathway for the network to follow.

Acute Care Pathway

33. An example of a clinical pathway is the acute pathway version 1.9 developed in March 2022 (AC/05). The pathway is divided into 4 stages: Admission (initial 3 days) Phase 1 (7days) Stabilisation (day 8 onwards) and recovery/discharge (week leading up to discharge).

34. For mental health in the first 3 days there is the initial joint assessment between nurse and doctor leading to an initial treatment plan. The consultant reviews the patient within 2 working days of admission and the team seek background information from GP or Community Mental Health Teams. The patient is informed of and referred to advocacy as appropriate. In the first 7 days following admission, there is to be the first Multi-disciplinary Team review, formulation of a working diagnosis and treatment plan and discussion with patient around medication, either starting or reviewing current medication looking to optimise treatment. Care plans for keeping well (mentally well, keeping healthy and keeping connected to be drawn up with the patient. In the stabilisation phase a final diagnosis is to be formulated and discussed with the patient. There should be weekly review by a senior psychiatrist (Consultant or speciality doctor) with regular review of the care plans. In the discharge phase the patient is prepared for discharge in week leading to planned discharge. The GP is to be informed of discharge and discharge medication and a discharge summary is to be completed within 7 days of discharge and circulated to the GP and/or Community Mental Health Team. The complete discharge summary is to be provided within 7 days though the aim is to provide it at the earliest opportunity.

35. Physical health monitoring during the admission phase will be a physical health assessment completed by the admitting doctor and nurse, this will include blood tests, ECG and NEWS (National Early Warning Score). Smoking cessation advice will be provided. During the phase 1 7-day period, the treating team will liaise with patients GP re background medical history and medication history. Blood results will be gathered and fed back to the patient. Patient will be encouraged to attend exercise and gym groups and smoking cessation support and advice will continue. In the stabilisation phase the physical exercise within the patient's limitations will continue to be encouraged. At discharge, information on physical health and investigations will be included in the discharge summary to GP.

36. In the admission period, safety is addressed with a risk formulation on admission by the assessing doctor and nurse. This will inform an initial keeping safe care plan and determine level of observations for the new patient. During the phase 1 and stabilisation phases there will be continued review of observations, updated risk assessment in the MDT meetings and review of observation levels. In the discharge phase a crisis plan will be prepared with the patient, suicide safety plan may be discussed and patient supported in the creation of the plan at any point during admission (AC/06). A suicide safety plan is a cognitive plan exploring different options and strategies a patient can employ if feeling suicidal. This can include distraction strategies, reaching out to carers/family or mental health professionals. This was rolled out in 2022 following guidance released by the Royal College (AC/07).

37. Therapeutic activity starts in the admission phase by establishing a therapeutic rapport with the patient by the treatment team. In the 7 days of phase 1 there will be psychological assessments, OT assessments as required. Brief therapeutic interventions to promote stabilisation and help successful discharge will be considered. There will be a psychology formulation to help reduce risk and levels of observation and nursing 1:1 sessions with primary nurse or key worker on a weekly basis. Through the stabilisation phase, attendance at identified OT and psychology/ nursing groups will be encouraged. In the discharge phase the planning of discharge will be with the patient and will include a pre-discharge session for preparing the patient and completion of reports to ensure continuity of support and care or meeting any additional needs post discharge.

38. During phase 1 and the stabilisation phase family or carers will be engaged initially focusing on information gathering but then a joint review with carer/family if patient consents and appropriate. Similarly, at discharge, a joint review with family/carer as part of discharge planning with be held.

39. From phase 1, the team will liaise with any community based mental health team for background information and risk. If there is no CMHT referral and one is required, then a referral request will be made via the local Trust to identify the correct team and psychiatrist for post discharge. In the discharge phase, the team will ensure the discharge information is sent to the identified Home Treatment Team (HTT) or Community Mental Health Team (CMHT). Following discharge the patient will receive a 48 hour follow up call to check they are ok.

Forensic Pathway

40. Described below is a care pathway for forensic patients developed by the forensic network in 2022 (AC/08). The admission phase is defined as the first week. In this period, the medical team complete an initial medical assessment focusing on mental and physical health and diagnosis. Patients capacity

assessed and T2 T3 documentation is reviewed. The MDT will review the pre-admission assessment report and discharge planning will start. Observation levels will be set and reviewed daily. The psychology team will familiarise with initial risk screen and patient's immediate needs. OT will introduce themselves to start building a rapport. They will start assessing activities of daily living skills and patient's interest in meaningful occupation.

41. The nursing team will carry out an initial drug screen, smoking cessation advice and start to build a rapport. Social work will do an initial assessment of need, agree frequency of contact and request consent to liaise with family/carers. They will also liaise with the community team. The MDT will review risk of patient including pre-admission documentation. Level of MAPPA (Multi-Agency Public Protection) contact will be established and a positive behaviour plan started. OT will review any mobility issues and sensory needs. For physical health a GP referral will be made and a patient hospital passport. Dental and optician needs will be established. OT will support the patient to maintain a healthy lifestyle.

42. The second phase is a 3-month period where there will be monthly MDT review. Ashtons will review medications monthly and the initial Care Programme Approach (CPA) will occur. Ashtons is the pharmacy provider for Priory and have acted in this role at a Healthcare wide level since 2008. There will be ongoing assessment of patient using various scales including HONOS secure (Health of the Nation Outcome Scale with addition of a security scale). A Psychology assessment of risk and diagnostic formulation including HCR 20 and other relevant risk tools will be carried out. HCR 20 is a Structured Professional Judgement (SPJ) risk tool for assessing the risk of violence. A full psychology assessment will be reviewed in the first CPA including recommendations for interventions to meet criminogenic and mental health needs. OT will complete a further assessment of patient and report back to first CPA. The CPA will be an important decision making meeting involving the patient and making plans with the various elements of the team.

43. The next stage is ongoing treatment where the patient will complete various treatment programmes identified for them addressing behavioural, criminogenic and mental health treatment needs. Goals will be reviewed so discharge planning can be updated. Therapeutic activities can be individual and group based depending on patient's needs. Risk assessments will be updated and leave status reviewed. OT activities will form an important part of the patient's rehabilitation towards the next stage of their care in a less restrictive environment or the community. CPA will continue to be an important decision making meeting and may be attended by external professionals and commissioners, also family/carers depending on patient consent.

44. The discharge process will be dependent on progress and often liaison with the Ministry of Justice if under a forensic section. Each speciality will provide final reports and these will be shared with the receiving team whether in a lower level of security or the community. Relapse prevention and staying well plans will be established and shared with patient and receiving team. An important part of the discharge is collaboration with the locality team or receiving service. Any discharge usually has an opportunity for the patient to be supported and prepared for the next stage including visits to proposed accommodation or services. Community teams are encouraged to meet the patient and start forming a rapport. Social worker will liaise with family/carers where consent is permitting. MAPPA will be informed of discharge if appropriate.

Eating Disorder Pathway

45. This pathway was developed by the Eating Disorder clinical Network in June 2021 (AC/09). The plan divides the care of the patient into MDT input and a therapy programme. The pathway is divided into an admission, then three periods of care with a discharge at the end. It does not specify the time of each period. During the first 7 days the MDT will complete the patient assessment by admitting doctor and nurse within 72 -hours of admission. Care plans will be completed within 24 hours of admission as part of this process and target weight and goals agreed with the patient. A meeting of the care team with community team invited should occur in this period. Medical stabilisation of patient and initial meal planning will be a focus of the first7 days.

46. In the initial 3rd of the treatment, there will be work with the dietician on goal setting and the starting of 5-6 hours a day meaningful activity, including therapeutic activities and post meal supervision. There will be practical meal support, managing and tolerating anxieties about meals and weight restoration. Patients are encouraged in attending low intensity groups. The middle 3rd of the pathway will be continued following a tailored therapy programme with 3-4 groups a day and starting home and leave passes as appropriate. The final 3rdof the pathway will focus on home leave, thinking about future plans and building a new life. The discharge phase will be comprised of discharge planning and liaising with Home Teams and aftercare arrangements.

47. The therapy programme in the first 7 days will be a psychological assessment and introduction to the therapy team and explanation of the various groups and activities. During the whole admission the programme will include nurse key worker sessions weekly, individual therapy weekly and development of a personal therapy plan. Attendance at groups and post meal groups led by occupational therapy and dietician will also occur. Family support and joint family meetings will be supported and self-directed

activity and community meetings will complete the programme. In the discharge phase the therapy focus will be on developing a relapse prevention recovery plan with the patient.

Child and Adolescent Care Pathway

48. This is the Child and Adolescent Mental Health Services (CAMHs) Care Pathway for 2022 v1.9 (AC/10). This pathway is divided into 5 stages: Preadmission, Admission –first 48 hours, first 7 days, first 6 weeks and discharge planning.

49. In terms of mental health, the access assessment form is reviewed to assess the suitability for admission. The timescales for review adhere to NHS guidance within CAMHs service specifications. On admission, all young people must have an initial assessment and keeping safe care plan completed within 24 hours. They must be reviewed by a psychiatrist on first working day after admission. Background information must be requested from GP/CAMHs team by first working day. An information sharing agreement will be developed with the young person which will inform the keep connected care plan. Advocacy support and referrals are made as appropriate. HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents) and CGAS (an outcome measure that is clinician reported) are to be completed.

50. In the first 7 days a preliminary formulation and initial working diagnosis are developed, initial goals for admission are agreed with the young person, family and locality professionals. There is the initial multidisciplinary treatment plan and discussion around medication. The four care plans; keeping well, keeping safe, keeping connected, and keeping healthy are to be completed and an assessment of sensory needs. In the first 6 weeks a collaborative assessment and working diagnosis is established and communicated. Care plans are reviewed, initial CPA within 6 weeks and a welcome meeting with carers, parents, locality professionals. For discharge early consideration is given to discharge destination and pathway. A relapse prevention plan is developed collaboratively between MDT and young person, family and professionals. A section 117 discharge planning meeting is needed if patient is detained under Section 3. There is consideration of the legal framework (CTO) and completion of a discharge checklist. Discharge HoNOSCA and CGAS forms are completed.

51. In terms of physical health, an initial assessment will occur within 24 hours of admission with blood tests and ECG. Smoking cessation input is sought if required. In the first 7 days, there is feedback of any results of investigations to team and patient. Staff encourage engagement in appropriate levels of physical activity. For the first 6 weeks, there will be monitoring of physical health as per care plan. On discharge, physical health and investigations information will form part of discharge summary to GP.

52. Therapeutic activity options will be highlighted in the welcome pack and on initial admission, orientation to the ward and any religious, cultural, dietary, disability and communication needs will be identified. Young people will be issued with an individual therapeutic timetable within 2 working days. First key worker session with a named nurse, first OT session and first psychological session are held within 7 days. An individual education plan should be commenced within 7 days and the young person should be invited to attend a community meeting. Over the next 6 weeks there should be an ongoing review of the therapy programme which should include individual psychology focusing on stabilisation, weekly skills based psychology sessions, education activities and compliance with medication. Family and carer contact is encouraged throughout the admission.

Live Clinical Dashboards

53. During 2023, live dashboards were developed to support each of the clinical pathways. The purpose of these Dashboards is to support clinical teams at ward level in the monitoring of compliance to the clinical pathways. These dashboards would update in real time as tasks were completed. These dashboards have been designed as real time support for the clinical teams and therefore the data is not available in terms of audit. However, audits are completed on many aspects of the pathway and audit data is available for those. Currently, the Key Performance Indicators for the clinical pathways provided by the dashboards are:
    - Admission assessment being completed by the doctor and nurse within 72 hours of admission
    - Keeping safe care plan completed within 72 hours of admission
    - Risk assessment being completed within 72 hours of admission
    - Care plans completed and regularly reviewed
    - Outcome scales completed at admission and discharge

Assessment, Diagnosis and Treatment

54. The earliest policy guidance for Priory on Assessment, Diagnosis and Treatment available is C04 version 2 dated 01/01/2004. It states each Priory Unit shall have clearly defined criteria for the range of treatments and facilities available on site. That sites will not accept patients for admission if they cannot provide appropriate treatment and care. The clinical team will assess each patient admitted and develop a care plan for that patient. This process is carried out within defined timescales and subsequent treatment is guided by assessment results.

55. H04 version3 2009 adds some detail to the diagnosis process and care planning. An initial diagnosis if known is given by the admitting doctor and recorded in the service user management system (Medtrak) and service user notes. The consultant psychiatrist should regularly review diagnosis with a final ICD 10

diagnosis code entered on MEDTRAK on discharge. Following assessment an individual care plan should be formulated in collaboration with the patient with agreed objectives following current NICE (National Institute of Clinical Excellence) guidelines. The MDT will regularly review the care plan in conjunction with the Care Programme Approach (CPA) and any changes in objectives or treatment will be clearly documented.

