Witness Name: Dr Milind Karale

Statement No.: 2

Dated: 26 March 2025

Rule 9 reference: EPUT Rule 9 (11) and Rule 9 (11a)

LAMPARD INQUIRY

SECOND WITNESS STATEMENT OF Dr Milind Karale

I, Milind Karale, will say as follows: -

Introduction

1. I am the Executive Medical Director within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since 2012. My portfolio includes medical leadership and managing medical directorate, Caldicott Guardian and Research. I am the Responsible Officer for the purposes of revalidation of doctors with prescribed connection to EPUT.

2. I have been in employment with EPUT and predecessor organisations in SEPT since 2007.

3. I report directly to the Chief Executive Officer ('CEO'), Paul Scott.

4. I am a Consultant Psychiatrist (FRCPsych, MSc Forensic Psych, DNB, DPM, MBBS).

5. I would like to offer my sincere and personal condolences to anyone who has lost loved ones while receiving care from mental health services in Essex. This statement aims to address questions from the Lampard Inquiry about inpatient services at EPUT. No part of this statement is intended to diminish the impact that the tragic loss of life would have had on families, loved ones and the EPUT staff that cared for them.

Approach to the Inquiry Rule 9 (11) Request and Rule 9 (11a) Request

6. This statement is made in response to the requests by the Inquiry to EPUT under Rule 9(11) of the Inquiry Rules 2006. Under Rule 9 (11) dated 20 January 2025, EPUT was asked to provide information regards the inpatient pathway across all services within the scope of the Inquiry. On 19 March 2025, with reference 'EPUT Rule 9(11a), as a follow up to the information provided in my draft statement dated 20 February 2025, EPUT was asked to clarify some of the information made in my draft statement and provide a finalised signed version.

7. This statement is to be read in conjunction with the Trust's response under Rule 9 (6) as this details the profiles of the inpatient services which my statement relates to.

8. Whilst I have done my best, in the time available, to address all the issues raised in the Rule 9 request for the whole of the Relevant Period, there will be others who are better placed to provide more detail concerning the pre-EPUT period.

9. The request is broad in scope and goes beyond matters, which are within my own personal knowledge. The statement also supplies information regarding the former Trusts (North Essex Partnership University NHS Foundation Trust or "'NEP", and South Essex University Partnership NHS Foundation Trust or "SEPT"). This information is sourced directly from the electronic information or documents held by EPUT, as described further below, and I have relied on the accuracy of that information, together with the searches described below. Accordingly, this statement has been prepared following consultation with several senior individuals in the organisation. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

Essex Mental Health Service Provision

10. In my statement, the terms 'patient' and 'service user' are used interchangeably.

11. At the time of establishment, Essex Partnership University NHS Foundation Trust (EPUT) provided community health, mental health and learning disability services to individuals across Luton, Bedfordshire, Essex and Suffolk. Prior to this, services were provided in the North of Essex by North Essex Partnership University NHS Foundation Trust (NEP) and South of Essex by South Essex Partnership University NHS Foundation Trust (SEPT) and their former predecessor organisations. Details of predecessor organisations are referred to in Rule 9 (6a).

12. EPUT's current service delivery is influenced by changes in the commissioning arrangements over the years. This was driven by national policy and regional and local arrangements. Essex mental health services have had to adapt and respond to the differing contractual, legal and partnership arrangements that emerged over the relevant period, from 2000-2023. Health commissioning aims to ensure that the health and care services are provided effectively to meet the needs of the population. Since 1991, commissioning has taken place in the context of the purchaser / provider split, and SEPT, NEP and EPUT remained providers throughout this period.

13. Between 1997 and 2010, commissioning became the responsibility of the Primary Care Trusts. Primary Care Groups, which advised the Health Authority on commissioning,

evolved into Primary Care Trusts (PCT). By 2002, the Health Authorities merged into Strategic Health Authorities (SHA), and all commissioning services became the responsibility of the PCTs. **[MK2-001: NHS Commissioning before April 2013 (House of Commons, 2016)].**

14. In 2007, specialist services were commissioned by Specialised Commissioning Groups (SCG's), which brought together the Primary Care Trusts (PCT's) across a Strategic Health Authority (SHA) area. Specialist Commissioning was held at Regional Health Authority level. However, by 2013 Clinical Commissioning Groups (CCGs) were established and assumed the commissioning responsibilities previously held by PCT's. NHS England will be able to provide the Lampard Inquiry with further information on these changes.

15. The responsibility for public health and the commissioning of certain mental health services transferred to the local authorities in 2013. As a result, Essex County Council (ECC) took the opportunity to market test NHS services. For instance, Children's and Adolescent Mental Health Services (CAMHS) Tier 3 community services were tendered by ECC, leading to a division in the patient pathway, this shifted the community CAMH services from SEPT and NEP to North East London NHS Foundation Trust, while SEPT and NEP retained the Tier 4 inpatient CAMHS services.

16. In 2024, Integrated Care Systems (ICSs) took over the statutory responsibility for commissioning most of the NHS services previously held by the CCGs, whilst NHS England held responsibility for directly commissioning specialised services.

17. In 2021, the development of provider collaborative brought together certain specialist and sub-regional services in NHS Trusts to work together. This coincided with a reduction in regional level commissioning in favour of local collaborative. The provider collaborative aims to deliver benefits of scale and mutual aid within their regional area **[MK2-002: NHS Working together at scale: guidance on provider collaborative].**

The Mental Health Act

18. The delivery of secondary mental health services is significantly influenced by legislation; especially the Mental Health Act (MHA) (1983), which governs the formal detention and care of mentally disordered people in hospitals in England and Wales. The MHA covers the assessment, treatment, and rights of people with a mental disorder. Inpatients are either involuntary (referred to as detained) or voluntary (referred to as

informal). Throughout this statement, the terms informal and detained shall be used to describe voluntary and involuntary patients referred to in the Rule 9 (11).

19. The MHA: Code of Practice **[MK2-003: Mental Health Act 1983: Code of Practice]** provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and approved mental health professionals on how they should carry out functions under the MHA in practice. It is statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder. Staff have access to a Trust operational procedure for guidance on the MHA **[MK2-004: MHAPG1 Procedural Guideline for the Administration of the Mental Health Act 1983].**In this statement, I will refer to the following parts and sections of the MHA. Criteria for detention under the MHA stipulates that:

- the person is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- the person ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons; and
- appropriate medical treatment is available for the person (for detentions for treatment).

20. Table 1 below details the Parts to the Act and sections used within Essex mental health services:

Table 1: Parts of the Mental Health Act

Part	Description
Part 2	This part deals with civil (i.e. non-offender) patients who warrants compulsory admission to hospital and Guardianship. The commonly used sections under Part 2 of the MHA include, Section 4, Section 2, Section 3, Guardianship Order Section 17 - Leave of Absence from hospital and Community Treatment order. The allowed duration of the detention ranges from 72 hrs to 6 months depending on the type of the section of the MHA in place. There are also provisions within the Act to renew the detention if deemed necessary.

Part 3	This part deals with patients concerned in criminal proceedings or under sentence. Among other things, it allows courts to transfer/detain offenders in hospital for assessment/treatment of their mental disorder where particular criteria are met. It also allows the Secretary of State for Justice to transfer offenders from prison to detention in hospital or restrict/recall an offender in the community for treatment of their mental disorder.
Part 4	Part 4 deals with the consent to medical treatment of patients who are detained either in hospital or subject to community treatment orders in particular, it sets out when they can and cannot be treated for their mental disorder without their consent. This also deals with the type of treatments allowed and the need for statutory second opinion in those detained patients.
Part 5	This part of the MHA deals with the role of the Mental Health Review Tribunal. This sets out the duties of the hospital managers to refer cases to tribunal as per the Act and the powers of the tribunal discharge patients from their detention orders.

Mental Capacity Act

21. The Mental Capacity Act (MCA) 2005, is the legal framework that supports acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions for them in England and Wales. The Five Principles of the MCA are:

    - Everyone over the age of 16 can make decisions unless assessed otherwise.
    - All practicable steps must be taken to support someone to make decisions for themselves.
    - People can make unwise decisions in they have capacity.
    - All decisions made for someone must be in their best interest.
    - The option chosen must be the least restrictive.

22. Staff within the Trust are engaged with caring for patients who are detained under sections of the MHA or Deprivation of Liberty Standards (DOLS) under the MCA, or orders made by the High Court. Staff can access Trust operational guidance to support

them in practice with the MHA and MCA, and receive competency based mandatory training that is role specific **[MK2-004: MHAPG1A - Procedural Guideline for the Administration of the Mental Health Act 1983; MK2-005: MCPG2 - Mental Capacity Act and Deprivation of Liberty Safeguards Procedure].**

23. In addition to patients detained under the MHA, the Trust has informal patients admitted to the Trust services. There are exceptions to this as detailed in the information provided in the sections below on individual services. In summary, the key differences between informal and detained patients are detailed in Table 2 below:

Table 2: Differences between an informal and a detained patient

Area of Difference	Informal	Formal
Leave from the ward	The patient has the right to leave the hospital ward at any time, day or night. Not stopped unless have concerns about patients' health and safety.	Leave is agreed under Section 17 of the MHA and can be either escorted or unescorted. It can be limited to a boundary or perimeter within the Trust premises or outside.
Advocacy	Advocacy available on request	Entitled to help from an independent mental health advocate.
Right to Self-Discharge	Patient has the right to discharge themselves from the hospital ward at any time, day or night. Not stopped unless have concerns about patients' health and safety.	Not free to discharge themselves, if they try to leave, they can be stopped or brought back, and this may be against their will.
Treatment	No treatment provided without consent and an informal patient can withdraw their consent at any time.	The patient has the right to refuse treatment. However, treatment for the mental disorder can be given without their consent subject to meeting the conditions under Part 4 of the MHA

Personal belongings like mobile phone or other items which may be deemed risk to them.	Less formal restrictions on possessing them. Any restrictions agreed as part of their care plan with their consent.	Restrictions depending on the risk assessment or the type of the ward they are on (e.g. Forensic wards).
Statutory support following Discharge	Patient does not have the right to section 117 aftercare, which may affect the level of support in the community available to the person compared to a detained patient.	Patient has the right to section 117 aftercare if detained under section 3 or admitted under a hospital order or transfer direction. **[MK2-236: Your Right to After Care section 117 of the MHA]**. Section 117 aftercare is the help available in the community after the patient is discharged from the hospital. This can cover healthcare, social care and supported accommodation.

Inpatient pathways, systems and processes

24. The inpatient pathways across EPUT mental health services cover a wide range of ward types and specialities. Although there are many similarities in the way mental health services operate, referral routes will vary according to the type of service, national policy and legislation, the range of referring partners and differing commissioning arrangements. These factors have changed significantly between 1 January 2000 and 31 December 2023. Specific differences between services are detailed in the descriptions of individual services.

25. EPUT has Trust wide policies and service specific or site-specific policies, procedures, Standard Operating procedures (SOPs), Protocols and checklists. The admission, assessment and care operating policies for inpatients evolved by reviewing and including the content of the many corporate policies, procedures and standards developed in line with regulatory and national guidance, and best practice at the time. Regulatory inspections have provided the opportunity for learning, and is incorporated

into the development of admission, assessment and care operating policies across the organisation over the scoping period.

26. The Care Quality Commission (CQC) regulates the provision for mental health services and has two roles. All health and adult social care providers carrying out regulated activities, including those providing mental health care, must be registered with the CQC and meet certain legal requirements to register. Additionally, the CQC meets patients in private whose rights are restricted under the MHA, to hear their experiences and concerns, to ensure they know their rights and that staff are using the Act properly. The regulatory visits look at the patient's experience, including medication, treatment, privacy and ward environment.

27. Each admission into an EPUT unit should have a clearly defined purpose for assessment and/or treatment that can only be delivered in acute inpatient care and ensure that there is a therapeutic benefit to each admission. EPUT has developed a new Therapeutic Acute Inpatient Care Operating model in 2024 **[MK2-006]** to assist in delivery of standards set by NHS England's guidance for Acute inpatient mental health care for adults and older adults **[MK2-007]**

28. EPUT's historical provision of bed types, numbers and gender-based units and the changes that have taken place are submitted in Rule 9 (6a) in detail but its current provision for inpatient care is shown in Table 3 below:

Table 3: Current Wards and Beds by Service

Speciality	Bed Numbers	Number of Wards/units	Bed type / Sex / Units	Expected duration of stay
Adult Acute	32	2 wards	Mental Health Assessment Units mixed sex units, one each in Colchester (Peter Bruff ward) and Basildon. (Grangewater ward)	Short
	89	5 wards	Adults of working age male wards across Chelmsford, Harlow, Basildon and Rochford	Short

	86	5 wards	Adults of working age female wards across Harlow, Colchester, Basildon and Rochford	Short
	36	2 wards	Adults of working age mixed sex wards across Chelmsford and Colchester	Short
	25	2 wards	Adults of working age Psychiatric Intensive Care Units. Single sex unit in Basildon and mixed care unit in Chelmsford	Intensive
Older People (Includes functional and organic)	133	7 wards	Older adults mixed sex wards in Chelmsford, Colchester, Epping, Rochford and Grays	Short stay
	14	1 ward	An adult female ward in Clacton	Short stay
	70	2 NHS Nursing homes	Care homes for older adults in Clifton Lodge and Rawreth Court	Long stay
Mother & Baby Unit	6	1 ward	Mother and Baby unit in Chelmsford Essex	Short stay
Medium Secure	42	3 wards	Medium Secure male wards (Alpine, Lagoon and Forest) at Brockfield House, Essex.	Long stay
	12	1 ward	Medium Secure female ward (Fuji ward) at Brockfield House, Essex	Long stay
	12	1 ward	Medium Secure mixed ward (Aurora)at Brockfield House, Essex Pre-discharge ward with males and females staying in different flats	Long stay

Low Secure	53	3 wards	Low Secure male wards Dune Ward at Brockfield House, Wickford, and Edward House in Chelmsford	Long stay
	16	1 ward	Low Secure Female ward (Causeway) at Brockfield House, Essex	Long stay
CAMHS	28	2 wards	Child and Adolescent Mental Health Services mixed sex wards across 2 units Longview in Colchester and Poplars in Rochford, Essex	Short stay
	10	1 ward	Child and Adolescent Psychiatric Intensive Care (Larkwood) Unit mixed sex ward in Colchester, Essex	Intensive

Single sex accommodation

29. During the period, each Trust completed transitional works from mixed sex to single-sex wards as part of national initiatives, and the requirement for wards to offer single bedrooms and not dormitory layouts to improve privacy and dignity. Over the relevant period these changes have taken effect, as detailed in the Trust's response to Rule 9(6). In summary, a number of the NEP and SEPT wards had completed the necessary works for gender separation. Since the formation of EPUT in April 2017, works have continued, which included:

    a. The elimination of dormitories at Basildon Mental Health Unit, and Topaz Ward, The Crystal Centre

    b. The re-opening of single-sex wards at Cedar and Willow, Rochford Hospital; Cherrydown and Kelvedon, Basildon Mental Health Unit

30. In same sex wards, males and females do not share sleeping accommodation and is occupied solely by one sex. In mixed-sex wards, accommodation can be provided as either single bedrooms with a same sex toilet and washing facilities, or where patients are cared for in same-sex dormitories with single-sex toilet and washing facilities.

31. For this reason, gender can influence a bed placement for a patient. In adult and older adult acute services, the treatment wards across the Trust are single sex apart from Topaz Ward, The Crystal Centre. There are two Psychiatric Intensive Care Units (PICU); one has operated as male only unit since 2024, as part of a commissioning pilot scheme while the unit remains a mixed gender unit. A PICU admission would be a step up from a treatment ward due to the risk the patient poses to themselves or others and require intensive care. A patient could be admitted to a ward straight from the community due to concerns regarding their presentation, the risk to self or others or because of their previous history.

32. Consultation took place with the Consultant Psychiatrists to agree on responsibility for the patient wards, along with the multi-disciplinary team. Some wards remained mixed sex where changes were not feasible due to the location and availability of showers and toilets. In such cases, the wards implemented guidance on maintaining dignity, respect, and sexual safety. The measures included the use of female only lounges and swing rooms. Swing room is the term used to describe a hospital bed that can switch from a male to a female room to accommodate either sex for an admission on the ward during busy periods. These swing beds were typically located between the male and female corridors allowing flexible boundary while maintaining gender segregation.

Bed Management

33. Decisions regarding the selection of bed type and ward for admission is dependent on a number of factors, including age of the patient, severity of the presentation and the application of the MHA. This decision is made pre-admission by the referral sources and, depending on the service, agreed through the appropriate bed allocation system. The similarity is that all admissions have been through some form of gatekeeping through either the bed management or and more recently the collaborative admission process.

34. The Five Year Forward view for Mental Health (2016) **[MK2-008]** made the case for transforming mental health care in England and the common theme within the plan was building capacity within community-based services to reduce demand and release capacity from the acute sector and inpatient beds. Alongside this, the commissioning

model moved towards inpatient beds being "locality placed based" so that pathways of care for the patient are readily available.

35. Since 2000, there has been a marked increase in the number of mental health patients in Essex that are detained under the MHA and the demand has continued to rise, especially post Covid. However, this is a national pressure and the Mental Health Foundation reports that the proportion of people with a common mental health problem using mental health treatment has significantly increased over time. This has increased from one person in four aged 16 to 74 in 2000 (23.1%) and 2007 (24.4%), to more than one in three (37.3%) in 2014. The British Medical Association (Mental Health Pressures in England, BMA, 2025) refers to a record 5 million referrals during 2023 in England, up 33% from 2019.

36. EPUT currently operates a Capacity, Flow and Escalation Protocol designed to support a consistent approach across adult services in EPUT, aiming to optimise the patient flow throughout the system. This is to ensure consistent gatekeeping for admissions: to admit the right patients, to the right beds, at the right time and for the right duration. This also enables the Trust to maintain a clear oversight of the bed capacity and demonstrate a planned approach to admission process. In healthcare, flow is the movement of patients, information or equipment between departments, staff groups or organisations as part of a patient's care pathway and improving patient flow is one way of improving health services **[MK2-009: MHOP4 EPUT Capacity, Flow and Escalation Policy].** The protocol is currently being reviewed and updated to reflect the new national mental health Operational Pressures Escalation Levels status which has been implemented this year, and the new operating model to support purposeful admissions, along with locality SitReps which will commence on 1 April 2025 **[MK2-237 MHOP4 - Appendix 3 - SITREP EPUT Safer Staffing Template].**

37. Although this is the model EPUT is working toward, as detailed in the EPUT position statement, the adult and older peoples' services are challenged at the present time with a significant demand for beds and a high number of patients placed outside of Essex, and with the independent sector both within and outside Essex. Essex has also experienced a longer length of stay which has limited the Trust's ability to achieve this aim. These pressures and challenges are reflected across mental health providers nationally and not just in Essex.

38. Each person pending admission is discussed on the twice daily SITREP demand and capacity call and decisions made about the most suitable inpatient ward to meet the

individual's needs. Clinical decisions about priority for admission will be made by the Clinical Flow Lead, Clinical Director for Flow (Consultant Psychiatrist) or the Chair of the call. This is informed by the clinical presentation of each individual pending admission and the rationale for decision-making is documented. The Clinical Flow Lead/Chair maintains oversight of all opportunities to transfer care and will ensure people are placed as close to their home/usual residence as possible. For specialist services oversight is maintained by the provider collaborative.

39. In specialist services daily reviews are conducted for admission to Child and Adolescent Mental Health (CAMHS) and Mother and Baby Unit (MBU), although emergency admissions for both may be reviewed outside of this schedule. For CAMH and MBU, the review meetings are attended by various clinicians and representatives of the provider collaborative. In secure services the admissions review is held weekly and any pending admissions are discussed by those in attendance. The SITREP meeting supports bed management and identifies the live demand on the whole system. Admissions are agreed by the clinicians in the Trust who are members of the SITREP meetings. Consideration is given to:

    - How many MHA assessments are happening across the trust, including whole Health system that includes bed pressures and out of area placements.
    - How many MHA assessments are happening across the Trust.
    - How many crisis assessments are happening in A&E/Emergency Admissions Unit Departments.
    - Home Treatment/Gatekeeping Activity.

40. Admission to the specialist units in the Trust are in line with NHS England bed management strategy and arranged through provider collaborative arrangements. The providers within the collaborative are EPUT, Central and North-West London NHS Foundation Trust, Cambridge and Peterborough NHS Foundation Trust (CPFT), Hertfordshire Partnership University NHS Foundation Trust (HPFT), East London NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust.