56. H04 version 4 2014 expands on the detail of the assessment process and care and treatment. The formal assessment of the patient should occur within 2 hours of admission. The patient should be informed of the content of the admission process, confidentiality, scope of the questions, shared decision making and can be accompanied by a relative though it is preferable for admission assessment that the patient is seen alone. The assessment process should be allocated appropriate time for both recording content and covering the questions. Information on different treatment options and side effects should be provided and support for the patient if difficult or sensitive topics have been discussed. Holistic assessment will cover psychological, physical and social functioning, risk to the individual and others and any needs arising from co-morbidity and personal circumstances including relationships, cultural, housing, financial and occupational status. Views of the patient and family/carers should be taken into account. Consent to liaise with family/carers should be sought. Unless patient does not consent to contact, the family/carers views can still be obtained. The family views and any background information would be sought if the family details were known. However, if a patient does not consent to the family knowing details of their care and the family do not know of their admission, then finding details of family and contacting them would breach the patient's fundamental rights to privacy and confidentiality.

57. The approach to individuals' care and treatment should be person centred, recognising them as a person first and a person accessing services second. Following assessment an individual care plan is formulated. It should be written so the patient can understand it and contain the patient's priorities and goals for recovery. Any healthcare needs identified should have a corresponding care plan outlining what the patient and staff need to do to manage that condition. Where the patient may exhibit behaviours that might harm themselves or staff a support plan should be developed taking into account warning signs, triggers and helpful support strategies for the patient. A copy of the current version of H04 v08 2023 is enclosed (AC/11).

Physical Health monitoring of inpatients

58. The first policy guidance on physical health monitoring is H100 version 01 2013. This policy states that the GP and practice nurse will take the lead on routine monitoring of patients physical health. Metabolic syndrome and Type 2 Diabetes are particularly common in psychiatric patients. Routine physical health

checks and investigations will be carried out on a regular basis. On admission, recording of weight, height BMI abdominal girth, temperature and respiratory rate will be completed. Urine for analysis of protein, blood and glucose will be taken. Blood tests including full blood count, urea and electrolytes, liver function tests, blood sugars, full lipid profile and any other blood tests deemed relevant will be taken and sent to laboratory. A standard ECG will also be completed. Any refusals for blood tests will need to be recorded in the patients notes.

59. The policy then identifies different groups of patients depending on comorbid physical health conditions or types of psychotropic medication and lists types of investigations and regularity of repeating them during admission. Another table lists baseline blood tests and regularity of repeat tests for all patients. A cardiovascular review should be completed every 6 months for patients with identifiable risk factors. Lifestyle interventions for patients with risk factors should be identified and health awareness groups should be available for patients to attend. The policy outlines ongoing monitoring for patients during admission. It details specific monitoring for patients with metabolic syndrome, diabetes or on anti-psychotic medication.

60. Policy H100 version 5 2015 builds on the previous policy to add that prescribers have a responsibility to ensure appropriate monitoring of service users physical health takes place. They may delegate the responsibility for testing and follow-up to another appropriately trained professional but they still retain responsibility for ensuring the monitoring is completed. Care notes, the electronic patient record has its own section for blood results to be recorded. Any sudden change in a patient's physical presentation should lead to an immediate physical health assessment. Pregnancy testing should be undertaken when a woman is prescribed medication that is contra-indicated in pregnancy and there is a possibility that the woman could be pregnant. Where there is an identified physical health issue, there must be a physical health care plan in the core care plan Keeping Healthy. This should be reviewed monthly and updated if any change in physical health. A copy of the current version of H100 v07 2022 is enclosed (AC/12).

Contact with Consultant Psychiatrist

61. There is no specific policy detailing this and it would vary for different clinical networks. The patient would be seen by the consultant psychiatrist in the admission period and at each multi-disciplinary team review and CPA meeting. Any discussion with the patient on Mental Health Act matters would be led by the consultant and the majority of discussion and changes to psychotropic medication would lead to discussion with the patient before changes were made. Changes to leave would also have to be agreed by the consultant psychiatrist and most of these would occur in the MDT meetings. For short stay

admissions such as Acute and some Eating disorder admissions the frequency of MDT would be weekly. For longer stay admissions such as forensic the frequency would be monthly. CPA meetings would be 3 monthly and 6 monthly. Any request by the patient for a Mental Health Review tribunal or managers hearing would also lead to contact and an assessment by the consultant psychiatrist for preparation of the tribunal report and opinion.

Administration of Medications

62. Version 2 2004 is the first policy version available detailing Administration of medication. It states that for medication administration the person must be a first level registered nurse and must know the therapeutic uses of the medicine, normal dosage and side effects and any precautions or contra-indications. The medication shall be administered according to local policy, with the professional ascertaining that the prescription is unambiguous, the medication has not already been administered, identity of the patient is correct and the expiry date of the medication has not been reached. For controlled drug administration two professionals, one of whom must be a registered nurse or doctor must be involved. Staff will monitor the patient after administration and call the doctor if any change in their condition occurs. All medications are administered through a written prescription on a medication administration record (MAR) authorised by a doctor or nurse. Regular reviews of prescribed medication shall be carried out at least every three months.

63. H22 version 09 2014 stipulates that in a medical emergency such as anaphylaxis or opiate overdose, adrenaline injection or naloxone injections can be used without prescription. Local procedures should be in place to ensure that the registered nurse has the competency to administer medication. Medication reviews should be carried out when clinically indicated and at a minimum of at least every 3 months. Where possible medication should be prescribed after discussion with the service user and other relevant care professionals in the MDT.

64. H22 version 12 2017 notes that a prescriber can be a doctor or non-medical prescriber. The professional who administers the medication must be a registered nurse or doctor and as such is accountable for his/her actions with due clinical judgement applied. All registered nurses should complete the Medicines Management Competencies for nurses before they administer medication and this should be completed as part of their initial induction and for newly qualified nurses as part of their Preceptorship and sign off.

65. H22 version 14.1 2022 states that all registered nurse, nursing associates and locum agency nurses, who have had a full Priory induction should complete the Group Medicine Management Competency

Framework and administration before they administer medication. If the Registered nurse has not completed this, they should not be involved in administering medication. Sites usually aim to have all applicable staff complete the framework within their initial induction period.

66. In 2023, Priory rolled out an electronic prescription record. This roll out has had an impact in reducing the administration and prescription error rates and these reductions have been maintained since roll out.

67. The effectiveness and response of the treatment would be assessed on an ongoing basis with particular review in the MDT. All professionals would input into improvements in the patient's behaviour and mental state and also on side effects. In the prescribing process the doctor or non-medical prescriber would consider contra-indications and have access to online electronic versions of the British National Formulary (BNF) and a summary of product characteristics (SPC's) which can be downloaded from the Medicines Compendium website. Priory's contracted pharmacist would notify the person responsible for medicines of any drug alert or recall as appropriate and a record kept of any action taken. The doctor or pharmacist must report suspected adverse incidents involving medication to the Medicines and Healthcare Products Regulatory Agency (MHRA). For the period 2008 to 31 December 2023, Ashtons provided pharmacy services to all Priory Healthcare sites. This would include a site visit weekly to audit the prescription cards and carry out checks on stock being in date and fridge temperatures. This would form part of a divisional audit that would be reviewed quarterly by the drug and therapeutics committee. In addition to weekly site visits, Ashtons provided a 24-hour support line for questions relating to medication.

68. Medication prescribed for physical health conditions cannot be administered to a non-consenting patient with capacity. In a patient who lacks capacity then Mental Capacity Act 2007 principles should be followed. Medication prescribed for mental health conditions should always seek the consent of the patient. However, if the patient is detained and either in the first 3 months of their detention or has been placed on a form T3 they can be administered medication without consenting. Practically, if refusing oral medication in this circumstance the patient can only receive the medication without consent and cooperation if it is available in an intra-muscular form (H22, version 14.2 2023 AC/13).

Observation levels

69. Policy C47 V03 2005 defines nursing observation as 'regarding a patient attentively' while minimising the extent to which they feel under surveillance. It is not simply a custodial activity but an opportunity

for therapeutic interaction with the patient on a one to one basis. This policy details that a risk assessment is completed for all patients at time of admission, discharge and regular intervals in between, to reflect the levels of observation. The risk assessment is usually a multi-disciplinary task that reflects the overall view of the team and their approach and management of the patient with regards to level of observation. If a patients mental or physical needs change and if there is a need to increase the level of observations then this can be carried out immediately by the nurse in charge without input from other disciplines. The patient's safety is the usual reason for an increase in observations and the patients consultant should be informed immediately so a review of the observation level can be carried out at the earliest convenience.

70. The level of observations are: Level 1 General observations – minimum level of observations for all patients. Location of patients should be known to staff but not all patients needs to be kept within sight. Level 2 Intermittent Observations- This indicates a patient's location is being checked at regular intervals – for example 10, 15, 30 minutes. The exact times to be recorded in the patients care plan. This level of observations is appropriate for a patient who is potentially, but not immediately, at risk. Level 3 Within Eyesight –This level is required where the patient could at any time make an attempt to harm themselves or others or are at risk of absconding. The patient should be kept within eyesight at all times. Level 4 within arms' length – This level indicates that the patients being nursed are at the highest risk of harming themselves or others and need to be nursed in close proximity. On rare occasions, more than one nurse may be necessary. All in-patients are subject to general observations that include staff actively engaging and interacting with the patient. Where ever possible practice must always reflect the use of the most appropriate member and gender of staff for patients who are nursed on a 1-1 basis. The patient's views and needs will be taken into account, particularly where there is a history of sexual abuse and vulnerability, when allocating colleagues to undertake observations. However, it is not always possible to accommodate the patient's preferences such as same sex staff. It is essential that the gender of the colleagues and patient should be considered; these should be same sex where possible and it may be necessary for the colleague to be swapped, for example to allow the patient to use the bathroom. Colleagues undertaking observation duties must not deviate from care/risk management plans or make their own judgements in delaying/missing an observation, reducing the observation level or permitting a higher degree of privacy for a patient. This is particularly relevant when colleagues are observing a patient of the opposite gender. Colleagues undertaking patient observations should be relieved for 60 minutes every two hours. A key component of effective observations is therapeutic engagement, particularly during Level 3 or 4 observations. The colleague undertaking the observations should introduce themselves and attempt to establish a rapport with the patient, asking them how they would like to spend the time or finding out what helps them.

71. Policy H47 V05 2010 adds that for general observations it is good practice that at least once a shift a member of the MDT shall interact with the patient individually or in a group setting to assess the patients mental state. This should include assessment of the patient's mood, behaviour associated with risk and shall record this assessment in the care notes. For Intermittent observations it notes an alternative method of random timings but a specific number per hour. Nomenclature changes in this policy with the level now removed and just the name of the observation used: General observations, intermittent observations, constant observations: within eyesight and constant observations: within arm's length.

72. Policy H47 V07 2013 Added back the level 1, 2, 3, and 4 to the terminology. It also notes that multiple staff observations may on occasion be necessary. This may be required for short periods of extreme distress or where there is risk of significant violence or absconding. It also notes that environmental factors should be considered for the highest risk group of service users. This may include use of safer ligature free rooms or removing items from the environment.

73. H47 V08 2014 allows for combining of observations. For example constant observations whilst the patient is awake and intermittent observations whilst the patient is asleep. In this policy the Intermittent Observations are only carried out at random and irregular intervals but on a specific number of occasions per hour. The frequency should not be more than four per hour.

74. H47 V11 2017 states that risk assessment and review of intermittent observations should occur at a minimum weekly and constant observations should be reviewed daily. This policy introduces Presence checks which are distinct from patient observations and involve an allocated member of staff at regular intervals, such as hourly, to establish the location of all patients on the ward. These checks are not required on all wards but might be suitable for open wards with no locked door.

75. H47 V14 2020 states that whilst the nurse in charge can increase level of observations based on changes in the patient's presentation and risk assessment, the observation levels of a patient can only be reduced by a doctor; this will usually be the patient's consultant but out of hours can be the on-call consultant. A copy of the current version of H47 v21 2023 is enclosed (AC/14).

Restrictive or Coercive Treatment

76. Policy H122 v01 2019 defines restrictive interventions as deliberate acts on the part of the other persons that restrict an individual's movement, liberty and/or freedom to act independently. Examples include Physical interventions such as PMVA – management of violence and aggression, rapid tranquilisation

and seclusion. Restrictive practices refers to those practices that limit an individual's movement, liberty and/or freedom to act independently in order to maintain the safety and security of the site, service user and staff, examples include: Room searches, rub down searches, access to courtyards, kitchens or calm rooms and monitoring of communications and visits. Finally, blanket restrictions refers to rules or policies that restrict a patient's liberty and other rights which are routinely applied to all patients without individual risk assessments to justify their application. A copy of the current version of H122 v03 2023 is enclosed (AC/15).

77. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risk identified for particular individuals. The impact of the blanket restrictions on each patient should be considered and documented in the patient's records. Any blanket restriction should never be applied or introduced in order to punish or humiliate, but only ever as a proportionate and measured response to an identified risk. The policy goes on to list the healthcare blanket restrictions which include: access to alcohol, cigarettes on promises or whilst on escorted leave, illicit drugs or new psychoactive substances, illegal pornographic material, weapons, door to clinical areas being locked and access to court yards or outdoor spaces at night. The policy states that a patient would normally have access to all activities and opportunities associated with that unit. However, for clinical or risk based reasons, it may be appropriate for individual patient's not to have access to one or more of those activities. The reasons should always be explained to the patient.

78. Policy H128 V01 2022 Use of Force in Mental Health Units, defines force as the use of physical, mechanical or chemical restraint on a patient or the isolation of the patient. At Priory, we use physical restraint which is 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.

79. Mechanical restraint is the use of a device intended to prevent, restrict or subdue movement of any part of a patient's body, whose primary purpose is behavioural control. Chemical restraint is the use of medication, which is intended to prevent, restrict or subdue movement of any part of the patient's body, this includes use of rapid tranquilisation. Seclusion is the supervised confinement and isolation of a patient away from other patients, in an area from which the patient is prevented from leaving, where it is immediately necessary for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others. Long term segregation is a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and representative from the commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward on a long term basis.

80. The policy states that use of force should never be to punish, or inflict pain or humiliation. Where a person restricts a patient's movement or uses (or threatens to use) force then that should be used for no longer than necessary to prevent harm to the person or others, be a proportionate response to that harm and be the least restrictive option. Following any use of force, the patient, and where appropriate family or carers will be involved in post incident reviews where the impact both physical and emotional will be reflected upon. A debrief should also consider patients who might have witnessed the use of force. If any need is identified staff provide counselling or support for any trauma that might have resulted. A copy of the current version of H128 v02 2023 is enclosed (AC/16).

81. Management of Disturbed Behaviour C37 V02 2004 states that when using physical restraint it is used to take control of a dangerous situation and to contain or limit the patient's freedom for no longer than is necessary to end or reduce the threat to himself/ herself or others in the vicinity. It also notes that in any patient, where it is considered likely that rapid tranquilisation may form part of a treatment approach in the future then a clear written treatment plan must be written in the notes, appropriate medication prescribed and the treatment plan communicated clearly to the nursing team. Following tranquilisation the patient shall be placed on 1:1 observations and may be placed on a fluid chart. Patients who have been restrained will be seen the following day by the ward doctor, a senior member of the clinical team and the hospital director if any issues remain unresolved. There is a Committee that reviews the data on frequency of use of restraint and the training of staff to carry it out. However, the process followed during a restraint incident itself is not audited.

82. C37 V03 2006 states that a doctor and/or consultant shall see the patient as soon as possible and no longer than 12 hours following an incident of physical restraint.

83. C37 V04 2006 updates management of disturbed/Violent behaviour brings policy up to date with NICE Guidance (CG25) 2005. This includes that under no circumstances should mechanical restraint be used and the patients overall physical and psychological wellbeing should be monitored throughout. Post incident the patient should be seen by a doctor as soon as possible. Following a rapid tranquilisation a doctor should attend within 30 minutes of the alert.

84. H37 V05 2012 states that under no circumstances are patients to be restrained using mechanical restraints unless authorised by the Chief Medical Officer.

85. H37 V06 2013 states that following administration of medication for rapid tranquilisation, observation and monitoring of the patient must be carried out. It is recommended that this is done every 10 minutes for one hour then review the frequency with the Responsible Clinician. Monitoring should be determined by the MDT but may include pulse, temperature, respiration rate, alertness and sedation, EPSE (extra-pyramidal side effects) blood pressure, oxygen saturation, hydration and any other observations deemed appropriate.

86. H37 V07 2014 states that prone restraint must not be used as a planned intervention, if a restraint results in a prone position staff must disengage as soon as possible and re-engage if necessary. It also states that a suitably qualified and experienced member of staff will facilitate a de-briefing session with the patient within 24 hours of the incident. Post-incident reviews should include ensuring the patient's psychological and physical wellbeing. For post-rapid tranquilisation this policy amended what is monitored to be the decision of the nurse in charge and the doctor.

87. H37 V08 2016 updates the policy to take into account the updated NICE guidance (NG10) 2015. The policy states that PRN (as required) medication should not be routinely prescribed. The MDT should develop an individual treatment plan for disturbed behaviour and this should be reviewed regularly. If rapid tranquilisation is required to sedate the patient rather than treat an underlying mental health condition, then the minimum dose of medication that is required to improve the mental state of the patient to a point where it is possible to manage them without undue risk or distress to themselves or those around them should be administered. Following the administration of rapid tranquilisation medication then monitoring of patients should be every hour until there are no concerns. If the patient has a dose above BNF limit, appears to be asleep or sedated, has taken illicit drugs or alcohol, has a pre-existing physical health problem or has experienced harm as a result of any restrictive intervention then the frequency of observations should increase to every 15 minutes.

88. H37 V09 2018 recommends that a doctor should be immediately available to attend an emergency, if restrictive interventions including rapid tranquilisation might be used. Mechanical restraint requires authorisation of the Hospital Director and Medical Director.

89. H37 V11 2019 states that rapid tranquilisation must not be used on informal patients who have the capacity to refuse treatment and who has done so. In terms of monitoring a patient after rapid tranquilisation the NICE guidance recommends this should include pulse, temperature, respiration rate, alertness/sedation, blood pressure and level of hydration.

90. H37 V12 2020 introduces a section on mechanical restraint. It states it should only be used in exceptional circumstances where other forms of restriction cannot be safely employed. It should be used in line with the least restrictive principle and should not be an unplanned response to an emergency situation. The use should be approved following MDT consultation and carefully care planned. The patient should be under continuous nursing observations for the period of use. The patient should have a medical review at least one hour after the beginning of mechanical restraint. Subsequently, there should be ongoing medical reviews at least every four hours by the registered medical practitioner. Reviews should be more frequent if requested by nursing staff. The reviews should include full physical and mental health evaluations. If a belt is used to secure arms or wrists and a person cannot leave an area due to immobility then that is to be considered seclusion as well. Devices that constitute mechanical restraint include a bean bag or leg support that immobilises a patient's legs who is kicking out at staff, an emergency belt or mechanical handcuffs. There is only one case of use of mechanical restraint in the Priory Essex sites from the Datix incident reporting system, which was in place since 2019. This was for a single case in Chelmsford in the CAMHs unit in 2023 to support the patient attending A and E and manage the patient's risk of violence and aggression. There were no cases found on the previous system for recording incidents in use prior to 2019. I do not have details of any LADO referral associated with this incident.

91. H37 V14 2021 states an additional safeguarding element where if there are concerns about the potential or alleged inappropriateness or unlawful use of physical interventions by colleagues then there must be a referral to the Local Authority Designated Officer (LADO) or duty Social Worker. For mechanical restraint the nursing observations remain continuous but a nursing review is added every 15 minutes. The use of a beanbag is no longer classed as mechanical restraint. Safer clothing is included and should be used as a last resort intervention utilised proportionately in the management of high risk self-harm/potential suicide particularly where the use of ligatures from torn clothing is an immediate concern. A copy of the current version of H37 v16 2023 is enclosed (AC/17).

92. H37.1 V01 2014 the Use of Mechanical restraint and Soft Cuffs states that an Emergency restraint belt can only be considered on an individual service user basis. It requires a written application from the Hospital Director and Medical Director. The application must be agreed by the Operations Director, Service Line Director, Director of quality, Director of Safety and Chief Medical Officer.

93. H37.1 V04 2022 States that a plan of aftercare will be developed for each patient following the application/use of mechanical handcuffs/soft cuffs. This will include reference to psychological support

and emotional wellbeing of the patient. A copy of the current version of H37.1 v05.2 2023 is enclosed (AC/18).

94. C40 V03 2005 Seclusion of patients states that the original 1985 draft of the code of practice defines seclusion as the supervised denial of the company of the other people by constraint within a closed environment at any time of day or night. The patient is confined alone in the room, the door of which cannot be unlocked from the inside and from which there are no other means of exit the patient can open himself. It should only be used in cases of emergency where the patient can no longer be managed and where there is immediate danger requiring his isolation for his own safety or for the safety of others. It is a last resort and should cease immediately the danger ends – it should not be regarded as a treatment technique and should never be used for punishment or retribution.

95. The policy states that seclusion of an informal patient shall be taken as an indicator of the need to consider formal detention. Guidelines are laid out in the policy which include that the patient's safety and wellbeing is ensured, ensures the patient receives the care and support rendered necessary by his or her seclusion both during and after it has taken place. The decision to seclude can be made in the first instance by a doctor or named nurse. If the decision is taken by someone other than a doctor the doctor should attend immediately. A nurse will be readily available within sight and sound of the patient at all times throughout the seclusion and present at all times if the patient has been sedated. Patient's vital signs must be monitored at regular intervals. The aim of observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be terminated. The need to continue seclusion must be reviewed every two hours by two nurses and every four hours by a doctor. An MDT review should occur if seclusion continues more than 8 hours consecutively or 12 hours intermittently.

96. H40 V03 2010 distinguished a 'timeout' from seclusion. Time out is a brief intervention of 15 minutes in a room away from the common areas of the ward. It should not include the use of a locked room and should form part of a behavioural programme. It should be clearly documented in the care plan that it represents a means for staff to modify behaviour such as aggressive disruptive or destructive behaviour and should facilitate the achievement of positive goals. The policy states that seclusion should never be used as a means of managing self-harming behaviour and it is only when there is a risk to others that a potential self-harming service user can be secluded. A doctor or the professional in charge of a ward can make the decision to seclude and an MDT review must occur to review the need for seclusion as soon as practicable after seclusion begins. This review should establish the individual needs of the patient

while they are in seclusion and the steps that should be taken to bring an end to seclusion as soon as possible.

97. For patients who have received sedation, a skilled professional will need to be outside the door at all times with adequate care facilities available to them for a minimum of one hour after sedation has been given. For medical reviews if the patient is asleep the MDT can decide to not require the review until the patient is awake so as not to disturb the patients sleep. If any member of the MDT review dispute the need for seclusion then it should be referred to a senior manager. If a patient is secluded for more than 4 days then consideration to creating a long term seclusion plan should be given. This is created by the MDT and can define frequency of medical reviews to take place though nursing reviews remain 2 hourly.

98. H40 V05 2012 defines cooling off and assessment as different to timeout or seclusion. Cooling off is where following an altercation one or two patients are asked to return to their rooms until it is clear that this is no longer necessary for the safe management of the ward. Assessment is when the patient has been subject to a period of seclusion and following discontinuation is requested to remain in a limited rea of the ward. Debriefing sessions should be held with the patient and staff following any cooling off assessment. Timeout or seclusion is recorded in the notes. This policy states that in addition to the 4 hourly doctor reviews and the 2 hourly nursing reviews, each day there should be an independent review at least once daily by a doctor or suitable approved clinician who is not normally involved in the care of the patient.

99. H40 V06 2014 states that where a service user poses a risk of self-harm as well as harm to others, seclusion should only be used where professionals involved are satisfied that the need to protect other people, outweighs any increased risk to the patient's health or safety and that such risk can be properly managed.

100. H40 V09 2015 states that where the decision to seclude was authorised by the nurse in charge or approved clinician an initial medical review of the need for seclusion should be carried out by the responsible clinician or duty doctor within an hour after seclusion begins. If concluded that the seclusion needs to continue then the review should establish the individual care needs of the patient while they are in seclusion and steps to be taken to bring an end to the seclusion. Following the first review by the MDT the following medical reviews must continue at least twice in every 24 hours. At least one of those reviews should be by the RC. An independent MDT review should occur for any patient detained in seclusion for longer than 8 hours continuously or 12 hours intermittently.

101. H40 V10 2016 states that seclusion is the supervised confinement and isolation of a patient, away from others, in an area from which the patient is prevented from leaving. Its sole aim is to contain severe behavioural disturbance which is likely to cause harm to the patient and/or others. If a patient is confined in any way that meets this definition, even if they have requested or agreed to such confinement, they have been secluded and seclusion protocol must apply. This means calling it therapeutic isolation, timeout or open door seclusion does not alter the fact it is seclusion. This policy also states that seclusion should only be used in hospitals and in relation to patients detained under the Act. If as a last resort an informal patient is secluded then an assessment for an emergency application for detention under the Act should be undertaken immediately. If a patient is locked in seclusion room alone then a suitably skilled professional should, as a minimum, be readily available within sight and sound of the seclusion room at all times throughout the period of seclusion and they must have a means of summoning urgent assistance from other staff at any point.

102. Where it has been agreed in a Positive Behavioural Support (PBS) plan that family members will be notified of significant behavioural disturbance and the use of restrictive interventions, this should take place as agreed in the plan. This policy also states that in order to ensure that seclusion measures have a minimal impact on the patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible. Examples of flexibility might include eating meals in general areas of the ward having visits from family or using an outside courtyard for exercise. The opportunities for such flexibility should be considered during the reviews of the patient. In situations where the patient is subjected to a long term segregation (LTS) plan the area for the patient should contain: bathroom facilities, a bedroom, a relaxing lounge area. Local safeguarding teams should be made aware of patients in long term segregation. Staff should record hourly observations and the patient's situation should be reviewed by an approved clinician every 24 hours and at least weekly by the full MDT. There should be a monthly review by the site Medical Director (MD) or an independent psychiatrist if the MD is also the patient's consultant. Where LTS continues for more than 3 months then the patient should be reviewed by another hospital involving the commissioning authority and IMHA (where appropriate).

103. H40 V13 2020 states that when monitoring the duration of seclusion episode then if any patient is in seclusion for more than 7 days the consultant must inform the Clinical Director and Specialist Director for that service. A review call will then be arranged to include the patients MDT, Clinical Director, Specialist Director and Head of Quality. If the patient remains in seclusion for 21 days, a 24-hour notification must be completed and this will trigger an independent review of the need for seclusion to

continue. Thereafter, if seclusion continues it will be reviewed every 4 weeks by an independent review. A copy of the current version of H40 v16 2023 is enclosed (AC/19).