41. For secure services, only those patients who have been assessed and accepted for admission by the multi-disciplinary team (MDT) with the agreement of the East of England Provider Collaborative will be admitted to the service. EPUT is the lead for the

provider collaborative for medium and low secure services. The service is described in more detail in the statement.

42. The Mother and Baby Unit (MBU) is a specialist service which sits within the commissioning landscape of Perinatal Services. Mother and Baby Unit (MBU) admissions are through the collaborative arrangements for specialist commissioning to patients from the East of England. However, referrals can be accepted from anywhere within the UK and beds will be allocated by the collaborative dependent on appropriateness, need and risk. Hertfordshire Partnership University NHS Foundation Trust (HPFT) are the lead provider for Perinatal Services within the NHS region from April 2024. Prior to the collaborative, NHS England commissioned perinatal services directly.

43. The Child and Adolescent Mental Health Service (CAMHS) units receive referrals through the provider collaborative. These arrangements have developed in stages since its inception in July 2021. HPFT are the lead provider for Children and Young people's mental health services. The service is described in more detail in the statement.

Admission assessment

44. Inpatient admissions into EPUT services do not follow a single point of entry, and the processes vary across the specialities, as outlined individually within the statement. However, a common principle across all the services is that some form of assessment is undertaken prior to admission. The assessment includes a review of their records, where possible, to gather information from any prior assessments and care plans and to identify any advance choices Patient's wishes, wherever possible, should be considered when determining whether hospital admission is appropriate, including admissions under the Mental Health Act.

45. Some patients may have made an advance statement while well, outlining how they wish to be treated in the event of a future episode of mental illness. Staff take these statements into account during the admission assessment. As part of the welcome pack, patients are also offered an information booklet about advance statements at a time that is appropriate for them **[MK2-010: Advance Statement: What I would like to happen if I become unwell].**

46. When the assessing team concludes that an inpatient admission is required, the reasons are formalised in a 'purpose of admission' statement. This statement articulates the purpose for the inpatient stay and the intended aims of the admission. The admission

purpose is recorded in the referring gatekeeping assessment within the clinical record, as well as and the MHA documentation, together with an expected date of discharge, if possible.

47. This is shared with the person, and where appropriate, with their chosen carer/s and relevant partner services. Staff offer the patient an information booklet on the MHA at the appropriate time and a carer's support information booklet to the carers to guide them whilst supporting the patient. [**MK2-011: The Mental Health Act: What you need to know (EPUT, ref: EP0083); MK2-012: Carers Support: Information for Carers, friends and families (EPUT, ref: EP0915)].** These patient information leaflets were updated in 2024 from the previous iterations.

48. For individuals identified as requiring informal admission, the pathway is for them to be admitted to the Mental Health Assessment Unit, whenever possible. A thorough assessment of the persons mental health presenting need is completed at the assessment unit, leading to the decision to either admit the patient to a treatment ward or discharge the patient from the assessment unit to the care of appropriate community services.

49. Patient information booklets are available detailing their rights as an informal patient. Section 131 of the MHA (1983) emphasises the freedom for patients to be admitted without any formal restrictions **[MK2-013: Your Rights as an Informal Patient (EPUT, ref: EP0410)].**

50. If a patient requires intensive treatment because of the severity of their psychiatric symptoms, but they lack the capacity to consent (or are refusing consent) to treatment in the community, they should be assessed under the Mental Health Act against the criteria for admission under the Act. For patients requiring admission under the Mental Health Act, they are admitted to a treatment ward (as against assessment unit) and a bed is identified on a treatment ward by the bed management team.

51. EPUT's aim is for all new patients admitted to a ward to be introduced and orientated to their admitting ward within the first 12 hours and welcome information is made available to them and their carers as part of the immediate care they receive.

52. Each speciality has information designed for their own unit and for the individual needs of their patients. The welcome pack on admission contains key information regarding their admission and processes on the unit and a member of staff will explain this to them. On admission, every patient is allocated a keyworker who will coordinate their care on

the unit and will ensure that the patient has a basic understanding of what will happen in the facility, their responsibilities for themselves and they will orientate the patient to the ward environment **[MK2-014 to 016 and 018 to 021: Welcome Packs].**

53. Information regarding seeking a second opinion is accessible in "The Mental Health Act, what you Need to Know" **[MK2-011],** welcome pack for mother and baby unit **[MK2-018],** and parent and carer booklets for North Essex CAMHS **[MK2-230: Larkwood Parent and Carer booklet; MK2-231: Longview Parent and Carer booklet].** However, Consultants can seek second opinion from their colleagues outside the Mental Health Act in complex presentations or when requested by the patients or their families.

54. Within the first 4 hours of admission to the ward, as per the Royal College Standards, the immediate care needs for the admitted patient is assessed by the ward resident doctor (earlier called junior doctor) during normal working hours and by the on-call doctor out of working hours. This assessment is part of the clerking process explained later in the statement, in line with the Royal College of Psychiatry Standards (2019) **[MK2-023]**.

55. The resident doctor can access a more senior doctor including the unit consultant during the day for support and advice, or, the on-call consultant psychiatrist, out of hours. Several wards have a speciality doctor (also called middle grade doctors/SAS doctors) who can provide support and advice to the resident doctor.

56. The medical assessment/clerking will include:

    a. A full psychiatric assessment.

    b. Mental State Examination including a brief cognitive assessment, when indicated.

    c. Physical health Examination including baseline observations.

    d. Venous Thromboembolism (VTE) assessment, when indicated.

    e. Request Investigations (if already not available) such as ECG if clinically indicated, and routine bloods (full blood count, kidney, renal and liver functions, thyroid functions, blood glucose, lipid profile or any other investigation deemed appropriate for that patient).

    f. Medicine Reconciliation – at the time of admission - check for known drug allergies, information from admission handover or existing records, cross referencing with any details brought by the patient/carer. Medicine

reconciliation includes confirming the medications prescribed in the community and the medications taken by the patient. Receive Medicines Reconciliation Form from pharmacy technician when immediately available (during working hours).

g. Complete a medications chart and consider if any immediate changes or additions need to be made to the medication regime the patient is on to manage any immediate psychological distress.

h. Agree an initial engagement and observation plan with the patient **[MK2-024: EPUT admissions on Mobius E-SOP V5; MK2-025: EPUT admissions on Paris E-SOP V7].**

57. The consultant psychiatrist will see the patient formally (as part of MDT clinical review) within the first week but usually informally (for an initial assessment) before this on the ward. Medical responsibility for the patient during admission will be with the designated Consultant Psychiatrist and the Trust operates a functional model which describes how consultant psychiatrists work in either inpatient or community-based settings. The Trust functional model was proposed in the National Service Framework for Mental Health in 1999 [**MK2-026].**

58. At time of admission the admitting doctor makes a provisional diagnosis and agrees a treatment plan with the patient and the multidisciplinary team. The provisional diagnosis is discussed in the multi-disciplinary team meetings and recorded in the minutes and during the ward rounds. This is reviewed regularly at further assessments and may change later as more information or investigation results become available. Patients are discharged with the final diagnosis, which is recorded in the clinical records. The ward consultant psychiatrist is the clinical lead and has the overall responsibility of the treatment and diagnosis/es.

59. A holistic nursing assessment is undertaken within the first 24 hours of admission by a Registered Nurse and the paperwork reviewed, including any risk assessments or MHA paperwork for detentions that have already been assessed pre-admission. EPUT staff will undertake these assessments in line with the Trust guidance. This will include:

a. If patient is known to the health services, check information within Trust systems and that sent from referrer.

b. If known, identify care coordinator and liaise with all other professionals involved in the community.

c. Check that CPA Initial Assessment and MH Care Clustering (holistic assessment tool) used are completed.

d. For patient admitted under informal admission – read Informal Rights S131.

e. Give patient Rights Leaflet.

f. For patient admitted under the MHA - scrutinise Mental Health Act papers on ward, read Section Rights S132.

g. Give patient Rights Leaflet.

h. Ensure risk assessment / screening is completed and risk plan is devised within 4 hours of admission. Check the risk management plan is completed and amend where needed.

i. Determine the observation level based on presenting risk factors (this could be medics/nurse).

j. Based on initial assessment/ screening and risk assessment determine the appropriate level of observation.

k. Search and record patient belongings/inventory.

l. Search patient belongings (e.g., clothes, bag, cash, valuables, etc.).

m. Allocate keyworker.

n. Ensure patient is oriented to the ward and show the patient around the ward (their room, the canteen, common areas, etc.).

o. Give the patient a Welcome Pack (including info about mealtimes, visiting times, contact details, My Care My Recovery, home first leaflet, rights leaflet, sexual safety leaflet, Why We Hold You leaflet, Oxehealth fact sheet etc.).

p. Have patient complete ‘My Care My Recovery’ document with the staff/family assistance so that they can input on how they want to receive care.

q. Incorporate the above in Care Plan needs, where possible.

r. Discuss Oxevision (vision-based patient monitoring) use with patient and/or relatives. If patient doesn't have capacity, discuss in MDT.

s. Consider discussing Oxevision with next of kin/relatives etc.

t. Identify and inform next of kin of admission.

60. Within four hours:

a. Complete 72hr care plan (Registered Nurse).
b. Complete Methicillin-resistant Staphylococcus aureus (MRSA) Screening Tool, if needed.

c. Take baseline vitals - Pulse, BP, Temperature, Respiratory rate.

d. Complete NEWS2 chart (The National Early Warning Score 2 - to assess illness severity and risk of deterioration for patients in acute episodes of care in the UK).

e. Check for postural blood pressure (BP) (lying and standing).

f. Complete General Observation (Height/Weight/BP).

g. Complete Essence of Care Assessment (The eight Essence of Care benchmarks are: self-care, hygiene, nutrition, continence, pressure ulcers, safety in mental health, record-keeping and privacy and dignity).

61. Within 6 hours:

a. Complete Drug Screen and Urinalysis if clinically indicated.

b. Confirm pregnancy tests on people who menstruate.

c. Scrutinise Medication Chart to check for accuracy on medication chart if prescriptions are legal or legible.

d. If anything does not seem accurate, have the doctor review the medication chart.

e. Complete Waterlow Assessment (risk assessment tool in the UK, plays a vital role in identifying and managing pressure ulcer risk).

f. Complete Falls Risk Assessment.

g. Complete manual handling needs, if required.

h. Complete MUST (Malnutrition Universal Screening Tool) Assessment tool, refer to dietician if required (MUST is a screening tool to identify adults who are malnourished, at risk of malnutrition, or above the healthy weight range).

i. Complete Food and Fluid monitoring and complete assessment, if appropriate.

j. Complete Body Mapping Form.

[MK2-024, MK2-025, MK2-027: Oxevision SOP V11; MK2-028: CG87 Clinical Guidelines on the use of National Early Warning System (NEWS)].

62. The nursing assessment will include agreeing the Therapeutic, Engagement and Supportive Observation level in line with Trust policy **[MK2-029].** The full admission and development of the co-produced care planning process may take several days to complete, depending on the mental state of the patient and their ability to receive and give information.

63. The Trust has levels of observations, which are used to determine the minimum frequency staff are to observe a patient on the ward. The level of observation prescribed is based on several risk factors and are unified as follows:

    a. Level one / general observations: For patients assessed as low risk and the minimum level for all patients. The frequency of observation is once every 60 minutes.

    b. Level two / intermittent observations: For patients who pose a potential but not immediate risk. The frequency of observation is a minimum of four times at irregular intervals every 60 minutes.

    c. Level three / continuous within eyesight: For patients at immediate risk, who could, at any time, attempt to harm themselves or others. A nominated staff member will be allocated to each patient managed on this level of observation and the patient must be kept within continuous eyesight at all times.

    d. Level four / continuous within arm's length: For patients who pose the highest level of risk to themselves or others, and can only be managed by close proximity

of the staff member to the patient. A nominated staff member will be allocated to each patient managed on this level of observation.

64. A number of factors indicate why a patient may need to be cared for on higher observations levels, some of these risks are:

- Intent to harm self/others
- Personal safety
- Social/sexual vulnerability
- Self-neglect
- Risk of falling/wandering
- Risk of absconding
- To support agreed objectives in care plan, e.g. support with identified triggers/dietary intake/supervised visits
- Poor adherence to or non-compliance with treatment programmes/medication regimes
- Physical illness
- Unknown patient recently admitted
- Following a seclusion episode
- To provide an atmosphere where therapeutic risks can be taken
- Marked changes in behaviour/presentation
- Recent loss/bereavement
- Hallucinations - suggesting harm to self or others
- Paranoid ideas - where the patient believes that others pose a threat
- Reaction to medication **[MK2-029]**

65. The patient's property is checked on admission for items that may pose a risk to themselves or to others and any prohibited items are retained for their safety. Searching an individual or their property can be experienced as a traumatic/intrusive procedure. However, it is paramount that searches are undertaken to prevent serious harm or injury to the service user and staff.

66. The Trust Search Procedures assist staff with identifying the type of searches to be carried out, prevention of harm and provides a list of prohibited items. The policy guides staff in undertaking the search procedures with efficiency whilst minimising discomfort or distress to individuals and maintaining their dignity throughout the search **[MK2-030: CLP75 Search Policy].**

67. This Policy does not fully cover searches for all services and the secure services have their own protocol **[MK2-182: SSOP22]**. Whilst CAMHS follow the Trust policy, the service adjusts itself for working with young people. Consent is gained from the patient, however in secure services consent can be overriding where dangerous, violent or criminal propensities of a patient creates the need for additional security. If the patient does consent, they agree to a person/property check on return from leave or admission, which can be ad hoc or planned, depending on risk. If the patient does not provide consent and has capacity and there is sufficient information to suggest risk, consent would be gained from the consultant and director to person search. A search is carried out in a private area to maintain privacy and dignity. This is to ensure the safety of the patient concerned, and the safety of other patients and staff.

68. If a patient is detained on admission and has restrictions from the relevant detention under the MHA, the patient is reminded of their rights under S132 of the Mental Health Act **[MK2-004: MHAPG1A]**. Section 132 places a duty on the Managers of a Hospital in which a patient is detained under the Act shall take such steps as are practicable to ensure that the patient understands:

    a. The provision of the Act under which the patient is detained and the effect of that provision; and

    b. The patient’s right of appealing against that provision to the First Tier Tribunal;

    c. This should be done as soon as practicable after the commencement of the patient’s detention under the Act.

69. This information is given to the patient verbally by staff on the ward and in writing by way of giving the patient a copy of the appropriate Department of Health Information conveyed in a Leaflet. **[MK2-011: The Mental Health Act- What you need to know].**

70. If it is deemed that the patient has not understood the information, the ward team will record this or in the case of the patient lacking capacity – the MDT must agree the course of action and record accordingly. The information must be conveyed to the patient again when it is deemed appropriate. Where possible and appropriate relatives/carers are given information. Patients are informed:

    a. Of the right of the Responsible Clinician and the Hospital Managers to discharge them (and for restricted patients, that this is subject to the agreement of the Secretary of State for Justice);

    b. Of their right to ask the Hospital Managers to discharge them;

    c. That the Hospital Managers must consider discharging them when their detention is renewed, or the Community Treatment Order is extended;

    d. Of their rights to apply to the Tribunal;

    e. Of the rights (if any) of their Nearest Relative to apply to the Tribunal on their behalf.

71. Patients are aided to request a Hospital Managers Hearing or make an application to the Mental Health Tribunal. They are also told:

    a. How to contact a suitably qualified Legal Representative and should be given assistance to do so if required;

    b. That free legal aid may be available;

    c. How to contact any other organisation, which may be able to help them make an application to the Tribunal **[MK2-031: MHAPG1 Appendix D – Right of Appeal for those Individuals subject to the Mental Health Act].**

72. Information about the advocacy service provider is shared with patients and is also included in the welcome booklet they receive. This is typically done within the first 24 hours of admission but may need to be repeated in different formats or at various times, depending on the patient's mental state, to ensure full understanding.

73. Patients are informed about the role of the CQC and of their right to meet visitors appointed by the CQC in private. Patients should be told when the CQC visit their hospital and be reminded of the role the CQC undertakes.

74. The Act also requires that the patient's Nearest Relative or nominated person should receive a written copy of the information given to the patient when they are detained – unless the patient requests otherwise **[MK2-032: MHAPG1 Appendix A Abbreviations, Definitions and Glossary of Terms].**

75. When providing the patient with information, they are told that the written information is copied to their nearest relative or nominated person, thus giving the patient the opportunity to object to the information being shared with the nearest relative or nominated person.

76. Unless otherwise, already assessed as lacking, capacity is assumed and as part of the admission process and in line with trust guidance. The MCA 2005 and DoLS (MCPG2), and the Trust policy and procedures [**MK2-005]** guide staff to recognise and take appropriate action when there is a concern regarding a person's mental capacity and if there is a need to lawfully deprive someone of their liberty.

77. Article 5(1) provides that a person can only be deprived of their liberty in accordance with a procedure prescribed by law and specific grounds. Further, any decision to deprive a person of their liberty, where that person lacks mental capacity, must consider whether it is the least restrictive way of achieving the legitimate aim e.g. keeping them safe or ensuring they receive the right medical treatment. Staff have access to guidance and support from the Trust procedure **[MK2-005]** and the safeguarding team when working and assessing patients regarding DoLS.

78. Patients on the unit are advised on their right to independent advocacy and staff can refer to advocacy services if requested by the patient or as a Best Interest's decision if they lack capacity. If the patient is an adult and restricted or being detained under the MHA, they are legally entitled to help and support from an Independent Mental Health Advocate (IMHA). An advocate is someone who will speak up for patients or support them to speak up for themselves.

79. If a patient doesn't understand what's happening to them, want to challenge a decision about their care or support, express their preferences or assert their rights, advocacy can help them. Advocacy helps ensure patients are as involved as possible in decisions

about their health and care. Independent professionals, known as Advocates, help patients understand their options, know their rights and express their views and wishes.

80. In July 2024, the provider of advocacy, commissioned by the local authority, changed from Rethink to VoiceAbility, across Essex and Thurrock. The Mental Capacity Act and Care Act states that one must refer eligible patients for advocacy, and the MHA states that one must let eligible patients know how they can access the service. A patient's eligibility for advocacy from VoiceAbilty is made directly to them and advice is provided in their leaflet **[MK2-033: Overview for a professional ESSEX digital]**.

81. Where a patient lacks capacity to make their own decisions, a best interest's decision includes a checklist of factors that staff must consider in determining an individual's best interests and will be considered in the initial assessment on admission. These include considering the views of anyone named by the patient as someone to be consulted on the matter in question' (e.g. family or friends) or 'anyone engaged in caring for the patient or interested in their welfare. The checklist says you should:

    a. encourage participation – do whatever's possible to permit or encourage the person to take contribute

    b. try to identify the things the person lacking capacity would consider if they were making the decision themselves

    c. find out the person's views – including their past and present wishes and feelings, and any beliefs or values

    d. avoid discrimination – do not make assumptions based on age, appearance, condition or behaviour

    e. assess whether the person might regain capacity – if they might, could the decision be postponed?

82. Staff will consider the medical, social, psychological and emotional benefits of a decision and that they fully explore with the patient the pros and cons of any proposed decision, providing full information of all potential risks and any reasonable alternatives, before determining decisions in best interests and record their professional reasoning. Staff have access to guidance and support from the Trust procedure **[MK2-005]** and the safeguarding team when working and assessing patients and best interests' decision.

83. On admission to the ward, staff will assess and where appropriate take action for any safeguarding concerns they may have by raising a safeguarding alert for adults or making a safeguarding children referral at the appropriate threshold for: Early Help, Child in Need or Child in Need of Protection, depending on the level of concern they may have. These actions will be taken in line with the Local Safeguarding Partnership arrangements indicated in the appropriate Trust safeguarding adult or child procedures [**MK2-044: CLPG39 Safeguarding Adults Procedural Guidance; MK2-045: Safeguarding Children Procedural Guidance].**

84. The safeguarding children and adult procedures have been reviewed and updated within the Trust every three years for a full rewrite, and an annual update for any significant changes in legislation and guidance since 2012. The latest version referred to as version 3 for safeguarding children and version 2 for safeguarding adults were re-written in 2023.

85. Safeguarding processes differ depending on whether the patient is a child or adult. The Children's Act (1989) defines a child as being up to the age of eighteen. For safeguarding children processes, staff are required to recognise and respond to harm or abuse of a child and where indicated make a referral to children's social care for the investigation and multi-agency planning to mitigate harm and protect the child. Safeguarding children is defined as protecting children from maltreatment, preventing impairment of children's health or development and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

86. When harm or abuse are suspected, a referral is made using the local Safeguarding Partnership template guided by policy and procedures. A referral is made:

- To determine whether the child is suffering, or likely to suffer significant harm. (S47) Children's Act
- A 'child in need' assessment under Section 17 to identify the needs of the child and ensure that the family are given the appropriate support in enabling them to safeguard and promote the child's welfare with their consent.
- An early help referral which is support that is offered to children and their families when additional support is identified which is beyond the scope of universal services with their consent.

87. When safeguarding adults, a safeguarding concern is raised and it is then determined if the threshold has been met for a S42 Care Act (2014) enquiry to be undertaken to decide

whether any action should be taken in the adult's case, and if so, what and by whom. Safeguarding is defined as ‘protecting an adult’s right to live in safety, free from abuse and neglect.

88. If a safeguarding concern is progressed by the local authority to a S42 enquiry, staff in the Trust will undertake the investigation for an inpatient, following the local safeguarding procedure. The adult will be consulted with and a planning discussion arranged to co-ordinate and identify the key people involved with the enquiry alongside any statutory or non-statutory reviews that may take place. A management plan will:

- Identify what steps need to be taken to assure the future safety of the adult
- Identify if there any support, treatment or therapy, including on-going advocacy
- Review if any modifications needed in the way services are provided
- Address how will the adult be supported to seek justice or redress
- Develop what the on-going risk management strategy will be

89. The enquiry can be closed at any point if the adult declines safeguarding support however the impact of the abuse or neglect will still be considered, including the impact on others. Otherwise, the enquiry is closed when all actions have been taken including the completion of the safeguarding management plan.

Specific Assessments/Considerations

90. On admission, initial assessments from the medical and nursing team will review any information supplied during the pre-admission stage of diverse patents needs and adjustments for language, cultural considerations or specific conditions like neurodiversity and physical/ cognitive disabilities and seek solutions and inclusion in the development of the care plan. Current pathways for funding for ADHD and ASD are Integrated Care Board dependent **[MK2-046: ADHD and ASD routes for referrals, January 2020]**

91. Staff across the Trust receive role specific competency based mandatory training on neurodiversity and the Trust has commissioned the Oliver McGowan Learning Disability and Autism training in 2023 developed for this purpose, which is NHS England's preferred and recommended training for health and social care staff. Compliance is monitored and reported across the Trust Community and Mental Health services and

whilst the on-line module is readily accessible for staff, the competency-based level 2 face to face training, launched in 2024 is provided externally and places are difficult to book owing to lack of availability [**MK2-238: Oliver McGowan training compliance].**

92. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers to ensure their staff receive learning disability and autism training appropriate to their role.

93. The CAMHS units have developed their own specific training package, delivered by the unit staff, to meet their young people's needs. All new starters attend the training to enable individualised patient support, and their education department facilitates work with the young people that is needs led and based on their admission assessments. **[MK2-239: ASD Session of Induction Training].**

94. Good practice document (NHS England, 2023) **[MK2-240: NHS England National Framework: All age Autism Assessment Pathways]** on full assessments of potential neurodiversity indicates that this specialist and complex assessment is undertaken by the MDT and include Psychology, Occupational Therapy (OT) and Speech and Language Therapists (SLT) and requires an analysis of current symptoms/presentation alongside a history to make a causal understanding. Inpatient Clinical Psychologists will assess the current symptoms and can undertake screenings to look at the likelihood of autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) etc. A positive screening test may or may not indicate neurodiversity, as these may also be explained by early trauma and mental health. The Clinical Psychology training puts clinicians in a good position to be able to make a formulation regarding this and offer training, consultation and advice to the MDT.

95. Over the relevant period, commissioning directives on undertaking assessments of neurodiversity have changed from being specified or removed from contracts along with the associated funding **[MK2-046: ADHD and ASD routes for referrals January 2020].**

96. In the absence of a diagnosis, staff supporting patients who report experiencing difficulties consistent with neurodiversity, can still consider making reasonable adjustments, where possible. Reasonable adjustments may include making adaptations to the ward environment and/ or the ward routine. This could involve ensuring the patient is able to access a quiet space on the ward if they are feeling overwhelmed, letting the patient know when things like fire alarm tests will happen, providing sensory items such

as noise cancelling headphones, if this is in keeping with the person's risk assessment. A sensory assessment by occupational therapist may also be helpful to further understand and support the needs of patients who are neuro divergent.

97. If a patient is admitted into a unit with an established diagnosis of ASD, the team would explore if the patient has got a "My Health Passport" in place. A Health Passport is an important document with all the useful information about a patient and will help staff to know the best ways to look after them.

98. If a patient is neuro-diverse or is experiencing difficulties consistent with neurodiversity, staff can allocate the most appropriate bed for their needs. Therapies and psychology work that can be adapted to 1:1 work instead of a group setting.

99. Literature is available in easy read format and interpreters and language line is available to assist with communication. Staff can arrange for interpreters who sign for patients with hearing difficulties. The patients' needs can be discussed in the multi-disciplinary team meetings so that a Positive Behaviour Support plan can be agreed. This process can help increase understanding of the patient's triggers warning signs and helpful ways of responding and alternative ways of coping and include what language to use and what not to use. Sensory strategies can be explored and consider what works and what wouldn't for the patient **[MK2-047 – 053: Easy Read documents].**

100. Wards have access for patients to multi-faith rooms, prayer mats and faith leaders for patients and can explore specific dietary requirements like vegan, kosher or halal to meet their needs. Occupational Therapists, in secure services offer patients group sessions on spirituality should they wish to attend.

101. Inpatient services have wards that can provide disability inclusive access and adjustments. Some of the wards offer bariatric rooms for patients that need them.

102. As detailed in Rule 9 (5) Time to Care, the introduction of wider skill mix teams was supported by an international recruitment campaign in 2022/23. The Trust now has Registered General Nurses alongside Registered Mental Health Nurses to support patients with physical needs. Staff can access specialist community health teams trust-wide through referral like diabetes and physiotherapists to engage with an inpatient with physical health needs during an admission episode.

Diagnoses and co-morbidities

103. At the time of admission, the admitting doctor usually will consider various differential diagnosis that refers to a list of possible conditions that share the same symptoms that the patient describes and is observed by the ward staff. This approach explores a series of potential diagnoses that could explain the symptoms a patient is experiencing and is line with widely accepted medical practice in NHS. The list is not the final diagnosis, but a theory as to what is potentially causing the symptoms.

104. During the first 24 hours of admission, a patient will have a provisional diagnosis (the most likely one from the list of differential diagnosis) that is given and recorded in the clinical records by the doctor. The diagnosis made can be a mental health, physical health or both. The provisional diagnosis is discussed with the patient in the multidisciplinary team meetings and recorded in the minutes, and during the ward rounds.

105. This is reviewed regularly at further assessments and is investigated using additional tests and observations, by the multi-disciplinary team. The provisional diagnosis may change later as more information or investigation results become available. All patients are discharged with the final diagnosis, which is recorded in clinical records, whenever possible.

106. This approach has not changed over the last 20 years; the only difference being improved access to information. Historically, EPUT and predecessor organisations had no easy access to any of the GP information. Over the last five to six years, this has improved with the availability of shared care portal and other medicine reconciliation practises, which came into effect in later years. . It is accepted that in some patients, the diagnosis may change over the course of their treatment in the community or during subsequent inpatient admissions, e.g. Drug induced psychosis later being diagnosed as schizophrenia, depressive disorder later changing to Bipolar Disorder, once more information on the patient is known and/or observed.

107. Investigative tests are requested by the medical and nursing team from the locality hospital facility for any physical health or mental health needs that are identified as part of the medical assessment. Assessments and tests to aid arriving at a correct diagnosis and treatment. The options can include:

- Urine Tests
- Scans - ultrasound, CT (computed tomography)/MRI head scans to determine or rule out organic causes
- Blood tests,

- Scans - ultrasound, CT (computed tomography)/MRI head scans to determine or rule out organic causes
- X-rays
- ECG (electrocardiogram)
- EEG (Electro Encephalogram – tracing of the brain electrical activity – e.g. in seizures)
- Urine drug screen (not always)
- Pregnancy tests

108. Patients admitted into inpatient services may present with comorbidities, usually identified as part of the admission/clerking process. The health needs will from part of the co-produced care plan and observations and monitoring will be planned with consent from the patient. Any new health issues identified on the ward would be investigated using the requested tests and a treatment plan initiated. This often involves liaising with relevant specialists in the locality general hospital.

109. In the last couple of years ,as part of the Time to Care initiative, Rule 9(5), the Trust has introduced skill mix teams on the wards that includes Registered General Nurses who can assist patients with their physical health needs. The Trust has technology solutions on its wards to assist with health monitoring which includes CCTV and Oxevision. This is described further in Rule 9 (3a) and staff are trained by Oxe-Academy and supported by guidance within the corporate procedures **[MK2-027]: Oxevision SOP V11**.

110. For patients who are unable to cooperate due to their mental health condition, physical examination and monitoring are attempted at regular intervals. When assessed on admission health needs are identified and developed into the care plan with the patient to support their health needs. The Trust undertook an international recruitment campaign in 2023 and recruited Registered General Nurses who support the delivery physical health care needs to patients on the ward. All the new staff undertook an orientation and training period which was competency based to prepare them to work on the wards.

111. The level of physical health checks undertaken is determined by their identified health needs and any comorbidities. If there is an exacerbation of their existing physical health condition or new concern is identified appropriate help is sought from the specialist in that area. The urgency of assistance will depend on the nature of the problem and the

patient's presentation at that time. e.g. in emergencies patients may be referred to the accident and emergency department or in less urgent situations a discussion can take place with the relevant specialist to formulate a management plan, or in non-urgent cases, a referral will be sent to the specialist in that area for review in their outpatient clinic.

112. The Trust has corporate guidance for staff in the form of Physical Health guidelines **[MK2-054]: CG55 Physical Health Guidelines]** and follow NICE guidance to assist with them to monitor and manage patients with comorbidities during the inpatient stay. The National Institute for Health and Care Excellence (NICE) produce guidelines that are evidence-based recommendations for health and care in England and Wales. **[MK2-241: PH56 Vitamin D Supplement use in specific population; MK2-242: GH185, NICE, Bipolar Disorder: Assessment and management; MK2-243: CG178 – NICE, Psychosis and schizophrenia in adults, prevention and management; MK2-244: PH48 Smoking cessation in secondary care; MK2-245: QS86 Falls in older people Jan 2017].**

113. Staff will liaise with specialist teams like diabetes and palliative care teams to meet the individual needs of patients admitted to their units and can access specific health condition related guidance to support their care of patients. The Trust licensed for the use of the Marsden Manual for nurses to access specific clinical guidelines and this is referenced in the Trust corporate overarching guideline **[MK2-054: CG55 Physical Health Guidelines; MK2-055: CLP79 Overarching Clinical Guidelines (Marsden Manual)].**

Interactions with staff

114. The staff that interact with patients include members of the multi-disciplinary team which has a core membership of:

    a. Consultant Psychiatrist and other medical staff;

    b. Nursing staff and Mental Health Support Workers - includes patients' key worker;

    c. Psychotherapists, Clinical Psychologists and psychology team – offer range of psychological assessments and treatments;

    d. Occupational Therapists – work with patients to regain and carry out tasks within their recovery;

    e. Speech and Language Therapists (SALT);

f. Activity coordinators – new posts introduced as part of a new inpatient operating model called Time to Care (as detailed in Rule 9s(2, 5, 5a);

g. Social workers;

h. Approved Mental Health Professionals.

115. The type of roles and the numbers of staff working in adult inpatient services has varied over the relevant period.

Psychology

116. In adult inpatients services, the role of the Psychological Services team within the MDT for adult inpatients is to support the diagnosis, treatment and care of the patient. Psychological service provision has increased over the relevant period across all areas of the Trust. The older adult wards have their own dedicated psychology support. The service provides:

- Psychological assessments/specialist assessments;
- Formulations and a range of brief evidence-based interventions (individual, family and group) which help stabilise the current crisis episode and promote treatment choice.
- The team works into EPUT's adult wards, including Rainbow MBU.

117. All patients have access to inpatient psychological ward-based groups. Assistant Psychologists (APs) and Clinical Associates in Psychology (CAPs) offer 'Visible & Available' time (V&A) which allows briefer informal psychological engagement conversations. V&A refers to members of the psychology team, used on the adult inpatient wards but more widely since, dedicating time in their working week to be visible and available in the ward communal areas. This allowed time for initiating conversations, checking in with patients, answering questions and noticing and observing (assessing) what was going on. These were opportunities for psychological perspectives like noting if someone might need help with relaxation/breathing, recommending a group from the group programme or needing a safe person to talk about what was on their mind.

118. Some patients may benefit from psychological consultation to the MDT, some from a direct assessment and intervention, but not all will be appropriate or want 1-1 inpatient psychological work. There is the opportunity for onward referral to psychological

services in the community, where appropriate **[MK2-056: Adult Inpatient Psychological Services Feb 2025].**

119. There are multiple types of Psychological Treatments offered to patients including:

    a. 1-1 psychological treatment will tend to be integrative, drawing on a range of NICE evidence-based models dependent on patient need, such as Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Compassionate Focussed Therapy (DBT).

    b. Psychological groups may include; Art, drama, music therapy, CBT/DBT informed groups, open talking spaces, psychoeducation (e.g. sleep hygiene) and self-soothing groups (e.g. mindfulness).

    c. There will be variation on group content depending on patient need and staff skill mix.

    d. Indirect Work: The Psychology Team also offers indirect interventions to inpatient ward teams. E.g. consultation, reflective practice, support spaces and staff training including; one day 'Neurodiversity' training (started 2024) and one day 'Managing Personality Disorder and complexity' training (started approx. 2019) **[MK2-057: Psychological services within the Acute Adult Mental Health Care Pathway].**

120. Each site has had access to psychological services over the relevant period, but this has gradually grown over the years to dedicated support, although some area with vacancies are still short of meeting the recommended psychological guidelines **[MK2-057: Psychological Services within the acute adult mental health pathway].** For each area, any unique psychology provision is detailed in paragraphs page below.

121. The team consist of Clinical/Counselling Psychologists, Psychological Practitioners (e.g. CBT Therapists), Arts Psychotherapists (e.g. music, art), Clinical associate in psychology (CAPs), Advanced Placements (APs) and when appropriate, Clinical Psychology trainees, undergraduate psychology students and volunteers.

122. Since 2024 and as part of Time to Care, all adult wards have access to Art Psychotherapists. Staffing is regularly reviewed and national guidelines monitored. An Assistant Psychologist project which focused on Improving Access to Psychology was successfully piloted and from this, 9 CAPS posts were developed and approved by the executive team in April 2021 [**MK2-058: Inpatient Out of hours AP's Document].**

123. In older adult services, defined as aged 70 and over and those between the ages of 65 and 70 for patients with a frailty score of 5 and above, the Mid Essex Psychology services team have implemented a pyramid of care (Goodey, 2024) [**MK2-254: Pyramid of Care]** to organise the psychological input for an individual on the ward. The aim is to have an ethos and commitment that everyone who comes onto the ward should have psychologically and spiritually informed care.

124. An individual is tracked on the pyramid during their admission. The basic aim is that each individual will immediately be able to have psychologically informed care and for this to be imbedded in the ward culture and to be able to access therapeutic groups. Therefore, negating the need to be referred. The pyramid is comprised of the following areas:

    a. Formulation;

    b. Psychosocial Interactions;

    c. Psychological Therapeutic Groups;

    d. Team formulations;

    e. 1:1 (both direct and indirect work);

    f. Family & Carers;

    g. Multidisciplinary Team Working **[MK2-059: Ruby Ward Protocol].**

125. On discharge from the service all information will be shared with community care coordinators and where possible the psychological therapists working in the community team. Specifically for patients receiving care from Mid Essex specialist and dementia frailty service, the psychological therapies ward staff may attend community MDT meeting to feedback regarding formulation and input on the ward. **[MK2-060: Standard Operating Procedure Mid Essex Specialist Dementia and Frailty Service (SDFS) and Ruby Ward - Psychological Service]**

126. The Mid Essex psychology team working in the specialist's dementia frailty service offer patients and carers, several brief sessions to assist them in their transition from ward to their home. In Mid Essex locality, the individual art therapy may continue in the community after their discharge.

127. In Mid Essex, prior to 2011, there was no funded dedicated psychology provision to inpatient services. Between 2011 and March 2021, the resource has increased with current provision being a Principal Clinical Psychologist, Art Psychotherapist and an Assistant Psychologist. The current team offer the pyramid of care, family and carer support and participate in MDT meetings, ward reviews, discharge planning to offer psychological perspective.

128. In West Essex, there was no ward based psychological therapist staffing provision prior to 2018. Community Psychologists accepted very occasional referrals on case-by-case basis but from January 2018 until September 2023, there was an increase in psychology resource to extend the workforce that is supported by placements of Doctoral DClinPsy students, Widening Access Programme Assistant Psychologist and an MSc CAP placement to achieve minimum provision level **[MK2-061: Roding and Kitwood Wards Psychological Provision].** Staffing since this time has been kept under review in the safer staffing and Time to Care work that the Trust undertook to constantly review staffing numbers on the wards.

129. In South Essex psychology provision was in a similar position with no dedicated funded resource pre 2018, and over several years developed to the current provision supported by Time to Care (rule 9(2), (5a), (5b) funding to its establishment today **[MK2-062: South Essex Psychological Services for Older People]**.

130. The psychology team are aware of physical health co-morbidities as part of the biopsychosocial MDT admission assessments and consider the impact on patients' psychological care plans. The psychology team attend the weekly MDT ward review meeting on both wards, presenting their work with patients and families and sharing a psychological perspective on all patients. They input to Care Planning at the weekly MDT with in-patients, and their families who attend in person or virtually.

131. For those patients and family members referred to psychology they undertake specialist assessments: mental healthcare needs and risk assessments, neuropsychological assessments, which cover cognitive and mental health, and assessments of challenging needs/behaviour. The former two are usually 2-4 appointments over 1-2 weeks; the latter is usually behavioural observations and interviews across 3-4 weeks.

132. The Psychology team also have delivered training to the ward staff on person centred approaches to understanding challenging needs and provide a structure for effective interventions that keep people with dementia at the centre of care.

133. The Psychology team contribute to the MDT risk assessment. They consider the patient's choice and their own appraisal of the mental health risk and response to treatment. They also, with consent/Power of Attorney, involve the patient's family and next of kin in balancing risks against recovery, to work towards positive risk taking.

134. The Psychology team, alongside the MDT liaise with community agencies to ensure discharge plans mitigate risks where possible. The psychology 2023 service evaluation of all admissions in 2022 [**MK2-255: Psychology Service Evaluations]** found a high proportion of inpatients were not known to any mental health service prior to admission and so recognise the importance of ensuring safe discharge plans where patients will not 'fall through the net' again.

135. With regards to the North East Older people wards; there was no dedicated inpatient psychology post until March 2015. Prior to that, referrals were accepted on an ad-hoc basis for psychological assessment and therapy. The service model changed in 2015 from an older adult mental health service to an age inclusive specialist dementia **[MK2-064 Psych Services in NE Essex edited Report from 2009].**

136. Other members of alternate therapists can be part of a unit's multi-disciplinary team such as Art therapy, Dance and Movement therapy, Gym and Fitness instructors. Each member of the multi-disciplinary team introduces themselves to patients informally when they first meet them on the ward and then formally as part of their first care weekly review **[MK2-065 Standard Operating Procedure North-East Specialist Dementia Psychology Service].**

137. Most of psychology work is completing assessments that are aimed at understanding onward psychological needs, risk, and care/intervention needs based on formulation. The approach used is mainly Acceptance and Commitment Therapy (ACT) and Cognitive Behavioural Therapy (CBT), as well as aspects of systemic and integrative models. EMDR (Eye Movement Desensitisation and Reprocessing) can be provided but there a low need this service currently. The psychology team support the ward in providing a trauma focused approach. Measures used in assessments include:

    a. Geriatric Depression Scales (long and short – based on engagement).

    b. Geriatric Anxiety Scales (long and short – based on engagement).

    c. Measures of grief, e.g. Inventory of complicated grief.

    d. Older Persons Quality of Life Questionnaire – short form.

e. Values questionnaire.

f. Adapted versions of the difficulty thermometer (a stroke scale, but it looks at various aspects of Activities of Daily Living and cognition that work well with OAs).

g. The Brief Geriatric Suicidal Ideation Scale.

h. When required, a measure should be taken around activities of daily living, e.g., Barthel's Index of ADLs.