Recreational occupations and activities

104. There were no policy references to this. The care pathways above contain some information on OT activities and assessment of patients. I have approached the OT professional lead for Priory Kath Mason for a more detailed response. She states: All Priory hospitals create a bespoke activities and intervention programme encompassing both therapeutic programmes run by Occupational Therapy (OT) and Psychology colleagues and recreational/ social activities in the evening and weekends and diversional activities/ social and recreational. Therapeutic programmes involving group work and individual sessions would be based on the needs and risks of the patient population in collaboration with patients and MDT at the time. This would be a combination of on ward/site groups and individual interventions primarily focused on OT, Psychology and Nursing staff. In addition to on site programmes community interventions are facilitated within recovery programmes for those in rehabilitation/community facing services. These interventions range from psycho-education, education, vocational focused, independent living skills as well as risk based psychological interventions. All wards have access to group rooms, activity rooms and where appropriate ADL kitchens. All social and recreational activities provided through consultation with current patient groups and facilitated by ward staff. All sites/wards have a budget that supports resources of this kind. These activities can range from creative pursuits, sports and fitness to board games.

Leave from the Ward

105. DP07 V03 Leave of absence Section 17 2008 states that a patient who is liable to be detained in a hospital can only leave the hospital lawfully, even for a short period of time by being given a leave of absence in accordance with Section 17. Leave of absence can be granted by the responsible clinician for specific occasions, indefinite or specific periods of time. Periods of leave can be extended in the patient's absence. Leave is not granted until the patient has been resident for sufficient time to allow an adequate risk assessment to be undertaken. Leave forms part of the patients treatment plan. The Responsible Clinician cannot delegate the decision to grant leave to anyone else. They are responsible for undertaking any appropriate consultations and may make leave subject to any conditions they consider necessary in the interests of the patient or to protect other people. Section 17 authorised leave may be at the discretion of the nurse in charge. It is crucial that such decisions fall within the terms of the granting of the periodic leave by the Responsible Clinician (RC) and that they review decisions and their implications immediately prior to the leave and explicitly record the circumstances in writing.

106. Leave should be properly planned in advance. Leave may be used to assess an unrestricted patient's suitability for discharge from detention. The patient should be fully involved in the decisions to grant leave and should be able to demonstrate to the professional carers that they are likely to cope outside the hospital. If leave is to be with family and friends they are to be consulted with the consent of the patient. However, if the patient does not consent then such leave cannot be granted. If the leave is to be escorted then this can be provided by a member of the hospital staff. If a patient is subject to special restrictions in accordance with Section 41, 45B or 49 MHA 83 then the RC can only grant leave with the consent of the Ministry of Justice (MoJ) and in compliance with any time limitations or other conditions as stipulated by the MoJ. Leave may be revoked by the RC if it is considered to be necessary in the interests of the patient's health and safety or for the protection of others.

107. MHA07 V06 2015 states that a personalised risk management plan will be given to the patient when going on day or overnight leave from hospital. The outcome of leave should be recorded in the patient's records to help inform future decision making. In recording leave an up-to-date description of the patient should be recorded. In addition, a photograph should be included in their notes with the patient's consent. If the patient lacks capacity then the Mental Capacity Act (MCA) can be used with best interest consideration. A patient can be escorted by a non-member of hospital staff if they have written permission of the hospital managers authorising this.

108. MHA07 V09 2018 states that Leave arrangements allowing a patient to return home for a day or longer should be communicated to the local commissioning team and the GP in case the patient needs to access services locally, as well as to ensure good communication with colleagues external to the site. This is particularly important for patients who are travelling some distance home. For restricted patients requiring urgent hospital medical treatment the permission of the MoJ can be inferred but they must be notified as soon as possible. The RC is responsible for undertaking a risk assessment and putting in place any necessary safeguards, undertaking appropriate consultations, including liaising with local services and other agencies including MAPPA, considering any conditions they consider necessary in the interests of the patient or for protection of people. Leave may be granted to a general hospital in a medical emergency without the RC's authorisation if seeking the authorisation would delay the patient from receiving urgent medical attention. A copy of the most recent version of MHA07 v10.1 2023 is enclosed (AC/20). This policy was replaced in 2024 with H132, whilst this new Policy post-dates the Relevant Period, for completeness, a copy of this policy is also enclosed (AC/21).

109. The types of leave for patient's detained under the Mental Health Act are escorted leave or unescorted leave. With escorted leave this is usually escorts provided by the hospital staff, usually part

of the nursing team. In rare occasions it can be escorted by a family member or friend but this requires written authorisation by the hospital managers. If the patient is to be accompanied by a friend or family member then this is not escorted leave and would be classified as unescorted leave. There is usually a progression from escorted leave to unescorted leave as a patient progresses towards their discharge. Leave can also be community leave beyond the boundaries of the sites grounds, home leave, to a patient's home or their family/carers, and also can be ground leave – either escorted or unescorted within the grounds of the hospital. For informal patients leave off the ward is not prescribed by the consultant but is rather an agreement between the treating team and the patient with agreement on where and when they are going and when they are due back.

Risk Assessment of Leave

110. Guidance for the completion of the 5-point risk assessment is within HG12 V02 2023. Five-point risk assessment applies to all service users for any inpatient ward. It must be completed for the first leave of the day and includes any escorted or unescorted leave to therapy units or off ward dining area. The guidance states that patients on level 2 observations i.e. several times an hour checks should not generally be granted unescorted leave on or off the site. Any unescorted ground leave would be by exception and would require clear justification and a discussion involving the patient's consultant psychiatrist, the MDT and the patient. Patients on level 2 two checks per hour could be granted unescorted ground leave but again a clear justification for this would need to be explored.

111. Any patient on level 3 or 4 constant observations must not be granted any leave within the hospital grounds or community. Only in exceptional circumstances would escorted leave be considered. If a patient is being granted leave for fresh air then they must meet the criteria for unescorted community leave. The five-point risk assessment askes the following questions: Has there been any significant self-harm or aggressive behaviour in the last 24 hours; what is the patient's mental state, including an assessment of any self-harm or suicidal thoughts, relational security; has there been any change in the patient's interactions with staff or others, have they been compliant with their medication in last 48 hours; check the patient's section 17 leave status. These questions would form the basis each day on whether the nurse in charge would grant section 17 leave authorised by the RC. It allows a consistent approach to the assessment of the patient for leave each day. This risk assessment in its earliest form of guidance was released in 2022. In addition to this risk assessment the MDT would complete a weekly or monthly risk assessment in the MDT depending on the frequency of the MDT meetings. This would also inform the granting of Section 17 leave to the patient or changes to it. For forensic patients there may be additional risk assessment details fed in to the MDT by the forensic psychologist as they update various forensic risk tools. A copy of the current version of HG12 v03 2023 is enclosed (AC/22).

112. C35 Clinical Assessment and Management of Risk V05 2009 sets out that the principle of risk assessment and management is to enable clinicians, patient's and carers to plan to manage any risk highlighted. The frequency, severity and pattern of any previous identified risk aspects are considered when conducting any risk assessment and compiling a risk management plan. The risk assessment tools should be used for the completion of all risk assessments.

113. Risk assessments should not be carried out in isolation- the past history should be considered, as should views of professionals, carers and the patient. Changes in risk should be communicated to relevant others. Risk assessment is defined as the process of assessing the likelihood of a harmful event occurring, and estimating the likely impact should the event take place. Risk assessment must involve a calculation of both probability and impact. Clinical risk assessment is a method for evaluating the level of risk associated with a patient. The risk could be to the patient being assessed, in relation to their environment or to others. Risk management strategies and interventions should be used by practitioners to control or minimise risk. Central to any risk management plan in mental health is the Care Programme Approach (CPA) process. Once the risk is identified and quantified, a care plan is developed for the patient which aims to reduce the risk as much as possible through specific interventions. These address ongoing assessment, monitoring, treatment, supervision and safety planning. Clinical risk management is the development of a systematic, organised effort to eliminate or reduce the likelihood of harm, damage or loss. Requirements of risk management are the means by which the risk of harm is reduced, transferred or eliminated. Effective efforts are underpinned by high quality risk communication. The assessment and management of risk is the responsibility of all clinical staff and of the patient. It is not a one off activity but a continuing responsibility.

114. Where possible, patients should be involved in the formulation of risk assessments and management plans. It is also expected that completed risk assessment documents are shared and discussed with them. It should be an open and participative process. The risk assessment/management process start as early as possible during the referral process and continues through the patient's admission. Risk assessment and management should be viewed as an integral part of the CPA process.

115. There are four key components of the risk assessment process: a consistent approach to describing risk used across all the units, easy to use forms that clearly communicate and document risk, regular collection of data on service user risk and the provision of clinical care and rigorous audit and continuous improvement to ensure the provision of a consistent level of clinical care. The level of risk is re-assessed at any time of significant change for the patient. It is also re-assessed routinely during the regular MDT reviews. Staff observations are critical to risk assessment. Care plans should be adjusted as risk changes.

Clinical risk assessment is usually based on: a detailed history of the patient, knowledge of previous risk behaviour, including outcomes, details of the patient's circumstances at times of risk behaviour, knowledge of previous intentions, awareness of significant anniversaries and other triggers, presentation of the patient's mental health difficulties and finally, the patient's current behaviour and mental health.

116. The risk assessment should be completed as part of the initial assessment and referral process, on admission, any subsequent reviews during the MDT, CPA or changes in risk presentation during admission. They should form part of any transfer to another unit or to the community.

117. H35 V07 2015 expands on the risk assessment process adding in consideration of possible protective factors. These involve identifying with the patient what has helped them and reduced risk in the past. These are unique to each individual but can include resilience, good problem solving skills, strong social support, economic security future plans and hope. A protective factor may also be progress with the admission building up skills and managing underlying mental health aspects of their presentation through psychology and/or medication. The policy gives a structure to formulation process and the clinician at the end of the risk assessment process should have an understanding of the 5 W's: who, what, when, where and why plus how collaborative is the patient likely to be with any risk management plans. The starting point in beginning the care planning process is to consider how willing the patient is in collaborating with the clinician. This will determine whether or not a negotiated care plan is possible. In this case, the patient's perspective and objectives are taken into account and the patient will take responsibility for his or her safety. If the patient is not able to achieve this then the team need to assume responsibility for the individuals safety and safety of others. Essential ingredients each care plan must contain are: a statement in relation to the patient's need, an objective to be addressed, interventions to achieve the objective and an evaluation date.

118. H35 V09 2015 introduces the importance of positive risk management to ensure appropriate safeguards are in place which enable an approach based on the needs of the individual service user. A risk stratification system is introduced of low, medium and high risk. A low risk patient may have a past history of violence or other risk but a repeat of such behaviour is not thought likely. They have been assessed as likely to cooperate well and contribute helpfully to risk assessment and management and they may respond to treatment. A medium risk patient is one who is capable of causing serious harm but in the most probable future scenarios, there are sufficient protective factors to moderate the risk. The service user evidences the capacity to engage with and occasionally to contribute to planned risk management strategies and may respond to treatment. A high risk patient presents a risk of committing

an act that is either planned or spontaneous, which is very likely to cause serious harm. The service user requires immediate risk management, including planned supervision and close monitoring and when the patient has the capacity to respond, intensive organised treatment. The policy notes that the completion of the risk assessment and the associated keeping safe care plan for patients must reflect the overall view of the MDT and their approach and management of the patient concerning level of observation. A copy of the current version of H35 v13 2024 is enclosed (AC/23).

119. In relation to achieving the balance between protecting a patient from harm and the objective of improving their clinical condition the two are often not competing but rather mutually supporting goals. As a patient improves in mental state in response to medication or psychology then this will often lead to a reduction in their risk to self or others. The overall risk level is a big determinant on the balance of risk management and positive risk taking. A high risk patient being one with a significant risk of harm to self and others and unlikely to currently engage whilst a medium to low risk one can be engaged with some interventions that are likely to both reduce risk further and improve the patients mental state and progress towards discharge.

Transfer of patients between units

120. The majority of detained patients admitted to Priory and PIC units would complete their admission within the Unit they were admitted too. Priory discharge data shows that between 2020 and 2023, there were 12,054 discharges to the patient's usual home, 839 discharges to relatives and 786 to temporary accommodation. This compares to 2523 discharges to a NHS mental Health Hospital, 746 to another Priory site and 593 to another non NHS facility. There are a number of reasons for a patient to be transferred to another Unit. The first would relate to the patient being repatriated to the local service. This could be for a number of reasons such as being closer to their local area and family and carers, to support the ongoing stepdown or discharge of the patient or because a bed has become available where before there was no capacity to admit locally.

121. Another reason for transfer could be risk related. If the patient presents with an acute risk profile that cannot be safely managed in the current setting then the patient could be transferred to a more secure setting that can safely manage the risk. Examples of this are a patient moving from an acute setting to a Psychiatric Intensive Care Unit (PICU) to manage an acute disturbance of behaviour that cannot be safely contained in the acute setting. Such transfers would be coordinated with the local commissioners and could be an internal transfer within Priory or PIC or could be back to local services depending on availability of a suitable bed. With patients detained under a forensic section such as a

Section 37 (41) the patient could be escalated up to a more secure setting including high security of which there are only three hospitals in the UK providing that level of security.