138. Infrequently the following have been used:

a. Million Multi-Axial Inventory.

b. Elements of the Detailed Assessment of Posttraumatic Stress (DAPS).

c. A measure of sleep – e.g. Pittsburg Sleep Quality Index.

d. Measures of Self-Compassion.

e. Screening measures – Frontal Assessment Battery, Addenbrookes Cognitive Examination

f. A measure of medication side effects – Glasgow Antipsychotic Side-effect Scale (GASS).

g. Specific mood measures such as Young Brown Obsession and Compulsion Scale.

h. Our neuropsychological assessment battery.

139. The team are often involved in the risk assessments for patients. In managing risk, particularly at discharge, the team works with the patient to develop a crisis/emergency action plan that highlights the triggers, early warning signs, preferred/helpful strategies, what others can do to support, who is most effective at supporting them, who can they contact, what services can help etc. A discharge summary is provided by the psychology team that is added to support the discharge plan for ongoing recovery. **[MK2-149: CG24 Discharge and Transfer Clinical Guideline].**

140. A behaviour recording system **[MK2-068: Behaviour Recording Sheet]** has been developed that is based on behaviour measures such as the Overt Aggression Scale. The aim is to get a rough overview of Activating, Triggering Behaviours, Consequences (ABCs) that can then guide a functional analysis. The main aspect of the team's role is to support staff around interventions and behaviour analysis and provide 1:1 or family support frequently. The team provide support to staff around training and knowledge and have provided multiple training sessions for staff around behaviour, dementia-friendly interventions, and understanding dementia. The team have an open-door policy for support. Post incident debrief support is available for both wards on an individual and group basis.

Activity Coordinators

141. Activity coordinators work throughout the Trust inpatient units. They support patients in various activities. For instance, the Physical Health and Wellbeing Coordinator in Secure Services provides opportunities for daily exercise by a trained exercise professional, who supervises and facilitates gym exercise programs in a gym and sports hall setting. They provide therapeutic and leisure-based sports activities daily like football, badminton and walking groups.

142. The coordinator provides and supervises the bespoke exercise programmes requested by the MDT so that patients use physical health interventions to improve their physical health outcomes. A daily timetable of gym and sports use is provided to accommodate patient’s time in gym sessions and open sports sessions. The coordinator will introduce themselves to the patient on the ward or sometimes ward round and then regularly when integrated into sessions.

143. Wellbeing groups, including spirituality discussion sessions and nutritional advice, are available to patients. Participation in these activities follows medical screening clearance and includes an induction process, along with a consultation to identify physical health goals and how best to support them. The coordinator supports the Physiotherapy team in assessing a patient’s requirements for Physiotherapy intervention and support **[MK2-069: Spirituality Group Sessions].**

144. Activity coordinators engage individuals in activities that are diversional and recreational. The purpose of these activities is to reduce the negative consequences caused by boredom, mental distress, being away from their home environments.

145. Activity Coordinators are responsible for providing a positive and effective regular programme of activities that provides a predictable routine and structure to the ward, supporting patient's physical and mental wellbeing. The activities will run daily on the wards, including weekends and evenings and around other scheduled happenings on the ward e.g. lunch, MDT meetings, therapy sessions, assessments etc.

146. Patients will have a choice about participating; the Activity Coordinators and members of MDT will explain the therapeutic benefits of taking part.

Occupational Therapists

147. Occupational Therapists in older adult services will identify individual skills, deficits, strengths, weaknesses, challenges and develop modification to the home and environment and provide compensatory and environmental strategies to both patients and their careers.

148. In Adult In-patients, Occupational Therapists assess, formulate and provide recommendations regarding mental and physical functional ability of patients, ability to undertake life skills and activities of daily living necessary for independent living, with or without additional support and/or adaptations.

149. During admission, OT assessments include:

    a. Initial assessment/screening tool/information gathering to determine baseline functioning.
    b. Support engagement in meaningful activity.
    c. Model of Creative Ability (MOCA) assessment, review/functional levelling.
    d. Review equipment provision and environmental needs.
    e. Discharge planning – Transition assessment in preparation for discharge from hospital, summarise assessment & treatment and liaise with CMHT and family.
    f. Home assessment and/or equipment assessment (if required).
    g. Active daily living (ADL) assessment.
    h. Group intervention for example: snooker, gardening, walking, seated exercises, board games.
    i. One to one interventions.
    j. Equipment provision; linking with social care or housing provider.

k. Psychoeducation (one to one/group); including DBT with psychologist.

l. Discharge preparation (facilitated at in-patient units).

m. Voluntary/education/employment support.

n. Activities of Daily Living skills – e.g. budgeting, domestic skills, cooking/meal prep, self-care.

o. Social integration: social group/leisure group/coffee morning.

p. Physical health interventions.

Physiotherapy

150. Patients on inpatient units receive physiotherapy intervention if an MDT referral is made. Referrals are made verbally via MDT meeting or emails, or through electronic clinical systems. The physiotherapy input may vary from in-house provision or through the acute care provider across Essex similar to access for primary care patients. Following referral, patients receive holistic physiotherapy assessment and individualised physiotherapy management care plan.

151. Care plans for treatment and management are extensively discussed and worked on in conjunction with the MDT care plan. Based on individualised holistic assessment, clinical analysis and its outcome, physiotherapy treatments are offered either through individualised one-on-one treatment and/or through group exercises.

152. The goals of assessment and interventions are to improve patients' mental and physical health as well as safe discharge planning. Falls assessments, mobility, balance and strengthening exercises are completed and care planned based on initial assessment and reviewed with MDT.

Dietetics

153. Patients receive dietetic intervention depending on MDT referrals. The Trust can access specialist dietetic support from professionals for patients when there is clinical need. Referrals are made through electronic clinical systems and MDT meetings, which like physiotherapy vary from in house provision or through the acute care provider across Essex, in the same way as a patient in primary care would access the service. The dietitian will work with the rest of the MDT team to help patients eat well and develop a positive relationship with food, using tools and techniques, such as behaviour change, motivational interviewing and mindfulness.

154. Dieticians can support children and adolescents, adults, or both. Some dietitians will work in one specialist service such as eating disorders while others have split roles across several services. Dietitians working with forensic mental health hospitals provide nutritional care to service users residing on the hospital's ward.

155. Some individuals with learning disabilities may require nutrition support, including tube feeding, due to difficulties in chewing, swallowing, or complex medical conditions. Dietitians collaborate within multidisciplinary teams to assess nutritional needs, formulate appropriate enteral nutrition plans, and provide education and support to caregivers **[MK2-246: Dietetic Practice Based Learning in mental health, eating disorders and LD, 2024]**

156. Following a referral, patients receive specialist dietetics assessment and individualised dietetics management care plan. Care plans for treatment and management are extensively discussed and worked on in conjunction with the MDT care plan. Based on the individualised assessment, clinical analysis and its outcome, dietetics treatments are offered either through individualised one-to-one treatment and/or through group activity.

Speech and Language Therapy

157. The Trust has access to specialist Speech and Language Therapists that help a number of different mental health conditions. Some patient's social and communication skills may have suffered as a result of their illness. Speech and language therapists support and help patients overcome these issues by thinking about communication in a different way or by offering solutions to their difficulties. Some patients suffer from a change in their ability to swallow meaning a speech and language therapist will be able to assess this and plan treatment accordingly.

158. Speech and Language Therapy (SALT) service provides two types of assessment:

- Communication assessments – SALT provide support to ensure patients can understand their diagnosis and treatment options, express their views and access talking therapies as part of care

- Dysphagia assessments – difficulties with eating, drinking and swallowing.

159. SALT support patient safety by reducing the risk of swallowing problems, which can lead to malnutrition, dehydration, choking or aspiration pneumonia.

160. Speech and language therapy for mental health problems may include assessments, reviews, reports, therapy programmes, groups, training, advice and education. SALT provide support to families to increase understanding of communication needs and safe eating.

161. People with speech, language and communication needs (SLCN) may need support to make informed decisions because the communication difficulties can make it more difficult for people to understand, think and talk about decisions. Speech and language therapist play a key role in supporting people to make decisions, demonstrate their mental capacity or express their wishes and preferences about different decision options.

Social Workers

162. The social workers work within the MDT team and their role helps empower patients to live the life they want. Social workers help patients navigate the things that matter to them like financial security, relationships and housing for example – all of which can have a profound impact on mental health. They connect patients with community resources, such as support groups, to enhance their access to essential services and help develop care packages to meet their needs. By taking the lead in discharge planning, social workers aim to smooth the transition from hospital to home, ensuring patients can safely function in their usual environment.

163. The social workers meet patients on admission, unless they are too unwell to do so. The social workers see the patients at ward rounds depending on the individual unit's frequency, which ranges from weekly to fortnightly. They would also see the patients whenever they need to for issues such as benefits, family visits, looking at accommodation needs or whenever the patient request for the social worker to meet with them. Social workers are employed by the County Council and the Unitary Authorities.

164. Social workers help patients to assess their needs and co-create a unique care plan to help them achieve their goals. This includes pre-discharge planning work, arranging funding to provide direct support or to see friends and family.

MDT approach

165. Each member of the team will have planned formal interactions that are scheduled as well as informal opportunities on the ward depending on acuity. The frequency of

interactions is at a minimum of weekly for formal reviews through ward rounds, care reviews, multi-disciplinary meetings and key worker interactions, and informally during every shift that they are on the ward. Patients can request additional meetings with any member of the multi-disciplinary team and depending on their acuity; this may be more frequent according to their needs.

166. New members of staff on the ward introduce themselves formally at the patient's first review meeting during the week that they start or informally during their first interaction with the patient whilst on shift. Staff will repeat this on the patient's first ward round.

167. Patients are made aware of the roles of the team at the first review at the first review meeting and whenever a new member of staff meets the patient. This is supported by the name badges that staff wear and by the staff uniforms that are worn by the nursing staff. Uniforms are colour differentiated according to the seniority of the staff member and are displayed on the safer staff boards on the wards that the patients have access, and which is updated every shift.

168. The minimum level of contact with the consultant psychiatrist is set within the standards by the Royal College of Psychiatrists, which EPUT adheres to **[MK2-023]**. Patients are seen on a ward round as a minimum expectation, which take place weekly or fortnightly depending on the unit that the patient is on and the needs of the patient. Each patient's discussion on the ward round takes 30-45 minutes. Patients' and as appropriate families are included in these meetings

169. In general, on acute admission wards, the patients are seen more frequently than this and sometimes can be daily depending on their acuity or care needs. This could be hourly for a patient that is very unwell and needs close oversight of care. Patients are seen by consultant psychiatrist and doctors working on the ward and the multi-disciplinary team.

170. In some of the units, the Consultant Psychiatrist is co-located at the unit and therefore accessible on site. There is a dedicated Consultant per ward for adult inpatients. The assessment units have more than one Consultant.

Assessments

171. All patients on the ward receive a comprehensive holistic health assessment during admission, which includes mental and physical health, spiritual beliefs, cognitive health and behavioural elements, as well as social and personal circumstances which is

undertaken by the multi-disciplinary team. In addition to this core assessment that every patient receives some patients may require more specialist assessments for their needs. These include;

a. Initial assessments may include attention deficit hyperactivity disorder - if the patient seems restless, may have trouble concentrating and may act on impulse. Although this is not a routine assessment for inpatients.
b. Comprehensive assessments for Autism Spectrum Disorder are less common during periods of acute mental health crisis, as the individual's current level of distress may limit the reliability or feasibility of such evaluations.
c. Cognitive assessments may be considered when appropriate.

Treatment

172. Treatments on the wards include pharmacological, psychological and social interventions.

173. Psychological treatment options available include:

a. Cognitive behaviour therapy – this is a talking therapy that can help a patient manage their problems by changing the way they think and behave.

b. Anxiety management training - this form of intervention is based on cognitive behavioural therapy principles and helps the patient to understand the impact of anxiety and its relationship with physical symptoms and how to manage them better.

c. Couples' Cognitive behaviour therapy – this aims to strengthen partners' communication skills to allow partners to safely disclose their needs and emotions, without risk of their partner's negative reactions.

d. Art therapy - this therapy uses art as a way to help individuals express themselves and address their emotional problems.

e. Psychodynamic Psychotherapy – Based on the psychoanalytic principles exploring patients' previous experiences and its influence on the current situation. There were multiple types of psychodynamic psychotherapy available to the patient.

f. Family Therapy - the type of psychotherapy that focuses on improving the communication within the family unit thereby bringing positive changes to the patient as well as the rest of the family.

g. Eye Movement Desensitisation and reprocessing (EMDR) - helps a patient process and recover from past experiences that are affecting their mental health and wellbeing. It involves using side to side eye movements combined with talk therapy in a specific and structured format.

h. Flash technique - this technique involves having the patient at least partially resolve a traumatic memory without consciously engaging it. This has been provided on the mother and baby Unit.

i. Alternative therapies – Art, Gym and fitness, Dance and movement, Cooking, Yoga.

174. All units recall having multi-disciplinary teams throughout the relevant period. Available treatments are offered to inpatients from a multi-disciplinary team of nursing, medical and allied health professional team, this has changed little over this period. Allied health professionals include Occupational, Art, Music, Dietician and Physiotherapists and they provide system-wide care to assess, treat, diagnose, and discharge patients across all health and social care. An Allied Health Professional describes a large cluster of health care related professions and personnel whose functions include assisting, facilitating, or complementing the work of physicians and other specialists in the health care system. All these therapists have been or are providing care to inpatients in EPUT across the services. Inpatient units have activity co-ordinators that schedule activities on the wards offering a holistic approach to treatment including physical health.

175. Treatment has always been offered as therapeutic programmes on the wards and those programmes are often a mix of informal and formal activities. For some inpatients, 1:1 psychology may be provided, and others will benefit from group psychological programme that is patient led longer-term psychological work in the community.

Medication

176. The arrangements and provision of medications have seen significant change over the relevant period and are summarised in the following paragraphs for context and changes. Exhibited documents in this section are from pharmacy shared and personal folders and may not be the final version that was discussed at Executive Team and other

committee meetings. The recommendations they contain may also not have been fully adopted, so sensibly the minutes of the relevant meetings should be referred to for the definitive position. A detailed account of pharmacy services over years that has been provided in this statement is contributed by the Chief Pharmacist, who has been working in EPUT and predecessor organizations for a prolonged period.

177. Prior to April 2010, pharmacy services were provided to SEPT via Service Level Agreements with the pharmacy departments at Basildon & Thurrock University NHS Foundation Trust (BTUH) and Southend University NHS Foundation Trust (SUHT). Services were provided from the main pharmacy at Basildon Hospital and a dispensary at Runwell Hospital. The in-house service went live in SEPT in April 2010 **[MK2-071: SLA Review ET 03.02.09; MK2-072: Tender outcome ET 16.02.09; MK2-073: Pharmacy Services ET 18.08.09; MK2-074: Services ET 23.02.10].**

178. Prior to February 2011, pharmacy services were provided to NEP via Service Level Agreements with Colchester Hospitals University Foundation Trust (CUHFT), Mid Essex Hospitals Trust (MEHT) and Princess Alexandra Hospital (PAH). In January 2010, NEP agreed to the development of in-house pharmacy services.

179. Services transferred in a phased manner from the three acute trusts starting with Marlborough House (MEHT) in January 2011 and followed by CUHFT in March 2011 and Princess Alexandra Hospital in April 2011. The Chief Pharmacist led the process **[MK2-079 Pharmacy Services EMT 05.12.11].**

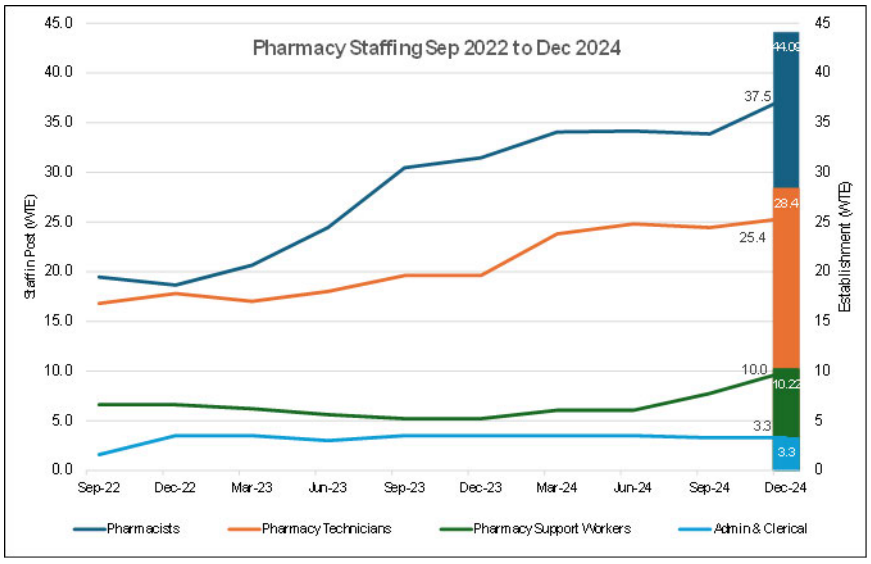
180. The current Chief Pharmacist took on the role of Interim Chief Pharmacist for NEP in addition to the equivalent role in SEPT in the period leading up to the merger between SEPT and NEP to create EPUT **[MK2-080: Chief Pharmacist ET 20.09.16].**

181. By mid-2022, staffing levels within EPUT pharmacy services had reached a critical point with overall vacancies above 15% for 13 of the previous 24 months. By June 2022 50% of pharmacist posts were either vacant or working out their notice and 25% of the pharmacist workforce had resigned over the previous three months. This was felt to be a cumulative consequence of the efficiency savings required post-merger and the impact of the COVID-19 pandemic.

182. The pharmacy Business Continuity Plan was enacted in response to the lack of staff, resulting in a significant reduction in service provision to wards, teams and clinics, particularly in relation to clinical pharmacy services. Only activities relating to dispensing/supply, immediate patient care and safety critical tasks continued at that time

[MK2-085: Staffing ET 03.06.22; MK2-086: Staffing ET 04.10.22; MK2-087: Staffing PECC 23.02.22; MK2 – 088: Staffing PECC].

183. The NHS Long Term Workforce Plan (NHS England, 2023) aims to grow pharmacy technicians in future years to meet the demand for pharmacy services. The situation has been reflected in the Trust Corporate Risk Register since 2022, although the level of impact and those tasks covered by the business continuity plan have reduced over time. Shortages of pharmacy staff is a national issue, which makes resolution more challenging. As of December 2024, vacancies continued to account for 9.9% of posts, although staff are expected to fill several of the remaining vacancies over coming months. Community pharmacy closures have released some pharmacists into the market and the recruitment situation appears to have improved over the last 6 months.



Storage of medicines

184. In May 2015, a brief appraisal of medicines storage areas within all SEPT inpatient wards was undertaken, which identified those areas which already had air cooling facilities in their clinic rooms, along with other issues relating to medicines storage. Capital funding was agreed to support compliance with the Department of Health recommendation that drug storage areas be mechanically temperature controlled, the British Standard pertaining drug cupboard locks and the storage requirements of the Misuse of Drugs Act **[MK2-089: Storage CPPG21 July 2015].** After the creation of EPUT a similar audit was undertaken in April 2017 in North Essex which resulted in an equivalent programme of works to that undertaken in South Essex two years earlier **[MK2-090: Storage ET 31.10.17].**

Administration of medicines

185. Processes relating to the administration of medicines are detailed in the Trust's Procedural Guidelines for the Safe and Secure Handling of Medicines, which is closely aligned to original Duthie Report and subsequent revisions of that guidance. In SEPT, the procedural guideline for the safe and secure handling of medicines was CLPG13, which sat under a brief policy CLP13. Versions of this document appear to have been in place since before 2003, as a 2007 approved version of the policy refers to a first amendment date of 22.01.2003 [MK**2-091: CLP13 & CLPG13 Oct 2007].**

186. Administration was detailed in section 21 and medicines could be administered by the following staff:

    a. A registered nurse;

    b. A student nurse accompanied and supervised by a registered nurse;

    c. Trained designated care staff;

    d. A qualified associate nurse practitioner;

    e. A student associate nurse practitioner accompanied and supervised by a registered nurse.

187. Section 22 defined the procedure to be followed for the administration of medicines, while section 23 related to self-administration by patients. Section 31 provided specific guidance for staff working in units without full time registered nurses.

188. Medicines management training was defined as 'core practice' training with an update interval of three years. Delivery of the first course was direct, with e learning thereafter.

189. A report to the Executive Team in February 2009 indicates that CLPG13 was updated to remove 'designated carer' from the list of people in section 21 authorised to administer as the Trust no longer ran units which did not include a qualified nurse. Guidance for the management of medicines in such units (section 31) was removed at the same time [**MK-092: CLPG13 Feb 209].**

190. During 2008, discussions took place, which recommended that medicines management training, which had been cut from a full day to half-day course in 2007, should return to a full-day course with the introduction of additional e-learning elements relating to medicines calculations and rapid tranquilisation. Medicines management returned to a full day training course by 2009 including policy, calculations, physical health monitoring

and rapid tranquilisation **[MK2-093: Medication Training ET 04. Aug; MK2-094: Medicines Training Programme 2009].**

191. By April 2010 medicines management training had been enhanced to include an observed assessment of a medicines administration round undertaken by senior nursing staff trained by the pharmacy team **[MK2-095: Medicines Management Assess 1; MK2-096: Medicines Management Assess 2].**

192. In April 2010, SEPT implemented an in-house pharmacy model for dispensing/supply and clinical pharmacy services. At approximately the same time, the Trust acquired mental health services in Bedfordshire and Luton, which had previously been provided by Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust (BLPT). Minor amendments were made to CLPG13 at that time, although a longer-term programme was put in place to integrate the policies across Bedfordshire, Essex and Luton. The April 2010 update made no changes to the arrangements for administration and reflected the training requirement of direct learning with competency assessment by observation and e-test **[MK2-097: CLPG13 May 2010].**

193. This integration process was completed by early 2012, although interim documents were adopted and operated in Essex (CLPG13a) and Bedfordshire and Luton (CLPG13b) each based on the prior local version. Compared with earlier versions more detail was provided in relation to staff permitted to administer medicines (section 15) and the procedure for undertaking a medicines administration round (appendices 13 & 14). The training requirements remained direct learning with competency assessment and e-test (section 22) **[MK2-098: CLP13 ET 17.01.12; MK2-099: Draft CLPG13 Integrated V1.4].**

194. Between 2013 and 2015, the approval process for policies and procedures changed, and thereafter they were approved by the Clinical Governance and Quality Sub-Committee. Updates to CLPG13-MH was made May 2015, June 2016 and November 2016 but made no changes to staff responsible for administering medicines or the required qualifications, experience or training **[MK2-100: CG&QSC CLPG13 – MH May; MK2-101: CG&QC CLPG13MH & CHS; MK2-102: CG&QC CLPG13MH & CHS Nov].**

195. The NEP medicines policy consisted of 25 documents (‘tabs’), with Tab 1 reflecting general standards for the management of medicines. Section 19 of Tab 1 required that medicines be administered by two people, one of who must be a registered nurse or medical practitioner. Further details on administration were provided in Tab 7, which stated that the second should ideally be a registered nurse, but could be a care assistant,

support worker, pharmacist, pharmacy technician or doctor **[MK2-103: MedPol Tabs 1-21 Jan 2017].**

196. Following the creation of EPUT, an updated policy and procedural guideline for the safe and secure handling of medicines was adopted in May 2017, which largely reflected the old SEPT documentation. Some parts of the old NEP Medicines Policy where not incorporated into CLPG13 but handled in different ways. A separate procedure guideline for handling medicines in the two units registered as nursing homes (CLPG13-NH) was approved in September 2017.

197. In 2023, the policy and procedural guidelines were reviewed, updated and combined into a single medicines policy incorporating the safe and secure handling of medicines across all settings except trust units registered as nursing homes.

198. Since the development of in-house pharmacy services in 2010 in South Essex and 2011 in North Essex (see section 1), clinical pharmacy services have been provided to inpatient wards.

199. Clinical pharmacy is intended to promote the safe, clinically appropriate and cost-effective use of medicines. To achieve these aims, pharmacists and pharmacy technicians work closely with medical and nursing staff and are ideally ward based or spend a significant proportion of their time in a clinical setting. Pharmacy professionals review prescription charts for accuracy and completeness, identifying drug incompatibilities, providing advice to the healthcare team and to patients, and assessing the pharmaceutical needs of individual patients. This enables pharmacists to make a comprehensive assessment of medication and individual risk factors, thereby helping to optimise the therapeutic management of each patient.

200. It is a legal requirement that a pharmacist clinically checks a prescription before the dispensing process is completed, regardless of whether the prescription is written for an inpatient or outpatient. This clinical check assessed safety and therapeutic effectiveness, which can be affected by patient factors, type of medicines involved, administration and monitoring requirements.

201. Professional judgement is applied to factors such as patient demographics, weight/height, allergy information, drug-patient and drug-disease state factors, indication, dosage and frequency, monitoring requirements and risk assessment, formulation, licensed/unlicensed status, formulary status, ethnicity, renal/liver impairment, falls risk, child-bearing potential, intolerances (i.e. lactose, gluten) and dietary and religious preferences (i.e. vegetarian, pork-free, observing Ramadan).

202. The legal status of prescriptions will also be checked both in relation to medicines legislation, including the Misuse of Drugs Act, and the requirements of the Mental Health Act in respect to consent to treatment.

203. Pharmacists and pharmacy technicians will intervene to clarify prescription charts, promote efficacy or economy or to prevent or reduce adverse effects. This will include annotating prescription charts (whether paper or electronic) to provide information on correct administration (timing in relation to food, swallow whole for modified release preparations, etc.). They follow up with nursing or medical colleagues on information that may be missing, for example, pregnancy or breastfeeding status in perinatal patients, blood plasma levels in patients receiving drugs where therapeutic monitoring is required.

204. Pharmacists and technicians also work directly with individual patients, to help them understand the importance of taking their medicines, discuss side effects they may be experiencing, other concerns they may have about their medicines and help to improve adherence. They also work with groups of patients, relatives or carers to provide more general education on how certain groups of medicines work (e.g. antidepressants, antipsychotics, lithium), things to look out for (i.e. side effects and interactions) and to help support adherence.

205. The ideal setting for provision of clinical pharmacy advice to prescribers is the ward round or multi-disciplinary team meeting so that interventions can be made when an initial decision to prescribe is being taken, or medicines regimen reviewed.

206. The way that pharmacy services are set up in EPUT and in both SEPT and NEP before it, divides staff between a central dispensary and those who are based on clinical sites across Essex, as displayed in table 4. This is intended to provide easy access to wards/clinics by pharmacy team members and good access to pharmacy staff for other clinicians.

Table 4: Trust dispensary locations

	SEPT	NEP	EPUT
Main dispensary	Rochford Hospital	Chelford Court, Chelmsford	Chelford Court Chelmsford
Satellite Dispensaries	Basildon MH Unit	-	Basildon MH Unit Kingswood, Colchester

Ward Based Staff	Rochford Hospital Basildon MH Unit Brockfield House, Wickford	The Lakes, Colchester Linden Centre, Chelmsford Derwent Centre, Harlow	Basildon MH Unit Brockfield House, Wickford Kingswood, Colchester Linden Centre, Chelmsford Derwent Centre, Harlow St Margaret's, Epping
Community Based Staff	-	-	Grays Hall, Thurrock Resource Centre, Brentwood The Gables, Braintree Rochford Hospital Derwent Centre, Harlow

207. In the two years post-COVID pharmacist vacancies rose dramatically, and it is only in 2024/25 that input to wards has started to return to pre-merger levels.

208. In addition to the interventions from the pharmacy staff, the medical team regularly reviews the patient during their inpatient admission. The choice of the medication is based on the available clinical information at that time and the accepted national guidance such as NICE, evidence based prescribing practises in line with British National Formulary (BNF) and the local prescribing policies.

209. During the regular reviews, the patients are asked about their views and experiences with the prescribed medications. This may also be checked by the nursing staff at the time of administration of the medication or interpreting secondary evidence such as blood levels. The response to the treatment will also be carefully monitored to make decisions on adjusting the dosage or changing to alternative treatments. Any adverse reactions reported by the patient or noted by staff are recorded within the clinical notes and appropriate measures are taken to rectify them.

210. This may include stopping or reducing the dose of the medication, providing measures to alleviate the side effects / adverse reactions or in severe cases seeking immediate

medical help from General Hospital if needed. The national mechanisms for reporting adverse reactions using the 'yellow card' procedure will also be followed if deemed appropriate.

211. Mental health services are often located in an environment where many of the nursing staff have trained and worked in psychiatry. As part of the Time to Care initiative, implemented in 2024, EPUT has invested in more general nursing posts, to improve the management and treatment of physical health conditions. Pharmacists are able to provide advice on the pharmacological management of conditions such as diabetes, asthma, cardiovascular disease and infections to prescribers and those administering medicines.

Formulary and Prescribing Guidelines

212. Recommendations on preferred drug treatments for commonly encountered clinical conditions are provided in the Trust's Formulary and Prescribing Guidelines (F&PG). These are intended to rationalise the range of products used with the organisation based on efficacy and side effect profiles compared with other drugs in the same therapeutic class. Prescribers are advised to refer to the British National Formulary (BNF) and the Summary of Product Characteristics (SmPC) for dosages, contraindications and side effects. Cost is considered where there are several drugs of similar efficacy and safety. The Trust's Formulary and Prescribing Guidelines (F&PG) for mental health or community services can be accessed via the staff intranet.

213. The F&PG has always been a dynamic document and is frequently updated in response to the latest national guidance and information. Reasons for updates include, but are not limited to changes, to:

    a. Guidelines, Technology Appraisals and Quality Standards published by the National Institute for Health and care Excellence (NICE).

    b. Guidelines published by the British Association of Psychopharmacology (BAP).

    c. MHRA Drug Safety Updates.

    d. NHSE Patient Safety Alerts.

    e. Changes to the marketing authorisation (product licence) of drugs.

    f. Newly licensed drugs and formulations of existing drugs.

g. Alterations to recommendation in the Maudsley Prescribing Guidelines and Psychotropic Drug Directory.

h. Decisions made by the Medicines Optimisation Committees of commissioning organisations about drug choices.

214. The Formulary & Prescribing Guidelines are available to prescribers on the Pharmacy and Medicines Management pages of the Trust intranet. It can also be accessed by healthcare professionals, patients and the public on the Trust's public website.

Clinical Guidelines relating to medicines use

215. In addition to the Formulary & Prescribing Guidelines, the Trust also operates a suite of clinical guidelines which address medicines-related topics. Frequency these arise from NICE guidelines or a Patient Safety Alert. In 2005, NICE published guidance on the short-term management of disturbed behaviour within in-patient psychiatric settings. SEPT responded with the development of a policy (CLP52) and clinical procedural guidelines (CLPG52) for rapid tranquillisation (RT) in 2006. Subsequent updates were made in 2007, 2008, 2009, 2011 **[MK2-109: CLP52 & CLPG52 ET 17 Feb 2009; MK2-110: CLP52 ET March 2011].**Title of the documents were changes in 2012 to use the terminology pharmacological management of acutely disturbed behaviour rather than rapid tranquilisation. Further updates were undertaken in 2013 **[MK2-111: CLP52 & CLPG52 ET 17 Jan 2012; MK2-112: CLP52 & CLPG52 ET Jan 2013].**

216. CG52 (SEPT) and Tab 9 (NEP) were integrated to form a new EPUT version in June 2017 and updated in October 2017, January 2020 and September 2023 **[MK2-114: CG52 CG&QSC June 2017; MK2-115: CG52 CG&QSC Sept 2023].**

217. In December 2007, the concept of medicines reconciliation at admission was introduced by a joint NICE/NPSA patient safety alert. SEPT established a working group which developed a standardised proceed for collecting and documenting information about a patient's medicines at the time of admission. The resulting policy (CLP63) and procedure (CLPG63) were agreed at the end of that year and was then updated in December 2009 and November 2010 **[MK2-118 – MK2-120: CLP63 and CLPG63].**

218. As full medicines reconciliation is intended to be a pharmacy-led activity this was accompanied by a pharmacy standard operating procedure (PHARM-D01) from the point that pharmacy services were brought in-house, which has been kept updated throughout SEPT and EPUT **[MK2-121: Pharm-DO1 V1 Medicines Reconciliation].**

219. In 2012, medicines reconciliation was incorporated into the main procedural guidelines for the safe and secure handling of medicines (CLPG13-MH v2), with the content of

CLP63 provided as a new appendix 18, and CLP63 and CLPG63 were retired. It remains part of this document within EPUT.

220. During an inpatient admission, if the patient is on a non-psychiatric medication and this is confirmed within the records, it will be continued unless it is contraindicated or has serious interactions with other psychotropic medications. The physical health medications will be discussed with the patient during the review by the doctor and the relevant specialist opinion will be sought if needed prior to making any changes. The medical team works closely with the pharmacist as well as the specialist nurses in diabetes and respiratory clinical services.

Observations

221. All inpatients on admission onto the ward in EPUT are assessed and dependant on their presentation and the risk of harm they pose to themselves, or others will determine the type and frequency of observations that staff will undertake. The Trust have in place levels of observations which are used to outline the minimum frequency staff are to observe a patient on the ward. Staff may on occasions place two members of staff on one patient when undertaking observations if the risk is perceived to be significant **[MK2-029: CLP8 Therapeutic Engagement and Observation Policy].**

222. As referenced in the Rule 9 (3c) submission the Trust has engaged in the use of Oxevision, Closed Circuit Camera Television (CCTV) and Body Worn Cameras (BWC) to enhance the ability to undertake patient observations.

223. Oxevision is used as an assistive tool for staff working on EPUT wards with a view to improving and enhancing patient safety. This means Oxevision is a supplement to actual in-person observations by staff. Further details regarding Oxevision are referenced in rule 9(3). BWCs are used on the wards and switched on when an incident is taking place. BWCs are in place and used for the safety of patients and staff as is CCTV. Door top alarms are designed to raise an alarm within the ward when a door, that has the system installed on it, is used as a ligature anchor point. The Trust has had a phased approach to the implementation of BWC **[MK2-141: CG29 Clinical Guidelines on the Prevention of Suicide].**

224. Restrictive Practice (referred to in the Rule 9 request as coercive treatment) Restrictive practices (coercive treatments) may have to be used to safely manage challenging behaviours and risks to patients. Different categories of restrictive practices are explained in the next paragraph. Restrictive practices on wards are monitored though Tendable audits, which also monitor any actions from the audits and any escalations to appropriate committees.

225. Restrictive practice (coercive treatment) can be categorised into:

a. Physical Restraint- any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of another person

b. Environmental Restrictions- this is to limit people's ability to move as they might wish, such as locking doors or parts of the building. This includes the use of electronic keypads with numbers to open doors, complicated door locking mechanisms and door handles.

c. Chemical Restraint- this refers to the use of drugs to modify a person's behaviour. Medication that is prescribed to be taken as and when required can be used as a form of restraint unless applied responsibly.

d. Forced care- It refers to actions taken to compel or coerce an individual to act against their will. This may include physical restraint to enforce compliance with instructions or requests, or situations where a person is told that Section 5(4) or 5(2) of the Mental Health Act will be applied if they attempt to leave, without the formal application of those powers.

e. Cultural Restrictions- preventing an individual from following the behaviours and beliefs characteristic of a particular social, religious or ethnic group chosen by them.

f. Decision making- deciding on the person's behalf or not accepting or acting on a decision the person has made.

g. Community contact- preventing an individual from participating in community activities, including working, education, sports and community events or from spending time in the community such as parks, leisure centres and shopping centres.

h. Contact with family and friends- preventing or limiting contact with the individual's peer groups, friends or family. For example, not allowing the person to receive visitors, make phone calls or allowing them contact with specific friends or family member.

i. Blanket Rules / Global Restrictions- refers to policy rules or customs that will restrict a patient's rights and liberty that are routinely implemented to all patients within a service without an individual risk assessment to justify its application. There needs to be justification for the implementation of blanket restrictions. This is avoided unless there are specific justifications which are deemed appropriate and necessary to address the risk or risks identified for the patient, the impact of a blanket

restriction on each patient should be considered and documented in their records **[MK2-142: Explanation of blanket rules information].**

226. Deprivation of access to normal daytime clothing- patients should never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living. However, there are circumstances where it will be appropriate and necessary to use restrictive clothing to prevent risks to self-i.e. tear-resistant clothing. Where this is implemented, a rationale for this must be recorded, the patient must be informed of reasons, reviews must be evidence (including least restrictive alternative strategies), and the use must be for the shortest amount of time **[MK2-143: CLGP41 Seclusion & Long-Term Segregation Procedure Appendix 3c].** Restrictive interventions include the following within mental health settings:

    a. Physical interventions (TASI – Therapeutic and Safe Interventions)
    b. Rapid tranquillisation - administration of medications to manage disturbed behaviour.
    c. Seclusion & Long-Term Segregation
    d. Restrictive practices as explained in earlier paragraph
    e. Room searches, personal searches and rubdown/pat down searches
    f. Property searches, including bags and clothing
    g. Access to courtyards, kitchens and calm room
    h. Monitoring of communications and visits
    i. Global Restrictive Practices

227. All ward staff are trained in TASI (Therapeutic and Safe Interventions) attending initial training and subsequent updates in accordance with trust procedure. TASI focuses on aiming to prevent the use of restrictive interventions through rights based, trauma informed and person-centred values to enable staff to adhere to the principles that underpin the use of restrictive practices and aim to reduce the use of restrictive physical interventions within the Trust. Physical intervention should only take place when all reasonable steps have been taken to avoid its use. If the patient's behaviour remains unmanageable despite the efforts of verbal de-escalation and there is a risk associated

with the behaviour, staff may need to utilise physical intervention. Physical intervention should not be used for any longer than is necessary, to minimise the risk of injury to the patient or to others. [**MK2-144: RMP05 - Therapeutic and safe interventions and de-escalation (TASID) procedure].**If restraint is required prone physical restraint (held chest down to defuse an incident) should not be used other than in exceptional circumstances;

- medical reasons;
- potentially to exit from seclusion room;
- administration of prescribed medication only if other intra-muscular sites are felt not appropriate.

228. The use of supine or seated de-escalation techniques, or the controlled release of a patient, may be considered when deemed appropriate and safe. This approach allows the patient to move voluntarily to an alternative area, mutually agreed upon by both the patient and staff.

229. De-escalation is considered a secondary prevention strategy, involving techniques—both verbal and non-verbal—designed to defuse anger and prevent the escalation of aggression. While medication may form part of a de-escalation approach, the use of medication alone does not constitute de-escalation **[MK2-144: RMPG05 Therapeutic and Safe Interventions and De-Escalation Procedure].**

230. Global restrictive practices are rules or policies that restrict a patient's liberty and other rights, which are routinely applied without individual risk assessments to justify their application. The 2015 Mental Health Act Code of Practice allows for the use of Global restrictive practices only in certain and very specific circumstances and the Trust aims to balance human rights with the safety of its patients. These are more relevant within Secure Services.

231. Within secure services, restrictive practices may be part of a wider framework of physical, procedural, and relational security measures, tailored to an individual's assessed need for enhanced security due to high levels of risk to other patients, staff, or the public. These practices are governed by appropriate policies and guidelines specific to the Secure Service. **[MK2-145: CG92 – Global restrictive practices clinical guideline]**

232. At times, it may be necessary to implement a global restriction to ensure the safe operation of a ward or unit. Such restrictions may include limiting access to specific

areas when environmental risks are present that cannot be managed on an individual basis.

233. The Mental Health Code of Practice 2015 recognises that, within Secure Services, restrictions may form part of the broader package of physical, procedural and relational security measures associated with an individual identified need for enhanced security. Under such circumstances, Global restrictive practices are permissible to manage high levels of risk to other patients, staff and members of the public.

234. The Secure Services operates associated policies and guidelines, which specifically cover the range of potential Global restrictive practices, which identifies the additional restricted, and prohibited, items that are appropriate for secure services **[MK2- 145: CG92 – Global restrictive practices clinical guideline]**.