122. Patients that are progressing in their care but might need either a less restrictive setting such as a move from PICU to acute or from Medium to low security or to a more rehabilitation focused setting may also result in a transfer to achieve the appropriate setting for the patient's ongoing care. Once again this could be within Priory services which has multiple levels and types of service or to the local services depending on resource availability. Any such transfer would always involve the commissioning body.

123. The process for a transfer of a patient may depend on the level of urgency. Ideally, it would have a transfer of information and a discussion between the current MDT and the receiving MDT. The patient should be involved in the process and where possible should be able to contribute to what happens in this process. If the patient is informal then it is unlikely that the transfer process will affect them. However, if it did, such as a move to local services then it would need their consent and cooperation to occur.

Care Planning

124. C34 Care Programme Approach V04 2009 (AC/24). The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. From October 2008 the term CPA no longer was used to describe the system of provision of mental health services for those with more straightforward needs in secondary mental health services. The CPA remained for patients with a wide range of needs from a number of services or who are most at risk. The purpose of the CPA meeting would be to formulate care plans and the meeting would be attended by all relevant professionals, the patient and carers if not contra-indicated. A copy of the current version of H34 v13 2021 is enclosed (AC/25).

125. As identified in the care pathways described in paragraphs 32 to 51, the planning of care would start as part of the admission or first 7 days of care. The main domains of care planning are: Mental health and wellbeing, physical health, safety and staying connected. The number of care plans created has varied over the 23 years between 2000 and 2023. However, too many care plans can impact on the ability of staff to follow these in day to day care. The above four domains were introduced to limit the number of care plans and make them more accessible for staff and patients. Care plans should ideally

be co-produced, involving both the team and the patient. Where possible they should be jargon free and person centred. The care plans should be reviewed and alter as the needs of the patient alters during their care. This means they could be reviewed at MDT meetings or at CPA meetings if this is part of the patients pathway. Another important element of care plans is that they should have MDT input and not be authored by just one profession. Generally, a care plan will be written as a number of identified needs for the patient and then from this a number of actions to address those needs and achieve the treatment objectives.

126. In addition to the admission process, regular MDT (and CPA if part of the patients pathway) the nursing 1:1 and other one to one sessions can be used to explore and update the care plans. Patients should be encouraged to have copies of their care plans but need to keep these confidential. As detailed in the care pathways described earlier various assessments may go to inform the care plans. Risk assessment will help inform the keeping safe care plan, physical health assessments and investigations might inform part of the physical health care plan. Mental state assessments and response to medication and psychology might inform the keeping well care plan.

127. Care plans were originally stored in the paper records of inpatients but as electronic CareNotes rolled out they had their own forms in the care notes. The care plans could then be re-planned which stored the record of the care plans but had the current copy accessible to staff and patients.

Discharge Planning and Process

128. C02 V02 Admission, Transfer and Discharge 2004 states that if a patient is to be transferred or discharged the practitioner should: inform the GP or RMO (consultant Psychiatrist), inform the relatives, complete a transfer letter, ensure the new hospital have all the information they require, document the transfer in the care profile and photocopy all the relevant clinical notes. Discharge planning shall begin immediately following admission and will include CPA assessment. The discharge planning shall involve the community healthcare team and other specialists services as appropriate. Prior to discharge the named nurse shall confirm that the GP and relatives are aware of discharge date, sufficient medication has been ordered and appropriate community services are aware of the discharge date and what care the patient will need. A discharge letter will be completed and copies sent to relevant community services and the GP. A copy of the current version of H02 v16 2023 is enclosed (AC/02).

129. C02 V03 2006 states that if an informal patient wants to take their discharge without medical arrangements or consent, the nurse in charge will needs to ascertain the reasons for this from the

patient. The duty doctor and nurse in charge will need to consider if the patient will be at risk whether to use an appropriate section of the Mental Health Act 1983. It would be at the discretion of the consultant or duty doctor as to whether medication would be dispensed to the patient to take home. The GP would need to be informed of the self-discharge.

130. H02 V05 2012 States that prior to a discharge the named nurse will confirm that: The GP and relatives are aware of the discharge date, sufficient medication has been ordered, appropriate community services are aware of the discharge date and what the patient will need, CPA date has been set or completed where required, required outcome questionnaires have been completed, a risk assessment has been undertaken and the patient is provided with a Priory crisis card identifying their next follow up appointment. A discharge letter will be completed and copies sent to relevant community services, including GP. CPA forms should be sent and if patient does not require a CPA then a statement of agreed care either in a discharge care plan or a letter. Any suicide risk identified should be included in the discharge letter.

131. H02 Version 6 2014 expands on the discharge planning process. Discharge planning should start at the point of admission and will be embedded in the CPA reviews with involvement of the MDT, the referring community team and other professionals as appropriate. Consideration must be given to carer involvement in the discharge planning process. The MDT will identify the proposed date of discharge, a clear discharge pathway agreed with professionals and services named in the plan. All professionals and services included in the discharge plan must be informed of proposed date of discharge, the date of the discharge planning meeting and formally invited to the meeting. A contingency and crisis plan should be agreed with the patient and their carers and recorded in the discharge plan. In a discharge against medical advice the policy states that 24 hours of medication will be given to the patient and the arrangements the patient must make to get a prescription in the community.

132. H02 version 7, 2015 states that where factors suggest that a patient has been assessed as an actual or a possible suicide risk, this must be recorded in case summaries and discharge letters. A verbal handover to the professionals whom care is being discharged to for example the GP highlighting the risk should be done and the discussion recorded in the clinical notes.

133. H02 version 8, 2018 states that clearly written checklists and handover documents assist in ensuring safe patient discharge. For this reason H form 11A (AC/26) transfer and discharge information checklist must be completed as part of the discharge process. For all patient discharges there is a requirement to clearly identify and document who will take responsibility for the patients care and treatment from

the point of discharge. This policy details the following documentation to be provided to the identified service or team responsible following discharge: a copy of the clinical notes from care notes, copies of mental health act documentation as required, a copy of current CPA/CTP report, copy of the relevant care plans, a copy of the risk assessment, a copy of the current medication prescription and a completed H form 11A. If being transferred to care of the GP then the above is not required and a discharge letter will be sent. This will summarise the patients care and treatment, any possible or actual suicide risk, the patient's care plan and prescription. The letter will be sent within 10 days of discharge.

134. H02 version 8 addresses where discharge is at short notice or on a Friday afternoon or during the night. Such discharges should be avoided as they are distressing for the patient and may be unsafe in respect of there being insufficient community and family support for the patient. In the event the NHS provider is insistent that the patient be discharged and the Priory MDT disagree or the patient does not wish to be discharged then: This must be raised at earliest opportunity with an outline given or the teams/patient's views, the responsibility for the decision made by the NHS provider must be re-iterated, concerns and actions taken must be documented in the care notes, responsibility for the decision must be re-iterated to the provider, if patient is too ill or refuses to leave consideration of the MHA assessment must be given.

135. H02 V10 2019 states that prior to discharge, arrangements (agreed with the patient) should be put in place to complete a post discharge telephone call (at a convenient time approximately 48 hours following discharge with those patients who are to discharged to: NHS community crisis recovery home treatment teams, NHS generic community mental health teams, Priory outpatient follow up care or to the family GP. The call should be made by an appropriate member of the MDT. The purpose of the call is to check on the discharged patient's wellbeing, to check that there is sufficient support and to offer advice if required. If patient does not answer the call then proportionate action should be taken such as leaving a voice message or calling at a later time or alerting the family or mental health team. The call and content should be noted in the care notes.

136. H02 version 12, 2020 shortens the period that the discharge letter must be sent to all involved in the patient's care post discharge to 7 days from the previous 10 days.

137. H02 version 14.1 2023 (AC/02) expands on the process for discharge to an NHS/independent provider, facility/crisis recovery home treatment team or community mental health team. The receiving team must be made aware, understand and confirm their responsibility for the patient's care and treatment from the point of discharge from hospital. A verbal handover, which must be documented,

should be given to those professionals to whom care is being discharged to assist in ensuring that key risk information is conveyed promptly and effectively.

Making information Accessible to patients

138. OP29.1 V01 Accessible Information 2016 states that Priory will meet the five requirements set out in the Accessible Information Standard. These are: Identify information and communication support needs, record these needs in a consistent way, highlight the needs in the service user record and clearly explain how they are to be met, share the information with other care providers (following consent requirements) and ensure that needs are met by providing accessible information and communication support as required.

139. On or prior to admission the information and communication support needs of service users and their significant others that are directly involved in their care, will be assessed. Best practice would be to do this on first contact with the service user. The primary method of doing this is to ask the patient so that their needs are identified. Following assessment it is important that it is the communication need that is recorded and not the disability. If information or communication support needs have been identified as being required, this will be highlighted in the patient's notes to alert all colleagues of the requirements and the method in which the needs will be met. In our electronic records this will be in the alerts section of the header banner of every page. As a routine part of referral, discharge and handover processes, any new service provider must be alerted to a patient's information and support needs using existing data-sharing processes. Processes are to be put in place to meet the communication and information needs for the patient as identified by the assessment.

140. OP29.1 V03 2021 states that in addition to robust assessment of information or communication support needs, sites will display posters on site asking patients, carers or families to inform care teams of any communication support they require. A copy of the current version of OP29.1 v04 2024 is enclosed (AC/27).

Confidentiality

141. LE06 Confidentiality V01 2017 states that as far as reasonable information is to be kept in strict professional confidence and used only for the purpose for which the information was given. Explicit consent from the service user is always required before information is disclosed. If service user does not have capacity to give consent, a best interests decision must be in place. Disclosure of information

occurs: with the consent of the service user, or without consent if required by a court or law or if necessary in the public interest. Staff are responsible and accountable for any decisions they make to release confidential information.

142. LE06 V02 2021 states that all colleagues who have access to confidential service user information will receive training in confidentiality issues, for both induction and refresher e-learning modules via the Priory Academy. A copy of the current version of LE06 v03 2023 is enclosed (AC/28).

Second Opinions

143. Within DP18 V03 Consent to Treatment 2008, there is a defined process within the Mental Health Act 1983 for second opinions for non-consenting patient's treatment with medication after the first 3 months of detention. Before the first three months of treatment ends the approved clinician in charge of treatment should seek the patient's consent to continue medication. A record of this discussion must be made in the patient's medical records. In a non-consenting patient there is an official role for a Second Opinion Doctor (SOAD). This is to provide additional safeguard of the patient's rights. The SOAD interviews the patient and discusses the care with the treatment team. They have to decide if the treatment proposed is appropriate treatment. The SOAD acts as an individual and must reach their own decision as to whether the proposed treatment is appropriate treatment for the patient's mental disorder. Any change to the treatment plan would require a SOAD opinion to be sort again to review the treatment. A copy of the current version of MHA18 v10 2023 is enclosed (AC/29). In the period of this Inquiry Priory did not have a policy specifically addressing second opinions outside of statutory second opinions via SOAD's described above.

Multi-disciplinary Team working (MDT)

144. There is no specific policy detailing the role and function of the MDT meeting. The MDT is a meeting that occurs at different frequencies depending on whether the pathway is a short admission one such as Acute or PICU or a longer length of stay such as forensic. In more acute settings the MDT meets weekly and in less acute settings it is monthly. The MDT is a reviewing and decision making meeting. It is attended by a representative of each of the professional disciplines involved in the patient's care, plus the patient and any carer or family the patient might request to be present. The meeting allows for a

review of incidents and progress, treatment in terms of attendance and progress and review of risk and medication. Care plans can be updated and leave can be reviewed. The strength of the MDT is that it represents a collection of opinions to reach any decision. The minimum membership for an MDT meeting would be the responsible clinician and a member of the nursing team plus the patient unless they decline to attend. However, ideally, you want all the disciplines present or at least having submitted an update of the patient's progress since the previous MDT. Reference to MDT is made in the care pathway descriptions above.

Healthcare records

145. C62 V03 Healthcare records 2006 states that a comprehensive healthcare record is maintained for every patient. The record is an up to date and chronological account of the patient's care. There is a summary of the record that contains all the patient's demographic details and all administrative details relevant to the admission. The record has a unique patient number which is recorded on each part of the record. Space is provided to record the patient's first language. There is an allergy alert system in place.

146. Health records contain the following: Patients details, GP details, name of admitting consultant, date of admission, transfer or discharge, details of patient's property, contact details of next of kin, Source of referral and pre-admission report, clinical reason for admission/referral, initial patient history, clinical risk assessment, any care and treatment plans, the daily care and progress notes, observations and consultations made by all health professionals involved in the patient's care, drug therapy records, any discharge documentation, incidents reports.

147. Storage of the paper records was required to be in the correct order with an effective tracking system. All confidential information must be kept in secure controlled locations, locked rooms or cabinets.

148. Electronic storage must be password protected. As an intrinsic part of any electronic system there must be an audit trail for each patient record that records details of all additions and viewings of the record.