235. Within other specialist services inpatient wards, such as CAMHS, Learning Disability and Perinatal, other restricted and prohibited measures may be identified as appropriate to meet the needs of these patient groups **[MK2-145: CG92 – Global restrictive practices clinical guideline].**

236. Seclusion is only used as a last resort and for the shortest possible time. Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. Where the patient poses a risk of self-harm as well as harm to others, seclusion must be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety and that any such risk can be properly managed. The patient will remain under constant observation during seclusion. Where Oxevision is in place, the Oxevsion equipped seclusion rooms are enabled to capture patient vital signs, supporting the staff when it is unsafe to enter the seclusion room or when the patient is asleep. Staff continue to observe the patient continuously.

237. Any patients who receive rapid tranquilisation whilst secluded will have staff present all the time and physical health observation monitoring will be undertaken and recorded on Modified Early Warning System (MEWS). Where patients have received pharmacological intervention to manage the disturbed behaviour a skilled professional positioned outside of the door is to monitor and record physical health signs for any adverse reaction to medication for at least the first hour after administration or until the effect of the sedation has entirely worn off, whichever is the later. From April 2025 a

question is being added to the Person-Centred Tendable audit tool to measure this aspect which will be recorded on the Quality and Safety dashboard and be monitored through the Mental Health Quality and Safety Inpatient meeting.

238. Long-Term Segregation (LTS) refers to 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 a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis.

239. The MHA refers to Long Term Segregation in order to reduce a sustained risk of harm posed to the patient or others. In such cases it should be determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period **[MK2-003: MHA 1983Code of Practice; MK2-146: CLPG41 Procedure for the use of Seclusion & Long-Term Segregation].**

240. Following any physical intervention staff will offer the patient a de-brief to allow them time to discuss the incident, explore any contributing factors and offer reassurance and support. If necessary and appropriate this will also be offered to other patients on the unit that may have been affected**.**

241. On admission, a history is taken from the patient of any previous restraints to ensure their voice is included on what did or didn't work for them before, should this be needed whilst on the ward. This will then be added to the patients care plan so that all staff on the ward are aware of their choices, should a restraint be required. A positive behaviour support plan may be included with their community plan that has a formulation of restraint having been discussed previously. Advice can be taken from the EPUT safeguarding team which can be included in the care plan.

242. The use of seclusion and long-term segregation in psychiatric practice has evolved in the NHS during the last 20 years. With increasing awareness of the impact of such practices on patients and staff, and their implications on human rights breaches, safeguards like the 2015 revised MHA Code of Practice, (DoLS) [**MK2-005**] were brought in to ensure that these practises are monitored closely. Seclusion should only be used in hospitals in relation to patients detained under the MHA and review processes followed. In line with this EPUT requires a mandatory MDT review attended by a

responsible clinician (consultant psychiatrist) at least every 24 hours while the patient remains in seclusion. This includes weekend and bank holidays.

Recreation

243. Meaningful recreational activities on an inpatient ward are beneficial in improving engagement and therapeutic intervention. The frequency, duration and nature of the recreational activities will depend on the type of the ward and these activities are coordinated by the occupational therapist and specifically allocated ward staff. These activities included karaoke sessions, music groups, quiz sessions, newspaper reading clubs, playing cards Jenga and other indoor activities. In addition to this, where wards have the facilities to access outdoor space use of gym equipment, basketball, badminton and other games are also available.

244. As detailed in the Trust's response to Rule 9(5a), further improvements were brought in with the introduction of Activity Coordinators on all wards, who will schedule timetables for the patients on group activities that will be available for them to join if they choose. Activities that are provided by the coordinators are detailed in the service type descriptions for which are available at each specialism.

Leave

245. Patients and carers have the right to expect that appropriate arrangements are in place in granting periods of leave from the hospital. The term informal is in reference to the Mental Health Act 1983 (amended 2007) and refers to patients who are not detained under the Act and have capacity to give an informed consent to hospital admission and treatment.

246. Although informal patients have the right to leave the ward (unless the patient satisfies the criteria for an assessment under the MHA) at any time, the Trust has a duty of care towards them, including responsibility for their safety and wellbeing. Leave arrangements are discussed and agreed with the patient and/or their carers when appropriate. The Trust guidelines provide a framework for the provision of safe and appropriate leave **[MK2-067: CG45 Clinical Guidelines for Managing Leave with Informal Patients and Patients Detained under the MHA]**. Each Inpatient Service will display these rights at the entrance and exit points of each ward. Leave from hospital for patients will be seen as part of their care and treatment and will be planned with a specified duration and purpose. Leave allows the patient, any carer and the Hospital team to assess progress made and their ability to cope outside of the Hospital environment.

247. Whilst individual leave arrangements are often tailored to the specific needs of the patient and their care, some broad parameters are discussed and agreed. The place or destination of leave is often specified and may include options such as within hospital grounds or a destination in the community, including their own home. The duration is usually specified and usually range from half an hour to a few days. The level of supervision during their leave is also specified and can range from unsupervised leave to always insisting on supervision.

248. A comprehensive risk assessment is undertaken and documented prior to the commencement of leave. Any overnight or long period of leave for an informal patient is agreed with the consultant or their deputy as part of the MDT meeting. A plan of leave will include the following:

    a. Period of leave and return date and time;
    b. Contact details of the patient and carer;
    c. Contingency plan if the patient fails to return from leave;
    d. A risk assessment (including risk of absconding, risk of failure to return, risk to self or other whilst on leave and safeguarding risks) should form part of the leave plan.

249. In cases of those under 16 years of age, the person who has parental responsibility for the young person must be informed and be part of the leave agreement process. For those over 16 years, but under 18 years of age, the adult with legal parental responsibility will be made aware of leave plans. The relevant Local Authority will be consulted where a care order has been made.

250. For the CAMHS units, all young people will be able to take leave from the unit subject to an individual risk assessment carried out by the MDT. This will usually be agreed at the weekly individual review meetings. It can also be agreed outside of these times when appropriate and individually risk assessed. Any agreed unescorted leave is managed safely and in accordance with safeguarding children's procedures. **[MK2-045: Safeguarding Children Procedural Guidance]** Potential risks will be identified in Clinical Review Meetings and individual action plans agreed.

251. The Consultant/Responsible Clinician (RC) for detained patients has an overall responsibility for care and treatment of the patient on the unit, including granting of appropriate leave. The Consultant/Responsible Clinician and multi-disciplinary team (MDT) together, with the patient and/or relatives/carers will discuss leave as part of the individual patient treatment programme [**MK2-147: Section 17 Leave Form].**

252. Section 17 of the MHA 1983 makes provisions for patients who are liable to be detained under various Sections of the Act to be granted leave to be absent from hospital subject to such conditions that are considered necessary in the interests of the patient or for the protection of others **[MK2-004]**.

253. Only the Responsible Clinician (RC) can grant leave and cannot delegate the decision to grant leave to anyone else, save that in the absence of the RC (e.g. if they are on leave) the permission can be granted only by the Approved Clinician who is for the time being acting as the patient's RC.

254. Patients are granted leave in accordance with their clinical presentation and a patient centred risk assessment that takes into account all relevant factors. The granting of leave must be part of a therapeutic process, whereby the patient begins to re-engage with life in the community. Leave should normally be for short durations of up to seven days. However, the Responsible Clinician may consider granting longer-term periods of leave, if consideration has been given as to the patient's suitability/eligibility to be managed in the community under the conditions of a Community Treatment Order.

255. Any proposal to grant leave to a patient detained under section 41 (Restriction Order) of the Mental Health Act 1983 must be approved by the Ministry of Justice. Occasionally, adult and PICU wards have patients under S41 recall. Patients who are on a Restriction Order or Direction (Section 41 or 49 of the Mental Health Act, 1983) will not be granted area leave until Ministry of Justice approval is granted, except in the case of medical emergencies This process can take some time, and the patient cannot have leave until written approval has been obtained.

256. Section 17 leave should be discussed at the MDT meeting or ward round and form part of the patient's overall recovery process. The membership for this forum should include as a minimum, the patient's Responsible Clinician (RC), nurse and/or the care coordinator/key nurse on the ward, and subject to feasibility and the patient's wishes, the patient's relatives/carers should be given an opportunity to contribute to the decision-making process.

257. Where a patient is being closely observed by the ward staff on an increased level of observation, they can only be agreed leave from the ward if a member of staff is able to supervise them. However, consideration is always given to the patient's need for support and/or monitoring whilst they are on leave, whether for a day or longer. Depending on the nature and level of risks, leave outside the ward may be allowed with family or carer as part of therapeutic approaches. Such leave will be agreed as part of the MDT involving the family or carer. On occasions leave is granted to patient on level 2

observations with their family/carer as part of their treatment plan. In all instances the risks must be outlined to the family/carer sharing any concerns the ward may have. what the unit is concerned about.

Risk Management

258. Risk is viewed by the Trust as being dynamic and multi-dimensional. Its approach to risk management is not solely focused on eliminating risk, but on balancing the potential benefits of taking risks with efforts to minimise potential harm—an approach that aligns closely with the principles of mental health recovery. The Trust is committed to supporting patient recovery, with safety as a core component. This is promoted through individualised care, encouraging choice, collaborative risk assessment and management, and the practice of positive risk-taking.

259. Clinical Risk is the likelihood or probability of an adverse and/or harmful outcome to an episode of mental illness or distress, or to a particular behaviour associated with that illness or distress. Risk Assessment is the process of gathering information about a patient's mental state, behaviour, intentions, psychiatric history (current and past) social situation, and forming a judgement about the likelihood or probability of an adverse and/or harmful outcome based upon that information.

260. When managing risk, staff continuously assess a patient's mental capacity and their ability to make decisions for themselves. People with capacity may make unwise decisions and for those that lack it, decisions made on their behalf must be made in their best interests and with the least restriction.

261. Staff have to take into consideration fluctuating mental states, particularly on elder care dementia wards. Staff should ensure that their choices and wishes are respected. Risk agreements, like in other units must be regularly monitored and reviewed. In such cases, active engagement with families and carers is essential. Formulation is the application of clinical knowledge in predicting risks, identifying cues and interviewing, to bring together a formulation of risk that is used in the Trust.

262. A safety plan is a prioritised written list of coping strategies and sources of support that patients can use during or preceding crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that patients can contact to help them lower their imminent risk. Key risk/safety management/safety planning activities are part of treatment, and this approach is consistent with the Recovery Model, which views patients as collaborators

in their treatment and fosters empowerment, hope, and individual potential [**MK2-148: CGPG28 Clinical Risk Assessment and Safety Management Procedure].**

263. Clinical risk assessment and safety management is part of the CPA, as previously detailed, however, the principles apply to those under 'non-CPA' as well.

264. If a patient is admitted or transferred to an in-patient facility for assessment/treatment, the frequency of review should increase proportionately with the risks presented. The review will involve the MDT and any other specialist or professional input as appropriate. An assessment of risk is reassessed/reviewed routinely every two weeks for secure services patients and in ward-round for inpatients. The Trust's minimum requirement for risk assessment is the completion of the screening tool and documenting in the patient's electronic records for the service.

265. Managing risk and ensuring therapeutic care is getting the right balance to ensure the recovery process is maintained for the patient. The risks can fluctuate and is often influenced by their mental state, comorbid use of substances, situational cues as well as their response to previous traumatic experiences. As part of the therapeutic engagement these risks are assessed regularly and following discussions with the patient as well as the family (if appropriate) a plan is agreed to manage them.

266. All inpatients are discussed in the multi-disciplinary team meetings and the care and the risks they present with, are reviewed. On admission, their risk is generally higher and after a period of treatment, as their symptoms improve, the risk may decrease.

267. This may lead to a reduction in their observation levels and an increased opportunity to participate in activities that interest them. It is important that risk assessments acknowledge the reduction of risk when this occurs, and the factors which have helped the patient in reducing their risk should guide the formulation of future risk/safety management plans.

Transfers

268. Safe and effective transfer of care should be undertaken with minimal disruption and risk. All transfers should be planned and managed in a sensitive way, ensuring all communication is clear to the patient, their relative/carer, referrer and the receiving service. The patient should be fully informed, and if able to do so, agree to the transfer prior to the transfer taking place. This must be documented in the patient's record. In

transfer of a patient below the age of 18, those with parental responsibilities for the child must be consulted. [**MK2-149: CG24 Discharge and Transfer Clinical Guideline].**

269. Following the decision to transfer a patient, the decision should be documented in the patient records along with the rationale for the transfer. The transferring team/clinician must ascertain who will take medical responsibility and act as responsible consultant/medical practitioner. The patient will be identified as medically and mentally (where applicable) well/fit for transfer by the medical team with recognised authority to do this.

270. Where the transfer is from a ward to another ward the process for transfer of clinical information is undertaken. The ward qualified staff will ensure that all medicines that have been individually dispensed for the patient are sent to the new ward along with their property.

271. A risk assessment must be completed prior to every patient transfer, to determine the appropriate mode of transport required, such as a secure vehicle, ambulance, taxi or private cars. The risk assessment must include number of staff required for escort and band to effectively and safely carry out the role of escort **[MK2-148: CGPG28 Clinical Risk Assessment and Safety Management Procedure].**

272. In secure services, the process for inter-ward transfers differs in that, for restricted patients, authorisation from the Ministry of Justice may be required. This must be clearly documented in the patient's record. Before a decision is made to move a patient within the service, the case must be discussed in a Multi-Disciplinary Team (MDT) meeting. The aim is to ensure that this process is carried out in a timely and safe manner, taking into account all aspects of care and treatment. Wherever possible, the patient's views are considered, and with the patient's consent, families are also informed. **[MK2-150: SSOP04 Protocol for Inter Ward Transfers within the Secure Services].**

273. A secure services patient considered for transfer by the MDT, while stepping down to a lower secure provision, should first be considered for socialisation and familiarisation or trial leave on the receiving ward. The admitting ward must formulate a socialisation care plan which must be transparent to the patient and the referring team. Following a decision by the MDT, the ward where the patient is to be socialising must be contacted and senior nurses must decide upon a named nurse on the receiving ward.

274. Following this, a decision from the interview and collection of information will then be discussed in the MDT meeting and a decision made as to whether the socialising is

appropriate, how often the patient will visit and for how long. Any problems or concerns encountered during socialisation visits will be discussed in the next MDT meeting.

275. There are many commonalities in the inpatient services pathways when there is a need for a patient to transfer into or out of the units. Transition may be one of the reasons for a transfer internally between units. This can be a transfer from Child and Adolescent Mental Health to Adult Mental Health services or similarly from Adults to Older Adult mental Health Services.

276. An inpatient may be transferred internally or externally for either a step up or step-down need for treatment. Inpatients in CAMHS, MBU, and Adult and Older Adult Services, may be stepped up to a Psychiatric Intensive Care Unit (PICU) or stepped down to a less intensive setting, depending on their clinical needs. Inpatients in secure services may step up or down internally between low and medium secure services or externally step up to high secure services, or be remitted back to custody.

277. An inpatient may transfer internally or externally to be closer to their home, particularly if their initial admission was to a specialist unit.

278. On rare occasions, there may be a need to move an inpatient to a different ward of the same speciality because of a safeguarding incident between two patients on the same ward. This is usually undertaken when there is a need to protect one patient from another patient.

279. An inpatient may be transferred to a general hospital to receive specific physical healthcare, such as cancer treatment. Transfers may also occur for specialised care needs not provided within the Trust's services, such as admission to an eating disorder unit.

Care planning

280. EPUT uses the Care Programme Approach (CPA) that provides a framework for care coordination and communication and is fundamental to the provision of a person-centred mental health service.

281. The care plan objectives are delivered in a coordinated approach within an integrated partnership between primary care, secondary care, voluntary services and nominated family and friends of the individual patient receiving a service. The assessment evaluates the patient's individual strength's, taking into consideration what coping strategies have worked in the past and identifies areas of need including finance, housing and occupation.

282. Risk management is key in forming part of the plan and individualised care plans are developed with the patient. Interventions will include 1:1 protected time with staff, attendance of individual or group therapies, use of medication and discharge planning. The welcome booklet given to patients on admission at the appropriate time provides details on Care Programme Approach for those patients that have one.

283. The booklet has information for the patient about the Wellness Recovery Action Plan (WRAP) in place that is developed with them and will accompany them home. This will help the patient to identify any early signs that that may mean they are becoming unwell and what they and their community care team should do to prevent them becoming more unwell. The patient will have a plan in place should they become unwell **[MK2-014: Welcome Pack V6 Inpatient Services; MK2-151: My Care My Recovery Care Plan; MK2-152 My Care, My Safety Plan].**

284. A patient may have already made a plan in addition to the current care plan where there has been a history of aggression or requiring restraints and about how they would like to be cared for, so their voice is included. Some patients may already have a community plan or a formulation or a positive behaviour support (PBS) plan where their history has been spoken about and discussed previously. These are created to help understand and support children, young people and adults who display behaviour that others find challenging. They are designed to guide those caring for them in their responses and actions at times of distress. Patients are involved when making decisions about their care.

285. These plans should be implemented alongside a risk management plan. The two plans will proactively and reactively manage risk and support the reduction of restrictions.

286. Care is planned and regularly reviewed with the person and their chosen carers so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission. This includes purposeful care in a therapeutic environment to support patients to get better quicker and reduce avoidable time spent in hospital **[MK21-53: CLP30 CPA Policy].**

287. The care is planned to deliver therapeutic activities and interventions and to optimise medication regimes that support the patient. Care plans are reviewed to ensure that they meet the purpose of the admission. Every ward has a multi-disciplinary team meeting where all disciplines are represented. In the meeting the purpose of inpatient admission, current presentation including risk, as well as the patient's history profile and its impact on their mental health, behaviour, and engagement is discussed.

288. The Trust is currently introducing the International Fundamentals of Care Framework, which outlines what is involved in the delivery of safe, effective, high-quality fundamental care, and what this care should look like in any healthcare setting and for any care recipient. The Framework emphasises the importance of nurses and other healthcare professionals developing trusting therapeutic relationships with patients and their families/carers. It also emphasises their needs and psychosocial needs. [**MK2-006].**

289. The patient's care plan is co-created with them and is personalised to their needs and reviewed and updated with the patient on a regular basis. Families and carers are involved in the process to ensure shared decision making with the patient is at the centre of their care. Inpatient wards have started to introduce lived-experience ambassadors to assist the nursing teams in understanding mental health inequality and ensuring we are meeting the needs of patients, families and cares from all diverse communities. Lived Experience Ambassadors are volunteers with lived experience in the work the Trust does to ensure patients and carers are central to the development of services and the organisation.

290. In secure services, Peer Support Workers have been recruited at Edward House. The Inpatient Peer Support Team launched in March 2023 and work alongside clinical staff at Essex Partnership University NHS Foundation Trust (EPUT) to support patients through their care and recovery. The team have expanded from 5 to 21 as of May 2024, and many more are being trained to be peer support workers.

291. The patient's Named Nurse and key worker are responsible for coordinating the care plan, with contributions from members of the multi-disciplinary team. Each professional may also maintain individual care plans relevant to their area of work, which are integrated into a single, comprehensive care plan. This care plan is part of the electronic patient record for each Trust area, and a paper copy is provided to the patient. **[MK2-151: My Care My Recovery Care Plan; MK2-152: My Care, My Safety Plan; MK2-192: My Shared Pathway].**

292. Formulations discussed within the multidisciplinary team are documented in the care plan to provide a shared understanding of the patient's experiences and needs. Any Personal Behaviour Support (PBS) plan developed is made readily accessible on the ward, ensuring all staff, including temporary workers can refer to it as needed.

293. The MDT will consider any trauma a patient has experienced to obtain a better understanding of the patients care needs. Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma

exposure can impact an individual's neurological, biological, psychological and social development.

294. Prior to an inpatient discharge an MDT meeting, is held, involving the patient and their family or relatives, the care coordinator from the community, and other clinicians who are part of the care. A detailed care plan is agreed during this meeting, which covers the patient's medical, psychological as well as social needs. this is recorded in the clinical notes. The care coordinator subsequently formulates this in as document which should be shared with the patient.

Discharge and follow-up

295. NHS England have determined the point at which someone is clinically ready for discharge is reached when the multidisciplinary team (MDT) concludes that the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting.

296. To enable this decision:

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing the discharge plan.

297. The MDT must also have involved any services external to the trust in their decision making, e.g. social care teams, where these services will play a key role in the person's ongoing care **[MK2-154: NHS England updated Clinically ready for discharge definition V1].**

298. The person's discharge will be proactively planned with them and their chosen carer/s from the start of their inpatient stay so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all post-discharge support provided promptly on leaving hospital. **[MK2-149: CG24 Discharge and Transfer Clinical Guideline]**

299. Discharge planning for all patients commences on admission and an estimated date of discharge is planned. For patients with a longer stay e.g. secure services, this may not

happen on admission but is considered during the patient's pathway at the earliest opportunity.

300. The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient journey. It should involve the development and implementation of a plan to facilitate the discharge from EPUT services to an appropriate setting, and include the relevant onward community team/service, the patient, and their carers and relatives.

301. As part of discharge planning, it is important to identify early on what is needed for the individual to feel both practically and psychologically prepared for discharge, while acknowledging that these needs may evolve during their hospital stay. The individual and their chosen carers should be provided with clear information about discharge options, given the opportunity to ask questions, and actively involved in co-producing the discharge plan

302. In most cases, patients are expected to return to their home or alternative accommodation in the community when they are discharged from hospital, with any further assessments and ongoing interventions, treatment and support that they require provided in their home or local community. Services need to work together to make the transition from hospital to home as joined up as possible, with the support outlined in the person's discharge plan provided according to agreed timelines. **[MK2-247: NHS Hospital Discharge and Community Support Guidance]**

303. In secure services, restricted patients under Part 3 of the Mental Health Act 1983 will require Ministry of Justice approval before transfer or discharge and dependant on their authorisation by the Ministry of Justice or a Mental Health Review Tribunal **[MK2-155: SSOP9 Discharge of Patients from Secure Services Protocol].** Transfers to other units require detailed referrals and good communication between the referring and receiving units.

304. Once the final decision has been made that it is possible to discharge someone: At least 48 hours' notice of this discharge date should be given to the person, their chosen carer/s and any services (both NHS and non-NHS services) that will be involved in the person's ongoing care.

305. The person's risk assessment should be updated, to include information on how any risks to self or others will be managed in the community or less restrictive discharge location. In line with NICE guidance on self-harm, **[MK2-248: NG225 Self-Harm Assessment, Management and Preventing Recurrence**] risk assessment tools and

scales should not be used to predict future suicide or repetition of self-harm, or to decide who should be discharged. Instead, person-centred approaches to safety planning should be used that involve the person and their nominated carer/s and consider individual needs, risks and contexts and personal feelings of safety. Once updated, the risk assessment should be uploaded to a clearly accessible place on the person's clinical record.

306. The nurse in charge must ensure that all medication required has been dispensed and given to the patient. In addition, staff must ensure any medication that had been brought into the ward by the patient on admission is returned to the patient, where appropriate. Medication planning for discharge should begin well in advance to ensure the pharmacy can provide all necessary medications in time. If the patient requires compliance aid to enable them to self-administer medicines safety and effectively at home, this may require additional time and liaison with other organisations about continued supply of medication.

307. The patient's property should be checked and accounted for by ward staff, returning all property and any valuables which have been held for safe keeping and the required records completed.

308. On discharge, a summary of the patient's admission, continuing treatment requirements/medications must be completed by medical staff and a copy forwarded to the GP within 24 hours of the patient leaving the ward, another copy given to the patient and a further copy should be within the electronic record of patient. A more detailed discharge letter must be sent to the GP within five working days of the patients discharge and a copy must be in the patient electronic record too. Where a patient has indicated that they would like to receive copies of letters relating to them, a copy should be provided to them.

309. The nurse in charge will ensure ongoing services and equipment (where appropriate) are in place prior to the discharge. Most patients will make their own transport arrangements, but the nurse in charge of the shift needs to check that this is the case and that the arrangements are appropriate. For some patients, particularly within older people's, services transport may need to be provided.

310. Where the person requires mainstream accommodation, and this is not available, interim temporary accommodation to support alternatives to admission and timely, safe patient discharge from EPUT Mental Health Inpatient Services is explored. Patients without accommodation are not discharged at the weekends as these departments e.g., housing

is not open to them for advice unless hotel or B&B accommodation funded by the EPUT Discharge Fund with the required community Mental Health support is in place and clearly documented.

311. Under no circumstances should children without accommodation be discharged without prior planning involving all relevant specialist services. The lack of suitable accommodation and placements is a major constraint and can prevent timely discharge from hospital. The Trust works closely with the relevant local authority and other organisations to seek suitable community placements but there is a shortage of supply, making this a very challenging aspect of the discharge process, often leading to delayed discharges. Delayed discharges may hamper further recovery of the patients who are clinically ready to leave the unit.

312. In certain instances, on inpatient wards there are occasions where informal patients may wish to leave at short notice, against the advice of the MDT and/or refuse further service involvement. This will be subject to assessment of the patient's mental and physical state, mental capacity safeguarding circumstances and the risks to self or others and risk of deterioration of physical health. If an informal patient chooses to self-discharge from the ward, the following will be completed by the named nurse or their representative at the time of discharge as a minimum requirement:

- Ensure that the discharge plans are documented in the notes
- Record possible medical consequences of the patient's decision and that they have been explained to the patient.
- Ensure that if someone is discharging another individual, they have parental responsibility for the child or they have Power of Attorney for health and welfare if the patient has no capacity. Also consider safeguarding in these circumstances.
- Communicate the decision of patient to self-discharge with families and carers (where appropriate) and provide chosen carers information on how to access community and urgent care pathway teams.
- The patient's GP should be notified within 24 hours of discharge, typically by faxing the discharge prescription form. A hard copy, including details such as admission and discharge dates, discharge medications, and primary diagnosis, should also be sent by post
- Notify the relevant community team/service allocated Care Co-ordinator.
- Ensure that for those with a history of self-harm in the last three months, no more than 7 days medication is supplied.

- Ensure that a qualified nurse gives the patient their discharge medication, if available on the ward at the time patient chooses to leave the ward. The nominated person must ensure that the patient understands the medication given, when it should be taken, and when and how to obtain further prescriptions.
- Ensure the patient is given crisis/service contact numbers. All conversations, actions and decisions made must be documented immediately in the clinical notes.

313. In mental health inpatient units where patients are detained under a section of the Mental Health Act (1983), the RC will authorise the removal of the section and complete the appropriate Mental Health Act (1983) paperwork. Prior to discharge there must be explicit plans in place to ensure on-going care. Any team or service which is to provide the ongoing community care should where possible be present at/or conference call to the discharge meeting and the patients care co-ordinator identified prior to discharge.

314. To ensure the involvement of patients and their carers at the earliest opportunity two letters are available which address the following:

- Admission to Hospital – this letter should be given to all patients admitted into hospital and relatives/carers made aware.
- Home of Choice letter – this notification letter should be used where the patient may not be able to return home and needs a nursing, residential or alternative placement on discharge.

315. When it has been agreed that a placement in a residential or nursing home is required, and the patient has been assessed as eligible for such care, every effort should be made to involve the patient and their carers in the decision-making process. Wherever possible, placement should reflect the patient's preferred choice, provided the environment is appropriate to meet their needs. This process must align with local authority purchasing guidance and the established procedures for identifying suitable placements.

316. Once identified the individual patient must be assessed by the MDT to determine the type of home most suitable to meet their needs. They must be advised at this stage that their preferred choice may not be available and therefore alternatives will be identified in accordance with their needs. This may necessitate discharge to a temporary placement in an alternative home. In some instances, there may be restrictions because of individual circumstances; for example, where a patient is restricted by law from an area of residence.

317. In some cases, it may not be possible to identify a place in the home of choice to coincide with the planned discharge date. The patient and their carers/relatives must be advised that a temporary /interim placement will be arranged until such time as the placement of choice comes available at which time arrangements will be made to transfer there as quickly as possible.

318. The expected date of discharge is discussed in the multi-disciplinary team meeting and recorded and will include any foreseen barriers. Discharge co-ordinators are available and present at most discharge planning meetings and discussions across the Trust in Adult services. Families and carers are involved in discharge planning, and this is particularly the case for older adult services with the aim to ensure that the patients voice is heard and included.

319. A crisis contingency plan is put in place on point of any transfer or discharge to support a patient's individual needs. An example could be, if a person in a mental health crisis goes to a hospital emergency department post discharge and is assessed, they may be treated, transferred to a mental health assessment unit or sent home with community support, or voluntary sector services are discussed and made with the patient's consent.

320. The age-appropriate crises and community teams, care coordinator, and community psychiatrist are involved in discharge planning and should join the discharge planning meetings so that they are well placed to offer continuity post discharge to the patient in the immediate aftermath of their discharge. Patient's care coordinator from the community mental health team usually represents the community team at the discharge planning meeting.

321. A care coordinator, usually a nurse, social worker or occupational therapist, acts as a contact for a patient and helps to develop, manage and review a care plan with a patient as part of the CPA process. They work in the community with other services to address the person's social care, housing, physical and mental health needs, and provide any other support the person may need.

322. Following discharge, community teams may provide additional support to assist with the transition from inpatient care to returning home. In Child and Adolescent Mental Health Services (CAMHS), this post-discharge support became divided between two providers due to a contractual change, after EPUT's ceased to deliver the community component (Tier 3) of the service. Prior to this change, patients discharged from EPUT received crisis support, which included daily visits for one week after discharge.

323. If an inpatient is discharged outside of the local area, ward staff will engage with the appropriate crises and community mental health services for the area that they are discharged to.

Follow up

324. EPUT participated in the initial NHSE pilot which set the 48-hr post-discharge target and as such EPUT have maintained the ambition for post-discharge follow-up to be completed within 48 hrs. Prior to this follow-up was within 72 hours. EPUT will organise and complete face-to-face (or if necessary, a telephone) follow-ups within 2-3 days post discharge for all patients from inpatient care.

325. The 48-hour follow-up follows a 48-hour clock, which starts at midnight on the day of discharge, meaning the follow up can be carried out at any time on Day 2 or Day 3, regardless of what time the patient was discharged. However, a 48-hour follow-up cannot be carried out on the date the patient is discharged.

326. Rather than allocating specific slots for the 48-hour follow up, the follow up appointment will be organised and booked in, as and when required. These will be prioritised by the care coordinator/ community / Home Treatment Teams (HTT) to ensure there is capacity for these reviews. This avoids the possibility of unused slots and allows for a more patient centric approach to the follow up appointment.

327. The process is that the ward team:

    a. Determines who is responsible for the follow up and care of this patient in the community.

    b. Decides who is responsible for carrying out the 48- hour follow-up.

    c. If patient has a care coordinator assigned on the treatment ward, then the follow up should be conducted by this person within 48 hours of discharge.

    d. If patient is on a treatment ward and is previously known to a community mental health team, then follow up should be conducted by the community mental health team within 48 hours.

    e. If community team are unable to complete a 48-hour follow up post discharge on a weekend, the care coordinator and/or ward MDT are to ensure HTTs have accepted responsibility to complete the post discharge follow-up. Wards should record this on the ward discharge list and in the patient's clinical record.

f. Patients who are not known to the community mental health team previously (so don't have a care coordinator yet) and discharged within a short timeframe (circa 7 days) will be followed up by the HTT.

g. If the patient is discharged from the Mental Health Assessment Unit (MHAU) then the HTT will be responsible for completing the post discharge follow-up. In some cases, it may be agreed that a member of the community team is best placed (and has capacity) to carry out their follow up, for example, when one or more of the following is true:

- The patient has an extended MHAU stay (circa 7+ days)
- The patient is deemed to be receiving treatment on the MHAU
- The patient has been assigned a care coordinator whilst admitted on the MHAU.

h) If discharged from Child and Adolescent Mental Health Services (CAMHS), North East London Foundation Trust (NELFT) will follow up patients discharged from the inpatient units.

i) For patients with a learning disability (LD) who require specialist LD services, the enhanced support team will carry out the 48-hour follow up. For LD patients admitted to EPUT wards (for either assessment or treatment), a member of the enhanced support team will be allocated to follow up with the patient in the community, based on capacity / availability (there are no care coordinators in the LD service). Patients with mild/borderline learning disability who are being treated on mainstream wards may not always be cared for/followed up by the LD services post discharge. This should be clarified during their discharge planning).

j) Decide the patient's discharge destination.

k) If a patient is being discharged out of area to a community or other team in another Trust, the named nurse on the ward or MHAU should contact the identified responsible community team to arrange follow-up care. An email should be sent to the appropriate team, and this communication must be documented in the patient's clinical records

l) If patient is being discharged to out of area but still belongs to the trust, the same process must be followed as if they are discharged within the area. If feasible, face-to-face meeting is preferable, but if not possible then organise a telephone/video call.

m) If patient is discharged to the EPUT area / community team from a hospital in another locality, it would be necessary for the 'home' team to ensure a referral and request for community intervention is made to EPUT. If referral is made and accepted by EPUT team, then post discharge follow-up would be made as usual.

328. If an individual is due for a 48-hour follow up absconds or self-discharges, the general responsibility for providing follow up does not change in these cases, although the practicality of doing so may be more difficult. In these circumstances, the following Trust policies and procedures would need to be implemented immediately. Absent without leave (AWOL) procedures **[MK2-249: CLPG34 Missing Person Absent without Leave Procedure]** should be followed as appropriate and whilst acknowledging that CPA Care Plans may not be complete, there should nevertheless be efforts made by the in-patient clinical team to make contact, and if sufficiently concerned for an individual's safety, request a police welfare check. If the level of risk or degree of vulnerability is thought to be sufficiently high and the patient is informal, it may be appropriate to consider an assessment under the MHA.

329. Exclusion list for patients who do not require a 48-hour follow up:

    a. Patients discharged to another NHS hospital for psychiatric treatment.

    b. Patient who has been discharged into a hospital for medical treatment that prevents them from being contacted e.g., on life support.

    c. Patients discharged from CAMHS will be handed over to NELFT who will take care of the follow-up process.

    d. Where legal precedence has forced the removal of a patient from the country

    e. Where a patient leaves the country within 48 Hours of discharge.

    f. In secure services, in circumstances where a patient is remitted back to prison, the telephone call/face-to-face follow-up does not apply.

    g. In an unfortunate circumstance when the patient passes away within 48 hours. The services, in such circumstance would contact the family.

330. Mental Health Liaison Teams are to be notified of any patients to be discharged to a General Hospital for medical treatment/and or end of life care. If access to the hospital is restricted (e.g., due to covid) discharge team may ask if the mental health liaison team

can conduct the follow up **[MK2-156: Post Discharge Follow-Up Electronic eSOP Standard Operating Procedure V1].**

Discharges in secure services

331. For Secure Services, discharge is much further ahead in time, and the discharge planning realistically starts approximately six months prior to a discharge date being agreed for the patient from the relevant interested party. Moreover, the patient and may be subject to the specific MHA restrictions for discharge planning to be started much earlier. An expected discharge date is still discussed and recorded on admission. **[MK2-155: SSOP9 Discharge of Patients from Secure Services Protocol; and MK2-157: SSO965 Estimated Treatment Duration and Discharge Date Protocol].**

332. The provisions of Section 117 (MHA 1983, amended 2007) after-care, concerning all patients detained within the secure services under the Mental Health Act must be fully complied with prior to discharge. The relevant responsible statutory bodies for section 117 aftercare are local social services, which are part of the local authority and the local NHS integrated care board (ICB). A designated (Section 117) meeting must be arranged with all parties involved in the patient's after-care to discuss particular needs and follow up arrangements. Documentation of this meeting must be made, and it should follow the principles of the Care Programme Approach [**MK2-155: SSOP9 Discharge of Patients from Secure Services Protocol].**

333. For patients not under the restriction of Ministry of Justice, the decision to discharge a patient will rest with the Responsible Clinician (in conjunction with the multi-disciplinary team) or will be ordered by a Mental Health Tribunal. In restricted cases, authority for discharge rests with either a Tribunal or the Secretary of State.

334. In the case of discharge into the community, appropriate funding and accommodation will be secured prior to the discharge meeting. The patient must also have an identified Responsible Clinician and allocated Community Care Co-ordinator prior to discharge, and, whenever possible, both these persons should attend the section 117 discharge planning meeting. Prior to the establishment of the Specialist Community Forensic Team (SCFT) in 2020/21, patients were followed up by generic community mental health teams. Since the introduction of the SCFT, some patients discharged from secure services may now be allocated a care coordinator from the SCFT, who provides ongoing community assessment and treatment support.

335. All the low secure wards except Edward House have a Social Worker as part of their MDT. Funding has recently been secured for a Social Worker for Edward House through

the East of England Provider Collaborative and will be recruited to shortly. Care Co-ordinator from the relevant community mental health team will be involved, at an early stage, in making the necessary discharge arrangements for the patient.

336. At the section 117 pre-discharge meeting, the care plan for the patient's after-care in the community or in his/her next placement should be discussed and agreed. The allocation of the Community Responsible Clinician and Care Co-ordinator will be confirmed at the meeting.

337. The professionals at the pre-discharge meeting shall decide on the date for the first review of the aftercare in the community / next placement. The date of this first review meeting is the date the future Responsible Clinician takes over responsibility and their name shall be recorded on the CPA record sheet.

338. The in-patient Responsible Clinician will ensure that a community-based Consultant Psychiatrist agrees to take over clinical and, for restricted patients, statutory responsibilities for the patient prior to transfer to the community team. A patient must not be discharged into the Community before a community-based consultant has confirmed responsibility for on-going treatment.

339. Following discharge, the inpatient Responsible Clinician can continue to provide advice and support to the Responsible Clinician in the community, primarily due to their detailed knowledge of the patient, having treated them for a prolonged period on the forensic unit. A representative or manager from the community team responsible for the patient's future care should always attend the Section 117/CPA meeting. In most cases this representative will either be the allocated external care coordinator or the team manager.

340. All Medium and Low secure patients should already have an allocated Care Coordinator, so a handover of care can take place prior to and upon discharge.

341. When preparing to transfer a patient to the community or other team, as a minimum, the following must take place:

- An initial telephone meeting to discuss the case with the Community Team Manager and to secure agreement to the proposal.
- The provision to the Community Team Manager of a historical summary of the service user, which should always include, as a minimum, the following information:
- The details of any index offence for the service user and the length of time they have been in forensic services.

- The key points of the patient's care needs.
- A summary of the patient's risk profile and current risk status.
- Any family engagement, involvement and assessed needs.
- The patient's medication regime and adherence with this.
- Key risk points and strategies.
- The up-to-date CPA documentation.
- An up-to-date risk assessment and crisis contingency plan.
- An up-to-date carers' assessment.

342. If discharge is planned to a residential facility, a placement must be secured and a date of transfer confirmed with the responsible commissioners. Arrangements will be made for transport and escorts, if appropriate. At all stages, the patient's Nearest Relative added will be informed, unless the patient opposes this. Documentation must be made in either situation. The "nearest relative" is a legal term and means the patient's family member who has certain rights and powers under the Mental Health Act. All agencies directly involved in care will be notified of the final arrangements.

343. All stages of the discharge process will be discussed with the patient, unless early discussion would affect the patient's clinical state or be thought to compromise the safety or security of the patient or others. In the latter case, the reasons for not disclosing the discharge to the patient must be documented in the clinical record.

344. In all cases of non-restricted patients, The MHA Administrators must be notified of the date of discharge, at least one full working day prior to that date (unless discharged by a Mental Health Tribunal) to allow the original section papers or Court orders to be made available to the community services.

345. The Welfare Office must be notified at least one full working day prior to the date of discharge, to allow final payments to be made into or from the patient's accounts, and for the account to be closed / transferred. Should the patient be discharged by a Mental Health Tribunal and leave hospital the same day, these actions will need to take place post discharge.

346. Where the patient is to be discharged into the community, an immediate discharge notification letter will be completed by the Responsible Clinician or his/her delegated deputy and sent to the patient's General Practitioner within 24 hours. A full medical discharge summary will be completed within 10 working days.

347. Arrangements to order discharge medications from the pharmacy will be made covering a period of up to 28 days. In the case of a patient being discharged on Clozapine (medication for treatment resistant schizophrenia that requires special monitoring arrangements, the pharmacist must be notified at least a week prior to the expected discharge date to allow time for the patient's Clozapine registration to be changed to the new Responsible Clinician. The patient, psychiatrist and pharmacy all have to be registered with the company supplying the clozapine.

348. Where the patient is to be discharged to another care/custodial facility, steps must be taken to communicate care plans in good time to the receiving agency (e.g. prison in reach team).