149. H62 V08 2016 states that Priory is committed to moving towards a fully comprehensive and complete electronic Health Record, thereby keeping a bare minimum on paper to eliminate duplication and to ensure that staff from all disciplines across the hospital can access records at all times. On Healthcare

sites where Care Notes is installed, the primary source of patient information is via this electronic patient record system. On sites where care notes is installed a patient folder can be set up to retain paper documents deemed necessary by the hospitals clinical governance system. However, these must be kept to a minimum and only the latest versions. In care notes the act of confirming an entry constitutes signing an entry.

150. All care notes content is regularly audited remotely and a report sent to all units. The standards to be maintained for all service lines are as follows: every episode must have a consultant and an ICD 10 code, every episode must have relevant outcomes measured at admission, discharge and appropriate interim periods, all clinical notes and confirmable documents must be confirmed by a qualified member of staff. The health records must contain evidence of physical health monitoring.

151. H62 V12 2022 states where Care Notes is in use all documents will be scanned into care notes on discharge or during an episode of care. Paper records must be disposed of as confidential waste once scanned into care notes. Authorised colleagues must have 24 hour access to health records. The records cannot be copied onto any other media such as CDs or memory sticks. Care note forms are set up to ensure all entries are dated, timed and have an identifiable author. A copy of the current version of H62 v13 2023 is enclosed (AC/30).

Complaints and raising concerns by patient's/family or staff

152. OP03 V01 Complaints 2012 states that the complaints process at site should be well publicised, easily accessible and clearly understood by service users, staff and the public. Complaint notices, explaining how a service user is able to access the complaints process and register comments and compliments are prominently displayed in the reception area of all services. Children, young adults, those with enduring mental health difficulties or learning disability should be provided with additional support to make their views known. Information on how to make a complaint should be made available upon request in other languages. Complaints are divided into those that can be addressed within the next working day and where the complainant is in agreement with a less formal process. There is also a more formal process. The more formal process has three stages: local resolution at service/site level, internal appeal and external review/independent adjudication.

153. OP03 V02 clarifies stage 3 of the formal complaints process. If not resolved by stage 2 then for NHS patients the complaint would go to Local Government Ombudsman/Parliamentary Health Service Ombudsman. If a healthcare privately funded patient then it would go via the ISCAS service for

adjudication (The Independent Sector Complaints adjudication Service). Complaint ownership at site sits with the hospital director and staff will be provided with the necessary basic training and up dates in communications and complaint handling to ensure that complaints are communicated and dealt with sensitively and courteously at all levels. A copy of the current version of OP03 v10.1 2023 is enclosed (AC/31).

Advocacy Services

154. OP17 V02 Advocacy 2009 states that independent advocacy is needed because some people are unable to speak up or feel that others may not be listening to their views and opinions. Advocacy therefore promotes and protects the rights and interests of the individual and support the individual in making their views heard. All service users have the right to expect information on independent advocacy in the form of leaflets explaining how to access independent advocacy and posters detailing how to access independent advocacy. The independent advocate is entitled to raise with the relevant person or organisations or professionals, any issues that affect the service user's needs, wishes and requirements. The independent advocate has the right and duty to represent only the individual's views. Managers of services have a duty to ensure all staff are made aware of the role of independent advocacy services and ensure information is available to service users and their carers.

155. OP17 V04 2016 states there are three types of advocacy: the independent advocate for the general population of Priory service users, Independent Mental Health Advocates (IMHA) for those service users detained under the Mental Health Act 1983 and Independent Capacity Advocates (IMCA) for service users who may lack the capacity to make important decisions about serious medical treatment and changes of accommodation. A copy of the current version of OP17 v17 2024 is enclosed (AC/32).

Whistleblowing

156. OP21 Confidential reporting (whistleblowing) 2011 details a confidential reporting system intended to encourage and enable employees to raise serious concerns within the company rather than ignoring or overlooking a problem or having to "blow the whistle outside". Concerns meeting the conditions for whistleblowing are known as 'qualified disclosures by workers'. This may be about something that: makes you feel uncomfortable in terms of known standards, your experience or the standards you believe Priory subscribes to, is against Priory polices, falls below established standards o of practice and care or amounts to improper conduct.

157. OP21 V12 2022 details the methods concerns can be raised: via the grievance process, contacting the Director directly, via a 24-hour independent free phone number or via a whistleblowing email. Details of the options are displayed in colleague communal areas. A copy of the current version of OP21 v13 2024 is enclosed (AC/33).

Freedom to Speak Up

158. OP67 V02 Freedom to Speak Up 2023 (AC/34) states that speaking up about concerns that colleagues have is important and helps Priory to improve the services it provides and provide a safe and secure working environment for colleagues who feel confident they can raise concerns without fear of reproach. Priory will appoint Freedom to Speak Up Champions at our hospitals. The team, although primarily employed by Priory in their substantive roles, will act independently whilst in their Champion role. Speaking up is not intended to replace any already existing channels for raising concerns. It provides another method for people to raise concerns that may fall outside of these defined processes, or where the processes have failed previously, or where individuals do not feel suitably assured to raise their concerns via these routes. The National Guardians Office states that workers can speak up about anything that gets in the way of high-quality effective care or that affects their working life. It is something that should happen as business as usual. Speaking up may take many forms such as a discussion with a line manager or raising an issue with the Freedom to Speak Up Champion.

159. Concerns in a first instance could be raised formally or informally with a line manager. However, where this is not felt appropriate they can use any of the following options: Local Freedom to Speak Up Champions, Freedom to Speak up Leads or Priory Freedom to Speak Up Guardian.

160. Priory will learn from concerns raised, the initial focus of the investigation will be the safety and wellbeing of service users and colleagues and improving the service Priory provides for service users as a whole. Where it identifies improvements that can be made, the FTSU leads will report divisionally through the triangulated learning forums of Healthcare and Adult Care.

Monitoring and Evaluating Practice across the Inpatient Pathways

161. Since 2011, the clinical networks have been responsible for monitoring and evaluating their care pathways. This could be done by audit or through the coordinated quarterly meetings with attendance from each site. Data has been provided for the networks to use in this process. As Priory has become more digitalised the data availably centrally has improved and a recent example is the live dashboards

that have helped to provide data for a number of Key Performance Indicators such as adherence to the care pathways, particularly the admission process, care planning and risk assessment processes. Local governance processes at site level will also have had a monitoring role for the various inpatient pathways on their sites. Outside of the time period for the Inquiry we are now collecting clinical outcome data that will in the future provide useful baseline and impact data on evaluating the treatment elements of the pathway.

PIC Sites 2000- 2016

162. As detailed in paragraph 8 the following section of this witness statement is based on a single version of PiC polices that were archived at the time of the merger of Priory and PiC in 2016. It is difficult to ascertain what period each policy covers prior to 2016 or how many previous versions of the policies existed prior to the merger. With those limitations in mind I will endeavour to address the questions for the PIC sites between 2000 and 2016. After that time the Priory polices covered all the sites.

Referral and Assessment for Admission

163. Referral and Assessment for Admission, Chapter 48 2015 (AC/35) states that each hospital should ensure that a key contact is identified so that in each case, the hospital maintains consistent and responsive communication between PiC and its customers. The key contact may change as the referral becomes an admission, though the change should not interrupt the exchange of information. The registered manager will be responsible for maintaining effective communication throughout the referral and assessment process. Locally, this may be deferred to the Referrals Manager.

164. When doubt exists around the suitability for assessment or admission, the Registered Manager will ensure the case is reviewed locally with the senior team and. Where a local solution is not considered appropriate, will refer the case to the Regional Executive Director (RED). If they cannot agree a solution within Region they will ensure the case is referred to the Central Referrals Manager. Where service alternatives are not available elsewhere within the Group e.g. Brain Injury Services, the ability to offer secondary options will be limited, though the referrer may be assisted with clinical management advice.

165. The referral will normally be in the form of a letter, including the reason for the referral and current presenting problems. Where further information is required, the referrals manager will liaise with the referrer and/or Commissioner. Emergency referrals can be made by phone call with little or no

supporting information. Upon receipt of a referral the Referrals Manager will establish with the Registered Manager if a bed is available as required by the referrer.

166. If following discussion between the referrals Manager, Clinical Director and Registered Manager, the view is that the patient is unsuitable the Regional Manager should refer the case to the Regional Executive Director. Possible reasons a patient might be unsuitable are: Does not require admission, Requires High Security, Needs non PiC services or requires alternative PiC services e.g. greater security. The referrer must be advised of the suitability for assessment within 1 working day of the initial referral.

167. The assessment should be within 2 working days. A pre-admission assessment will completed using an agreed template. If suitable, the Referrals Manager informs the referrer and Commissioner within 5 days of assessment. The assessing team should commence the transitional plan for admission. This should include immediate clinical collaboration with the current clinical team. This should inform the initial care pathway planning process. Transitional plans and the pre-admission needs formulation plans will be developed using standardised tools.

Admission

168. Once admission is agreed the patient may be placed on a waiting list if immediate admission is not possible. During period leading to admission, the PiC key contact will maintain communication with referrer or commissioner and the current placement team. This will include updating them on during admission process and post admission update to the commissioner with a clinical update on the patient's response and any interventions required by the escorting team or the hospital upon arrival. Transitions are a critical point in the secure pathway associated with risks and vulnerabilities for the patient. Transitions will include plans for continuing any existing treatment programmes, ensuring resources are available for meeting individual needs or additional support for patients moving from CAMHs to Adult Services. If patient is on a waiting list then this time is important for retaining close links with the existing placement, maintaining ongoing dialogue with the respective clinical teams. This will ensure up to date clinical information is available and there may be an opportunity for the patient to visit the PiC service and meet key members of the clinical team. Sometimes staff can visit the current placement to review management plans and discuss them with the current clinical team. Attending a CPA or MDT meeting at the current placement is another opportunity for collaboration with the clinical team and meeting the patient to answer any questions over the transition to PiC services. When a patient is first admitted to the PiC service. A 72 hour Care Plan is put in place that addresses immediate risk concerns and assists the patient's supported transition to the service.

169. Chapter 4 Assessment and Management of Clinical Risk 2015 (AC/36) states that the assessment and management of risk is an essential and fundamental part of the treatment and care provided by PiC. Accurate risk assessments and effective risk management re important components of the care pathway, ensuring that patient care is delivered in the appropriate environment and that their transition through the levels of security occurs at the appropriate pace, serving the best interests of the patient, whilst ensuring the protection of the public. There is no such thing as a risk assessment in isolation. What is assessed is a particular type of risk, over a particular period of time and in a particular environment. The risk assessment should facilitate a management plan as to how this risk can hopefully be modified by specific interventions. These plans are then implemented and evaluated. The assessment of risk is a shared responsibility that equally values contributions of all disciplines, clinical and operational. Risk management in all its aspects is an ongoing and evolving process. This process works best where the patient is well known and risk assessment and management is being carried out as part of ward review meetings, discharge planning meetings and at CPA reviews. Senior managers have a responsibility to provide training in both theory and practice of clinical risk assessment and management and to develop a culture of risk awareness.

170. PiC has implemented the Short Term Assessment of Risk and Treatability (START) and HCR 20 for all patients. Start consists of 20 dynamic items of a patients functioning, each weighed equally in terms of strength or vulnerability. HCR 20 is also a structured clinical judgement tool that focuses on the risk of long-term violence and recidivism. Risk management is a standing agenda item for clinical governance groups at all levels of the organisation.

171. Risk management is part of the care programme approach (CPA) and should be closely aligned with it. CPA meetings are drawn up to meet all the patients' needs including those relating to risk. This will be recorded by the MDT in the CPA document, creating a record of management plans addressing elements of risks to both self and others. Each risk tool has an identified member of the MDT who is responsible for completing this. However, this only occurs after discussion in a risk planning meeting attended by all members of the MDT.

172. The MDT will focus on social inclusion being one of the goals of the risk management process and support e patient achieving this. The MDT will work closely with the patient during the risk assessment process to identify strengths and what is likely to work. Close attention must be paid to the views of carers and others around the patient when deciding a plan of action.

173. When the MDT identifies vulnerability in a patient a strategy will be developed to support e patient, building on their positive skills. The emphasis will be on the recovery approach and on the next stage in developing the patient's ability to cope when feeling vulnerable or having difficult demands placed on them. Through regular reassessments the MDT provides opportunities for information sharing with the patient, their carer and can establish a forum in which risk assessment can be openly discussed.

MDT working

174. Risk factors may be static or changeable (dynamic). Interventions to reduce risk or adverse outcomes need to be focused on the dynamic factors. The MDT will apply a consensus model of decision making when applying clinical judgement. Positive risk management means that risk can never be completely eliminated and that management plans inevitably have to include decisions that carry some risks. The MDT needs to be mindful that taking a decision involving an element of risk may be a necessary part of the patients risk management. The MDT need to ensure that the patient, carer and others who might be affected are fully informed of risk based decisions, the reasons for them and the associated plans. The MDT will weigh up the potential benefits and harm of choosing one action plan over another and will develop plans that support the positive potentials and priorities identified by the patient, whilst minimising the risk to the patient or others.

175. Risk management planning by the MDT follows the risk management planning cycle. This involves risk assessment leading to risk formulation, developing risk scenarios, each with a specific management plan. These plans identify the monitoring, treatment and supervision requirements to minimise the risk of each specific risk scenario. The MDT gather information on each patient from the point of referral to ensure there is a rapid collation of information from multiple domains, including medical, social, psychological, occupational and nursing to develop an accurate knowledge of the individual patient and their social context.

176. The MDT uses a recovery ethos and My Shared Care Pathway to ensure that the patient is at the centre of their care and that the focus is on gaining knowledge of the patients own experience.

177. Ch16 The Care and Management of Transsexual Patients (2016) addresses the placement in a service opposite to the Gender recognised under UK law. It states that in all circumstances when a transsexual patient makes a request to be transferred to a service of their acquired gender a CPA must be held. The CPA meeting should include a Responsible Clinician from the sending and proposed receiving services; representation from the hospital Senior Management Team (SMT); the patient's primary nurse, other

members of the patient's clinical team and a gender dysphoria specialist if one is involved in the patient's care and treatment.

Physical Health

178. Physical Healthcare Policy Chapter 39 2014 (AC/37) states that PiC recognises the importance of providing a holistic care package to patients addressing their physical and mental healthcare needs through individual care planning. All patients will have a physical health assessment at point of admission to PiC services and at intervals throughout their admission and will have access to resources and facilities that support their physical wellbeing so as to ensure that their physical healthcare needs are not compromised by their stay at PiC services.

179. Each Region's Clinical Director will be accountable for the standards of patients physical healthcare. The Lead for Physical Healthcare is responsible for ensuring high standards of physical healthcare within the region/services and to ensure adherence to policy and strategy. The Clinical Director will ensure prioritisation of health promotion within their Region/Services, focusing on smoking cessation, diet and nutrition, sexual health, weight management and lifestyle choices. Patients should have easy access to appropriate health promotion information in a format which is accessible for all patients. GP's will get necessary access to make clinical entries into the patients care note records.

180. The Responsible Clinician (RC) has the responsibility of ensuring the completion of a full physical examination as soon as possible after admission within 7 days. Such examinations will always be undertaken by the General Practitioner. The RC will ensure the patients care planning takes proper account of their physical needs and wellbeing. In the event of a patient refusing any medical treatment, the RC must ensure that a capacity assessment is carried out.

181. The admitting doctor is responsible for ensuring the completion of an initial brief physical assessment within the first 24 hours. If patient refuses this must be clearly documented. The RC is responsible for ensuring the physical examination has been performed.

182. All patients should have a physical health assessment on admission. This should be immediate or in any case within 24 hours and followed by a comprehensive examination in first 7 days. Care notes has a standard proforma for these assessments to be recorded. Routine blood tests including FBC, U and E LFT, TFT, lipids and HbA1C will be taken, other tests may be required depending on known physical

health history. Tests will be taken as soon as is practicable and then on a frequency determined by the RC and GP.

183. Patients at a minimum should have an annual physical health review and baseline monitoring of observations should occur once per month, to include BP, BMI, weight and smoking status. A full physical health review should occur at first CPA and thereafter at every CPA (6monthly). An action plan with respect to physical healthcare should be agreed with the patient and incorporated into the CPA care plan. The MDT will review the physical health care plan monthly.

184. For patients with identified chronic physical health conditions, care plans should include management of their physical healthcare and follow NICE guidance. Access to specialist clinics should be provided. When discharged a patients physical health summary will be provided to the GP within 7 days.

Frequencies of meetings with Healthcare professionals

185. This was not captured in PiC Policy. PiC provided a forensic long stay service and the general frequency of MDT meetings were monthly MDT, 3 month initial CPA followed by 6 monthly CPA. Weekly Primary nurse or key nurse sessions should have been provided and OT and Psychology would vary according to need. The patient should have had access to their psychiatrist (RC) at least once a month individually but additional meetings on a required basis.

Administration of Medicines

186. Safe Storage, Control and Administration of Medicines policy Chapter 66 2015 (AC/38) states Medicines may only be administered on the authorisation of a medical practitioner or non-medical prescriber. This is a written prescription by the practitioner on the Drugs Prescription and Administration Record (Prescription Card). Under exceptional circumstances a qualified nurse or pharmacist may accept a faxed prescription from a practitioner or accept a clinical note made in Care Notes.

187. The nurse administering medication is responsible for ensuring that medicines are administered as prescribed. A nurse must never administer medication without an authorised prescription. Drug administration must always be carried out in the presence of a witness. The witness should preferably be a qualified nurse. However, it is recognised that there will be occasions when this may not be possible. In these circumstances then a pharmacist, doctor or Health Care Worker (HCW) can be the

witness. A HCW must undergo additional training and be assessed as competent to administer or witness injections.

188. The above management applies to both psychiatric and non-psychiatric medication.

Safe and Supportive observations

189. Safe and Supportive Observations Policy Chapter 25 2016 (AC/39) states that engaging people, even with extreme and challenging behaviours promotes a culture which supports recovery, hope and person centred care. Observations must be patient focused at all times and the views of the patient should be sort where possible. The least restrictive option possible for the safe and supportive management of the patient must be achieved. The intended effect is not simply to increase the level of safe and supportive observation and engagement, but to achieve a satisfactory outcome in terms of the well-being, safety and security of the patient and others in the immediate environment. The patient should be provided with information about why they are under observation, the aims of the observation and how long it is likely to be maintained. Observation is an opportunity for one to one interaction and should be undertaken by competent staff. The overall aim is to maintain a therapeutic relationship and reduce risk.

190. Care and support of the patient will be addressed specifically within an individualised MDT care Plan. This should anticipate the patients' needs, identify short term and long term objectives and indicate how the level of enhanced observations is to be applied. The frequency, intensity and duration of the behaviour will determine the level of observation necessary to manage the situation. The level of observations available are: level 1 general observations, level 2 intermittent observations, level 3 within eye sight and level 4 within arms' length. Level 1 is the minimum acceptable level of observation for all patients. Level 2 must be reviewed each day by the nurse in charge. A copy of the care plan must be attached to the observation record and entries at a minimum must be made every 15 minutes to the observation record. Level 3 must also be reviewed daily by the nurse in charge. Level 4 is similar to level 3 in terms of written record every 15 minutes and daily review by the nurse in charge. Observations levels can be initiated by the nurse in charge and can be reduced by the Lead nurse following discussion with the RC. Types of behaviour that might require supportive observations include violence and aggression either directed to self or others. It can also include absconding or escaping behaviours and for physical health and vulnerability.

Restrictive and Coercive Treatment

191. Care of Patients in Seclusion and Longer Term Segregation Chapter 29 2015 (AC/40) states seclusion should be used where it is considered that the patient's clinical presenting condition makes this necessary in all the circumstances of the case. It should only be used as a last resort and for the shortest possible time. Seclusion should not be used as a punishment, threat or because of a shortage of staff. It should not form part of a treatment programme. Seclusion should never be used solely as a means of managing self-harming behaviour. Where a patient poses a risk of self-harm as well as a risk to others, seclusion should only be used when the professionals involved are satisfied that the need to protect other people out weight any increased risk to the patient's health or safety arising from their own self harm and that any such risk can be properly managed.

192. If not authorised by a psychiatrist there must be a medical review within one hour or without delay if the individual is not known or there is a significant change from their usual presentation. Seclusion areas must be within constant sight and sound of a staff member. There must be a documented report by a person monitoring the patient every 15 minutes. Nursing reviews occur every two hours, face to face medical reviews every four hours until the first MDT. First MDT to take place as soon as is practicable. An independent MDT to review after 8 hours continuous or 12 hours' intermittent seclusion. Following the first MDT review the medical reviews should continue at least twice in every 24 hour period. The RC or duty doctor may decide that there need not be a review by a doctor between 10 pm and 8 am if: patient is asleep, remains asleep, has not received parenteral medication or any new oral medication, patient has not received any additional oral medication in excess of BNF limits and the patient has no current physical condition that necessitates closer medical supervision.

193. A suitably skilled professional should as a minimum be readily available within sight and sound of seclusion room at all times of the patient's seclusion. Aim of observation is to condition and behaviour of the patient and identify the time at which seclusion can be ended.

194. If rapid tranquilisation is used medical advice should be sought as to the level of observation required and whether it is safe to continue seclusion. Physical observations should be done when safe to do so and recorded in the care notes. The nurse taking the physical observations should use the NEWs protocols (where the hospital uses this protocol). Where it is not considered safe to continue seclusion after rapid tranquilisation, seclusion should be immediately terminated.

195. There are a smaller number of patients who present a risk of harm to others that is a constant feature of their presentation and is not subject to amelioration by a short period of seclusion combined with any other form of treatment. These patients may require separation from the ward community to maintain the safety of patients and staff, and this separation may need to continue for long periods. Long term segregation (LTS) is an intervention that is planned by the clinical team to manage continuing and longer term risk to other. Decisions for LTS requires the agreement of the MDT, commissioner and adult safeguarding. A medical review once every 24 hours and a weekly MDT. If it continues for three months or longer, regular three month reviews should be carried out by an external hospital. LTS care plans need to be approved by the PiC legal team and PiC Executive Medical Director and Director of Policy need to be informed.

196. The Safe and Therapeutic Management of Violence and Aggression Chapter 18 2014 (AC/41) states that if a situation is not controlled by de-escalation, the nurse in charge should coordinate the staff response which may include summoning further assistance and as a last resort physical intervention. Physical restraint should not occur until sufficient staff are present with a clear plan of action with staff who have approved training. Should physical restraint be required, the nurse in charge must ensure that a full nursing and medical review be carried out on the patient, including a physical examination as soon as is practicable. Physical restraint is used to take immediate control over a dangerous situation and reduce the risk of injury to patients and staff. In the post restraint review the principals of this are: find out if the patient has sustained any injurie, allow patient to vent any fears or anxieties, identify antecedents to the behaviour and possible causes, explain why the intervention was necessary, discuss alternative ways of communicating and encourage the patient to approach staff if feeling agitated or aggressive.

197. Rapid Tranquilisation Policy Chapter 28 2016 (AC/42) states Rapid tranquilisation (RT) is a pharmacological strategy used to calm the patient and reduce the risk of violence and harm, rather than treating the underlying psychiatric condition. There is no completely safe or completely effective RT regime. There is always a need to make a clinical assessment and judgement in balancing various risks in individual cases. Where RT has been administered physical observations should be carried out until the patient becomes active again. The following should be monitored continuously and documented regularly) during the period of restraint: pulse, BP, respiration rate, temperature, hydration levels and motor side effects. Where possible patient should be cared for in the recovery position. If patient is asleep particular attention should be paid to the patient's respiratory effort, airways and level of consciousness. If verbal responsiveness is lost as a consequence of administration of medication, a level of care identical to that for general anaesthesia should be given. Where patients' are heavily sedated

and immobile the risk of venous thromboembolism must be considered. Patients should where possible be encouraged to move around, take exercise and not remain in bed for long periods. Once a patient becomes settled, ECG monitoring is advisable and where possible a baseline ECG should be done. Electrolytes should be monitored if not recently checked.

198. Use of Handcuffs, Chapter 27 2014 (AC/43) states the use of handcuffs must always be considered where high risk patient's need to be escorted outside the hospital or in circumstances where a patient is to be returned to a hospital after escape or absconding. The decision to use handcuffs, the reason for their use, which includes a thorough risk assessment and escort plan for the trip, and any other instructions should be recorded by the RC or nominated deputy.

Transfer to another Unit

199. There was no policy detailing this. However, scenarios in Forensic PiC services for transfer include the patient escalating in their risk and requiring higher levels of security. For instance from Low to Medium or from Medium to NHS high secure services. Another scenario is a return to Prison if a sentenced prisoner either because they are now mentally stable or treatment didn't work. Patients making progress and becoming less of a risk might transfer to a less secure and more rehabilitation setting. Finally, patients may be transferred back to local NHS services.

Care Planning and CPA

200. Care Management and CPA Chapter 55 2016 (AC/44) states care planning is underpinned by long term engagement, requiring trust, teamwork and commitment. All service users (regardless of diagnosis, projected length of stay or detention status) will have a comprehensive Plan of Care. This plan will include: Needs Formulation, Pathway plan, Health Outcomes Plan, Activity/ Therapy plan and Individual Needs Plan. Patients should be able to access the most recent version of their plan at any reasonable time. Plans of care will be subject to continued review in addition to a formal Individual Care Review (ICR).

201. Individual Care Review meetings should be held for the benefit of patients and their carers and should run in ways they feel comfortable with and which maximise opportunities for involvement. At each meeting the date of the next review should be set and recorded.

202. Service users assessed as eligible for CPA level care will be entitled to: a pre-admission CPA/Section 117 meeting to ensure effective handover between agencies, A CPA care co-ordinator appointed to them, a say in who their care–co-ordinator is, Involvement of external agencies in the construction of the Plan of Care, a formal CPA meeting at a minimum of every 6 months to which external agencies are invited (this may replace the usual care review), representation from an independent Mental health Advocate (IMHA) at a CPA meeting without needing RC clearance. A solicitor and advocate may attend the section 117 component of the CPA and other parts if approved by the RC.

203. A preadmission baseline risk assessment will be completed with adults prior to admission, this will inform care planning until a validated risk assessment tool is completed. A medical admission summary should be completed in a timely manner following admission and an admission care plan should be developed and followed. When appropriate we use diagnostically suitable, clinically validated tools and instruments to assess risk.

204. In the Care planning process the patient is assisted to identify strengths, the things that will help them succeed and any vulnerabilities they have that they can be supported to address. The patient will have the opportunity to tell their team what they want from their care and how they see their pathway from here. Patients are supported to understand their disorders in ways that make sense to them and help them develop ways to manage it. Patient's will be supported to understand their medications and possible side effects. Spiritual, racial, cultural, sexual, gender, ability, socio-economic and physical health differences should be identified, respected and steps taken to combat any disadvantage people experience as a result of them. If a patient lacks capacity to make decisions they will be supported following the principles set out in the Mental Capacity Act 2005. Patients are encouraged to involve their carers, family or friends in the planning or reviewing of their care if they wish.

205. Based on the formulation, we agree with the patient the most realistic pathway they are likely to take from here and discuss each point on that pathway. The pathway is kept under review and if things change the pathway is adapted to take this into account. The pathway is planned with the primary goal of ensuring the most appropriate environment for service users' needs and risks.

206. Advanced directives/decisions or statements of wished are considered and referenced in care planning when these are available. Using the formulation staff work with patients to decide what health outcomes are going to be important to work on to demonstrate recovery. Staff communicate with the patient which health outcomes are going to be essential in order to move on and which ones they will

work on with the team but can take with them if they haven't finished when they leave. Patients will be informed of progress against each outcome at review meetings.

207. Patients will be encouraged to engage in activities and therapies that the team think will help them achieve their health outcomes. Using least restrictive principle we help the patient understand how activities and therapies will help them achieve their goals.

208. Based on what the team knows about the patient's level of engagement in activities we build a plan that estimates their length of stay with us. Crisis plans set out details of any early warning signs/ relapse indicators/ potential risks and actions that can be taken if there is a crisis.

209. Reviewing care is carried out in one to one sessions and in formal care review meetings.

Discharge Planning

210. Discharge planning starts at the point of admission and helps inform the care pathway. Mental Capacity Act 2005 needs to be followed to support those who lack capacity to make their own decisions. For service users detained under the Mental Health Act 1983 issues around discharge planning should be addressed prior to a Mental Health Tribunal to allow the tribunal to exercise their powers of discharge. Working with next service we try to avoid any unnecessary repeating of therapies they have already completed. Patients will be provided with copies of all their care plans to support their achievements while they were with PiC. Crisis and contingency plans are shared between services and through Section 117 meetings when this applies. Patients should not be discharged without a robust plan of care. An interim discharge summary should be produced within the first 24 hours if a full discharge summary is not available. All documentation is stored within care notes and is accessible by the members of the patient's team.

211. Discharge/Leaving the Service Chapter 56 2015 (AC/45) states that a member of the MDT will be allocated responsibility for coordinating the discharge. They should: make arrangements for the patient to visit the new placement where clinically indicated and practicable, provide the patient with as many relevant details about the new placement and environment, liaise with the receiving placement and confirm details of discharge, inform family, carers if patient is in agreement, make suitable escort arrangements, arrange transport, liaise with the Mental Health Act Administrator to ensure documentation is completed, supply appropriate amounts of medication to cover first few days of discharge, support patient being registered with a new GP prior to discharge and where appropriate

liaise with Ministry of Justice and MAPPA. A discharge summary should be sent to the GP within 1 week of discharge.

212. If the patient was being discharged back to Prison the MDT will need to coordinate with the prison in reach team to ensure relevant information has been transferred. At a minimum this should include a discharge summary and a risk assessment.

213. If transferring to another Unit in addition to the above the last two weeks clinical notes should be transferred to the receiving hospital at the time of discharge.

214. PiC policy did not stipulate any follow up monitoring or review post discharge

Confidentiality

215. Data Protection and Confidentiality Chapter 7 2015 (AC/46) states PiC is committed to following the patient confidentiality model as described in the NHS Confidentiality Code of Practice: Protect- look after the patient's information, inform –ensure the patients are aware of how their information is used, Provide choice – allow patients to decide whether information can be disclosed or used in a particular way and finally to improve – always looking for better ways to protect, inform and provide choice.

216. PiC works on the basis that sharing information to support patients care and to prevent risk to data subjects or others is essential. It is not acceptable that the care a patient receives might be undermined because organisations providing health and care to an individual do not share information effectively. Sharing personal information effectively is a key requirement of good information governance and health and social care professionals should have the confidence to share information in the best interests of their patients.

217. All staff must ensure following principles are adhered too: Person-identifiable/ confidential information must be protected against improper disclosure when it is received, stored, transmitted or disposed of, access must be on a need to know basis, disclosure must be limited to that purpose for which it is required, recipients must respect that it is given to them in confidence, the decision to disclose must be justified and documented and finally they must comply with the Duty of Candour – to act in an open and transparent way in relation to care and treatment provided to service users.

218. Confidential information should be used for healthcare purposes and unless appropriate circumstances are present, can only be disclosed with the informed consent of the patient. Where a patient lacks capacity, information should only be disclosed in the patient's best interests.

219. The eight data protection principles are adhered to by the policy, personal data must be: processed fairly and lawfully, processed for specific purposes e.g. healthcare, adequate, relevant and not excessive, not kept longer than necessary, processed in accordance with the rights of the data subject, protected by appropriate security (practical and organisational) and not transferred outside European Economic Area without adequate protection.

220. All employees are responsible for maintaining the confidentiality of information whilst working within PiC and after they have left the Organisation. Staff must only access personal information if they have a genuine need to know/legitimate reason. Unauthorised access or use of information will be investigated and may lead to disciplinary action or action under the Data Protection Act. All staff must complete the information governance training in line with the PIC training programme.

221. It is not practicable to continually request consent for information from patient's or family therefore they are to be informed to the best of staff ability on how the information they give may be used at their first appointment. This may include using a patient information leaflet. Advice must be provided in a convenient and accessible form and before a programme of treatment begins.

222. All transfers of personal identifiable information are subject to strict governance and technical security controls. All staff must follow policy for any inbound or outbound information requests. They must consider: What information is to be transferred, purpose of transfer, nature of recipient, method of transfer (e.g. is it secure) and the physical and technical security measures proposed by the sender and the recipient.

223. Organisations must agree an information sharing protocol with any partner organisation where it is anticipated regular information sharing will be required for personal data. The protocol will lay down the principles under which information can and should be shared, how it will be shared security and details of the information to be shared in line with legislation.

224. Where information is to be shared electronically, safeguards must be in place to ensure confidentiality e.g. secure email or encrypted devices.

225. Where confidential information needs to be disposed, care must be taken to ensure it is destroyed safely so that confidentiality is not breached and that decisions to destroy information is recorded in the destruction register.

Second Opinions

226. Consent Chapter 8 2016 (AC/47) states that the Mental Health Act permits medical treatment for mental disorder in detained patients to be given without consent with the requirements for Second Opinion Appointed Doctors (SOAD) to assess, review and agree proposed treatment. Valid patient consent should be sort whenever possible. For first three months of detention treatment can be given without consent or a second opinion. However, after this when not possible either due to refusal to consent or lack of capacity to give informed consent, then a SOAD is required to give a second opinion on the proposed treatment.

Health Record Content and Management

227. Health Record Content and Management Chapter 51 2015 (AC/48) states that PiC uses CareNotes, an electronic patient records system. It should be noted that key elements and content of the record system remain the same. It states that Health records should contain the following key elements: be accurate, enable the patient to receive effective continuing care, enable the patient to be identified without risk or error, facilitate collection of data for research, education or audit and available for legal proceedings.

228. The following information should be included in the healthcare record: a chronological account of the patient's care, a summary in the record that contains all the patients demographic details and all administration details relevant to the admission including date of admission, RC, diagnosis and previous admissions.

229. The record will contain following patient identification data: unique patient number on every page of the continuous record, name in full on every page, home address and postcode, date of birth, GP details, Gender, ethnic origin, family contacts, referral contacts, religion (if any) and up-to-date photograph.

230. The record will include the following clinical information: Diagnosis and reason for admission, risk formulation, patient history, report on initial physical examination performed by GP, regular and timely

progress notes, observations and consultation reports by all health professionals, a record of any therapeutic orders, a record of all diagnostic tests, all results of investigations e.g. pathology or ECG, details of verbal instructions/ information given to patients, a system of alert notifications such as allergies etc., a copy of discharge communication, cause of death where death has occurred and a copy of the post mortem report, review of clinical diagnosis and findings of post mortem examination and all communications with and information given to patient or family.

231. Any incidents must be recorded in IRIS (Incident Reporting System)

232. Any entry into the records should: be made only by authorised staff, be confirmed, be typed, include only approved abbreviations, be factual, be sure any dictated or typed notes are signed by the author and for student practitioners be countersigned by a registered professional. A qualified person should be responsible for managing the service, they should ideally hold the Diploma in Health Record Management or other suitable qualification.

233. A Health Record Committee should be established and responsible for: Setting the standard and policy for the format of patient health records, reviewing/revising record forms, procedures for the local management of health records, auditing to ensure recorded information facilitates the provision and evaluation of patient care, auditing standard of record entries, reviewing all audit activities related to health records. There should be a proper system of filing and access across 24 hour period.

Advocacy and raising concerns process

234. Advocacy in PiC Chapter 49 2016 (AC/49) states that PiC will commission a provider of independent advocacy service to offer an issue-based advocacy service to include: IMHA and generic advocacy, non-instructed advocacy where indicated, access to 24 hour answer service for patients to leave a message for advocacy and all advocates will have appropriate qualifications and security checks.

235. Advocates will support patients to ensure their views are heard and safeguard their rights, the outcome the patient prefers is the outcome the advocate will try to achieve, they will provide information to patients to help them make informed decisions, help identify any gaps in service provision, speak on a patient's behalf if they lack confidence, help patients be involved in decisions being made about their future and help patients make a complaint.

236. Complaints Policy and Procedure Chapter 6 2015 (AC/50) states a complaint may be made by a patient or any person who is affected by or likely to be affected by the action, omission or decision of the PiC facility or service which is subject of the complaint. The complaint can be made by a person acting on behalf of the patient. A complaint must be made within 6 months of the date on which the matter is the subject of the complaint or 6 months of the date on which the matter is the subject of the complaint came to the notice of the complainant.

237. Good complaint handling means: getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement.

238. Oral complaints may be logged in the patient's clinical record but must also be logged in the informal Complaints resolution log. If the complainant is not happy with informal resolution then they should be supported in making a formal complaint to the Complaints Officer.

239. Options for complaints include stage 1 –local resolution, if formal the complaint will be investigated and in more complex cases a review team may be established to examine the findings. Stage 2 non-local resolution/appeal would go to the Parliamentary and Health Service Ombudsman or local Government Ombudsman.

240. Freedom to Speak up: Raising Concerns (Whistleblowing) Policy chapter 45 2016 (AC/51) states staff must not suffer any detrimental treatment as a result of raising a concern in good faith. Staff can raise concerns about risk, malpractice or wrongdoing that may harm the service or the patient in our care. Any PiC employee, agency worker or temporary worker can raise a concern.

241. They can raise their concern with their line manager or the can contact the CEO, Regional Operations Director/ Executive Director or Director of Human Resources, Director of Policy, Executive Medical Director or PIC concern Line.

242. The focus of the investigation will be on improving the service we provide. Where it identifies improvements that can be made, they will be tracked to ensure the improvements are embedded. Lessons will be shared across PiC.

243. PiC Board will be given high level information relating to this policy about all concerns raised by staff.

PiC Clinical Governance

244. Clinical Governance, Chapter 22 2015 (AC/52) states that clinical governance is defined as a system through which health service organisations are accountable for: continuously improving the quality of their services, safeguarding high standards of care, ensuring the best clinical outcomes for patient care and creating an environment in which excellence in clinical care will flourish.

245. As outlined in Policy, the key components of clinical governance are: clinical effectiveness – how do we know we are doing the right things? What evidence do we have for what we do? Risk management – how can we minimise he chances of things going wrong? How do we learn from incidents and near misses? Patient focus and external stakeholder involvement – what is the patient experience of this service? Is the service safe and effective?

246. The Executive Medical Director has overall responsibility for clinical governance, reporting to the board. The PiC Clinical Governance Group (CGG) oversees clinical governance activity within PiC and the PiC Regional Clinical Governance Group oversees clinical governance activity within each region. PiC Registered Managers are accountable for ensuring their sites foster a culture where clinical governance principles, processes and systems are embedded at all levels of the hospital.

247. The Clinical Governance Group is supported by four networks: Specialist Recovery Network, Acquired Brain Injury Network, Learning Disability Network and the Specialist services Network. In addition focused time lined project groups are set up to undertake specific tasks. The agenda for clinical governance meetings is standardised across services.

248. PiC have clinical and outcome dashboards that report on numerous data covering patient safety, clinical effectiveness and patient user experience. These dashboards are reviewed by the CGG.

249. An annual clinical audit programme is included in the clinical governance annual plan.

250. A Sharing best Practice newsletter and two day conference is designed to ensure best practice is shared across PiC.

251. I believe that the facts stated in this statement are true. I understand that proceedings for Contempt of Court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

252. A list of supporting documents is enclosed as exhibit AC/53

Name: Dr Adrian Cree

Signed:

[I/S]

Dated: 25 March 2025