349. The service also undertakes a number of actions pre discharge and the service has a discharge checklist for all items and forms to ensure the process of discharge is effective. There are also after discharge actions included in the protocol [**MK2- 158: SSOP9 App 1 Discharge checklist].**

350. All relevant parties must be informed of the patient's discharge, including the Multiagency Public Protection Arrangement (MAPPA) co-ordinator if the patient is open to MAPPA, the GP with whom the patient will be registered and any non-statutory agencies involved.

351. On the day of discharge, the community/next placement key worker will be informed usually by email, of the patient's discharge by the Social Worker of the Discharging Team. In Units where there is no Social Worker, the Nurse in charge will be responsible for sending the email on the relevant forms for each Secure Service Ward/Unit. The Care Coordinator and current key worker shall ensure that the community care joint care plan is operational at the time of discharge and that all involved parties have been informed of the discharge and change of care provider. The details of the discharge shall be recorded on the relevant CPA paperwork.

352. All secure service patients discharged into the community shall have post discharge CPA review meetings arranged by the Care Coordinator at least every six months.

353. All discharged patients must be seen by their Care Co-ordinator within seven days of discharge. Once the patient has fully transferred to the community services, the inpatient team should be available to provide advice to the Community Mental Health Team when requested.

354. Following an inpatient discharge all services contact the patient between 48-72 hours after they have left the ward and the patient leaves with a community appointment that

is set for review. The National Confidential Inquiry refers to the risk of suicide being at its peak three days post discharge which changed practice within EPUT because of the learning. This followed the introduction of the NHS national CQUIN indicator in 2019/20 to incentivise NHS providers to follow up all adults within 72 hours of discharge from mental health inpatient care either directly into the community or into non-psychiatric inpatient care. A CQUIN indicator is a target set as part of the NHS Commissioning for Quality and Innovation framework which supports improvements in the quality of services and the creation of new, improved patterns of care. This initiative was informed by evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health [**MK2-159: EPUT 2019-20 NHS Standard Contract- DRAFT CQUIN Schedule].** The community mental health (CMHT) will contact the patient 24 hours post discharge, which is unique to secure services.

355. Dependent on the needs of the patient, an individual post discharge plan may include contact with the Community Mental health Team, S117 aftercare, engagement with the probation and supported accommodation services. Since 2021, the Trust has had a specialist Community team, SCFT. The aim of the service is to provide and promote a high quality comprehensive mental health service, whilst ensuring public protection to Mentally Disordered Offenders including those with mild/borderline Learning Disability and developmental disorders in the community [**MK2-040: SSOP72 Operational Policy for the Specialist Community Forensic Team (SCFT)].** The SCFT seeks to:

    - Reduce the length of stay in secure environments with supporting step-down and recovery in the community at the earliest appropriate opportunity.
    - Reduce the risk of re-offending behaviour, to prevent contact with the criminal justice system and possible re-admission to secure facilities/prison.
    - Provide a meaningful and collaborative approach to the appropriate management, risk assessment and treatment of this patient group. This will include providing support and assistance to inpatient facilities, while linking in with other statuary and non-statuary agencies; incorporating full/joint working as appropriate.

356. The service comprises of nursing, medical and psychological assessments of mental health needs, social care needs, therapeutic interventions, risk factors posed by this patient group and case management under CPA.

Engagement with other agencies

357. The inpatient unit multi-disciplinary teams will liaise and work in partnership with any agency or organisation that is working with, been referred to for a service, or been identified as a service that could benefit the patient because of their identified ongoing needs. Each patient will have an individualised set of care needs and requirements that covers a range of agencies and organisations that could be involved with a patient during their admission, discharge or because of any known comorbidities.

358. A number of partner agencies, both statutory and non-statutory (MIND, HARP, debt advice etc. or other charities) may be involved in the management of patients admitted to the ward. Their involvement is with patient's consent. The information shared between these agencies and the Trust varied depending on the nature of the problem they were assisting with and the consent given by the patient. The more common agencies that inpatient teams would work with are:

    a. Social services.

    b. Independent Mental Capacity Advocates (IMCA) - legal safeguard for people who lack the capacity to make specific important decisions.

    c. Independent Mental Health Advocate (IMHA) - support people with issues relating to their mental health care and treatment.

    d. Local acute Trusts.

359. Their involvement would be through co-production of My Care, My Recovery with the patient and their attendance in ward reviews and discharge planning meetings. Additionally, peers support workers are being rolled out across the Trust and advocates and translators are a vital source of engagement for the inpatient teams. The My Care, My Recovery plan supports the patient centred care plan that the multi-disciplinary team work with the patient.

Involvement of the patient and their support network

360. Personalised care for the patient is centred around the multi-disciplinary team working as equal partners with them and their chosen carer/s to reach shared decisions about the next steps in their care. When a patient is in crisis or acutely unwell as an inpatient the team aim wherever possible to recognise that the patient is the expert in their own lives and have valuable contributions to make about the support that they need both before, during and after their hospital stay. The multi-disciplinary team always try to ensure that the patient's thoughts, views and expectations are captured in their clinical records and strive to achieve to meet these where able.

361. A patient should be involved at each point of their admission assessments, care plans and reviews of their treatment during their stay as an inpatient. Their care reviews are attended by them and family and carers are invited to attend with the patient's consent. On occasions a patient might not consent for their family and carers to receive information but that does not stop the family from sharing information that will assist patient's care. Carers are provided with a booklet for Carers support when navigating their relative needing to receive mental health support **[MK2-012: Carers Support: Information for Carers, friends and families EPUT, EP0915].**

362. During the inpatient stay the patient's understanding is continually assessed. A formal assessment of their capacity will not be undertaken unless there is reason to doubt it. Any language barriers can be addressed using interpreters or language line which is a translation service the Trust use. The use of easy reads **[MK2-047 – MK2-053 and MK2-210 – MK2-217: Easy Read Documents]** and visual cards are available to assist with communicating with a patient who might need adjustments for any personal circumstances. During the patient's stay on the ward, observations are made by the multi-disciplinary team for any adjustments that may help the patient.

363. Patient's that have been users of the Trust services and representatives of patients on Secure Service wards have service user forums set up where they offer feedback to the Trust on their experiences. Patient representatives from Secure Services attend the Provider Collaborative meetings who have oversight of the service and will chair patient meetings on the unit providing feedback. The Trust use a patient feedback service called 'iwantgreatcare' which provides independent, real-time outcome metrics for performance management and contracting. I Want Great Care offers the Trust the system to collect large volumes of meaningful, detailed outcome feedback from patients that use the Trust services to understand how they experience using the Trusts services. In SEPT, the Trust utilised the process of mystery shoppers for a period of time to ascertain the experienced offered by the Trust. All Trust services have posters, paper surveys with prepaid envelopes, and business cards with QR codes for the online survey that people can use, and the questionnaire can be completed anonymously and easily **[MK2-161: One a Day Patient Feedback information for staff].**

364. More recently, adult wards have adopted the use of 'Psychology Essences'—a ward atmosphere scale completed by both service users and staff to help gauge changes in the ward environment, perceptions of safety, and overall experience of care. Ward atmosphere is a key aspect of mental health care, and this tool provides valuable

insights into how it is experienced. Data from the Essences audit is collected every three months

365. Individual members of staff in the Trust have an obligation to safeguard all confidential information to which they have access, particularly information about individual service users or clients, which under all circumstances is strictly confidential.

Second opinions and MDT

366. Second opinions are most commonly requested in situations involving uncertainty or disagreement about a diagnosis, dissatisfaction with treatment outcomes, or when a patient has a valid reason for wanting a different clinician involved in their care.

367. A second opinion is an independent expert assessment of a patient. Where requested by the treating clinician, the assessment is usually requested either to review a potentially controversial decision or to offer fresh options in a case where response to treatment has been unsatisfactory.

368. When a patient, relative, or carer requests a second opinion, it may be due to disagreement with or uncertainty about the consultant's diagnosis or proposed treatment plan. They may seek confirmation from another consultant or wish to explore possible alternative diagnoses or treatment options

369. In addition, the MHA sets out circumstances where a second opinion is a statutory (legal) requirement, with specific reference to second opinions in relation to treatment of detained patients. Part 1V of the Act relates to consent to treatment. The Code of Practice covers consent to treatment for detained patients and statutory second opinions, with paragraphs dealing specifically with the procedure for second opinions and the role of the Second Opinion Appointed Doctor (SOAD). Sections 57, 58 and 62 are the most relevant to the question of second opinions for detained patients. Treatments under S58 (ECT or medication after 3 months) require a second opinion from 'a registered medical practitioner appointed for the purposes of this Part of the Act by the Secretary of State'. Treatment under S57 requires the patient's consent and the authorisation by the patient's RC.

370. However, a request for a second opinion outside the terms of the MHA, including non-statutory requests for second opinions on detained patients is available to the patients and their families. **[MK2-162: CG43 Second Opinion Clinical Guideline].** In May 2024 NHS England announced the implementation of Martha's Rule. Martha's Rule is a major patient safety initiative, providing patients and families with a way to seek an urgent

review, if their or their loved one's condition deteriorates, and they are concerned that this is not being addressed.

371. The essence of the second opinion is that it is an independent opinion, based ideally on a face-to-face clinical assessment and relevant other information such as records, by the clinician providing the opinion. In most cases, an immediate colleague would be appropriate, as they would generally be more accessible. However, depending on the circumstances, it may be appropriate to ask a colleague in the same speciality based at a different location or a consultant from a different speciality if they have the necessary expertise. This must remain an area for individual judgement. The Consultant Psychiatrist can request the line manager, usually the Clinical Director to assist in identifying the Consultant for second opinion.

372. Requests for an opinion outside the Trust may occasionally be made. For example, this may be requested where a patient or relative/carer want an opinion by or referral to a specialist unit outside the Trust (e.g. the Maudsley). In some cases, this request may be clinically appropriate. In such cases, as per the current commissioning arrangements, the request will be made the by the treating clinician to the Executive Medical Director. The medical director reviews the request and may refer this to the joint panel called the (tertiary review panel) involving independent clinicians (medical and Psychology) and local commissioning representatives who will advise on further steps.

373. Where the treating clinician does not agree that a request for an external second opinion is appropriate, the treating clinician should offer a second opinion from another Consultant within the Trust. Situations may also occur where the patient or third party asks for an opinion outside the Trust because they believe another doctor from the Trust would not provide an independent opinion or if they have a grievance with the Trust as a whole, or they may feel that all doctors in the Trust are in allegiance and not therefore truly independent.

374. Under these circumstances, the treating clinician in this case should seek advice from their Clinical Director, for consideration of whether referral may be made for a one-off opinion to a Consultant outside the Trust. This referral would be for opinion only and would need to be authorised by the Executive Medical Director. In most of the cases, the Executive Medical Director will liaise with colleagues from other NHS organizations to offer an independent opinion. If the opinion is for a specialist tertiary service where funding is involved, for example, seeking a specialist opinion from Maudslay Hospital, the decision will be made by the tertiary review panel. In some circumstances it may be felt that it is in the patient's best interest to refuse a request for second opinion. e.g. a

patient who is detained in hospital who does not accept they are ill and where the MDT agree a second opinion would not be therapeutic and would re-enforce a patient's difficulty in engaging with treatment/the clinical team. In such an instance the use of the MHA appeals processes may be more appropriate than a second opinion.

375. The decision to refuse a request for a second opinion should be taken rarely and only after some careful consideration. In these circumstances the reason that the request has been declined should be given in writing to the Patient and documented in the clinical notes. The Patient should also be advised to seek support from the advocacy services and be facilitated to do so. If a request is refused, a full explanation should be given. All cases in which a request for second opinion is refused should be referred to the Clinical Director who will look at the case notes, discuss the case with the treating consultant, and if necessary the team looking after the patient and the patient, following which decision will be made about the appropriate course of action.

376. If a patient is unhappy with the care and treatment offered, in addition to a request for a second opinion, they can make use of the advocacy services or the complaints process. [**MK2-162: CG43 Second Opinion Clinical Guideline].** A patient may use the complaints process **[MK2-163: CP2 Complaints Policy]**

Records and evaluation of care

377. In this statement records and evaluation of care includes information for the EPUT period. All NHS records are Public Records and kept in accordance with the following statutory and NHS guidelines:

- Information Governance Alliance – Records Management Code of Practice for Health and Social Care Records 2016;
- Care Quality Commission – outcome 21;
- The Freedom of Information Act 2000;
- Data Protection Act 2018;
- Lord Chancellor's code of practice on the Management of Records issue under section 46 of the Freedom of Information Act 2000;
- Public Records Act: 1958 and 1967.

378. The Trust creates, receives and maintains patient records and information and a record is any information held on any format e.g. electronic systems, paper, and a patient's

record will include medical, nursing, therapist and any other professional's records that engage with them.

379. High quality record keeping requires:

- Establishing and maintaining consistent standards of record keeping throughout the Trust;
- Ensuring all their clinical records comply with professional standards and those of accreditation bodies i.e. GMC, NMC;
- Ensuring that their record keeping meet legal obligations to be objective and worthy of independent scrutiny.

380. All healthcare practitioners and staff involved in clinical care or undertaking research are professionally accountable for keeping clear, legible, accurate and contemporaneous clinical records. They are expected to record all the relevant clinical findings, any decisions made, information given to patients and any drugs or other treatment prescribed.

381. All clinicians have both, a professional and a legal duty of care to patients, and this involves maintaining appropriate clinical records. A patient's record should inform any clinician who has a responsibility for the patient, of all the key features which might influence the treatment proposed. It should also provide a contemporaneous and clear record of the patient's treatment and related features. A good record speaks volumes about the care a patient has received and has a vital role in minimising clinical risk.

382. For clinical records the purpose is to facilitate care, treatment and support of a patient and therefore, the records should:

- Include demographic, clinical and social care information;
- A record of assessment of risks and needs;
- Evaluations of care and treatment;
- Progress under CPA or other care plan arrangements;
- Results of biochemical and other tests if any;
- Prescription and administration of medication if any;
- The recording of any detention under the Mental Health Act 1983 as amended by the Mental Health Act 2007;
- Identify who has been responsible for which aspects of care and treatment;

- Identify when care and treatment was given.

383. The Trust has several electronic clinical records where the record is created within the system, and these vary across the Trust depending on the locality area and service (see Table 5 below).Each clinical records system is designed to provide a comprehensive patient record, whether the individual is receiving care in the community or as an inpatient, within the locality where it is used. The system captures the full patient journey and includes any overarching Care Programme Approach (CPA) that may be in place.

384. The patient clinical record has the relevant clinical templates for nursing and medical assessments, observations, medication, treatments and all the relevant MHA paperwork. Over the years, these have been refined resulting from changes to mental health services and statutory requirements. Learning from audits and incidents have improved practice along with the quality and details of the records kept.

385. Prior to the development of electronic records patient data was record in paper files and stored in locked units. Over the scoping period records have merged into electronic format and access to both were in place during the migration.

Table 5: Records

Area	Service	Records
South Essex	Adults Older Adult CAMHS	Mobius
West, Mid, and North Essex	Adults Older Adult CAMHS MBU Secure services	Paris
Trust wide	MH Services	Health Information Exchange (HIE) – summary record access for MH staff from Mobius and Paris
Trust wide	Community Services (physical)	SystmOne
Trust wide	IAPT	IAPTUS
Trust wide	Health and Justice	Excelicare
Trust wide	Substance Misuse	Theseus

Raising concerns or compliments

386. The Patient Advisory Liaison Service (PALS) can help sort out any concerns or queries a patient and their carer may have about the services the Trust provides. PALS is the

recommended route if the service concerned has been unable to resolve matters for the patient or carer directly [**MK2-163: CP2 Complaints Policy].**

387. If the concern involves either an ongoing/ current issue that requires immediate or urgent action or the patient does not wish to make a formal complaint, the PALS service can help. PALS staff will escalate the concerns to a senior member of staff within the service and follow this up on the patient's behalf to provide them with a response as quickly as possible.

388. If PALS are unable to provide a satisfactory resolution to the concerns raised (e.g. because they are complex and require a more thorough investigation) they may refer the patient to the Complaints Team for further assistance. Complainants will generally be existing or former patients/residents of the Trust's services, or people who are directly affected by the Trust's actions and decisions in relation to a patient's care, such as the family or carer of a patient.

389. A complaint can be made on behalf of another person, if the complainant:

- has been requested by the person to act as a representative on their behalf.
- has delegated authority to do so, for example in the form of Power of Attorney.
- is an MP acting on behalf of and by instruction from a constituent about their own care and treatment. (implied consent) or if the person at the centre of the complaint (e.g. patient):
- has died;
- is a child;
- is unable to make the complaint themselves because of
    - Physical incapacity; or
    - Lack of capacity within the meaning of the Mental Capacity Act 2005.

390. If any part of the complaint is about the complainant's own experience of the Trust service (e.g. how they were treated as a carer or visitor to the patient), the patient's consent to respond to those elements if doing so would not breach the patient's confidentiality. In these circumstances identification of which issues required consent, and which ones can be responded to without consent would be explored, and this would be explained to the complainant [**MK2-163: CP2 Complaints Policy]**. The first step in any complaint is to try to resolve at the local level within the ward or team directly. If this is not achieved the formal complaints process is followed.

391. Complainants may refer their case to the Parliamentary and Health Service Ombudsman for review where:

- They are not satisfied with the outcome of any Trust investigation for their complaint
- The complaint has not been resolved within six months (or such longer period as may be agreed before the expiry of that period with the complainant)

392. The Trust has decided not to investigate the complaint on the grounds that it was not made within the time limits (12 months of the event, or within a year of when you became aware of the problem you are complaining about.) As part of the complaints investigation process, the Complaints Liaison Officer (CLO) will identify lessons and opportunities for service improvement, and these will be agreed in collaboration with the service, and where appropriate, with the patient who has made the complaint.

393. All lessons and improvement actions identified from a complaint will be:

- Recorded with the complaint record on Datix incident reporting system;
- Followed up monthly with the Deputy Director of Quality & Safety for each Care Unit to ensure that actions have been completed, and learning is embedded;
- Considered for Trust-wide sharing in the monthly Lessons Identified Newsletter;
- Considered for sharing within various reports e.g. quarterly Care Unit Reports, Quality & Safety reports, Annual Report.

394. In June 2022, NHS England published the National Freedom to Speak Up Policy, mandating all NHS organisations to implement it by 31 January 2024. The Trust has since adopted this policy. Freedom to Speak Up (F2SU) training is part of the core competencies for all staff and role specific training is provided at an appropriate level which is monitored for adherence [**MK2-164: CP53 Freedom to Speak Up/Whistleblowing Policy].**

395. The professional Duty of Candour **[MK2-235: CP36 Being Open and the Duty of Candour Policy]** makes a clear requirement to be open with patients and families when mistakes occur. The Freedom to Speak Up review encourages an environment where staff feel it is safe to raise concerns with confidence that they will be listened to, and the concerns will be acted upon across the NHS.

396. All staff are expected to raise concerns related to safety, clinical practice, malpractice, or wrongdoing that may impact patients, the public, colleagues, or the Trust. For registered practitioners, professional regulatory standards require them to report

concerns when there is a risk of harm to patients. Every manager has a responsibility to ensure that staff feel able to raise concerns at any level of the Trust.

397. Managers must handle such concerns thoroughly and fairly, and ensure that staff are not subject to any detrimental treatment as a result. Staff who speak up should be assured that their identity will not be disclosed without their consent. To support this, the Freedom to Speak Up process—introduced following the Mid Staffordshire Inquiry—was established to enable staff to raise safety concerns easily and openly. Freedom to Speak Up is detailed in Rule 9 (9).

398. Detained patients when informed of their rights, are also made aware of the role of the CQC as a regulator of healthcare. Patients are advised that they have a right to speak to a member of the CQC if they have any concerns about their care. Patients may therefore decide to approach the CQC directly, if they wish to raise a concern.

399. Some of the wards have complaints boxes where patients can post any concerns they have and would like addressed. In addition, patients can raise their concerns through 'I Want Great Care'that collects patient feedback.

Monitoring practice

400. The Trust have adopted the Fundamentals of Care Framework to support measurable and consistent delivery of care and to provide a framework to support the Trust in monitoring practice. The Fundamentals of Care Framework outlines what is involved in the delivery of safe, effective, high-quality fundamental care, and what this care should look like in any healthcare setting and for any care recipient.

401. The Framework emphasises the importance of nurses and other healthcare professionals developing trusting therapeutic relationships with care recipients and their families/carers. It also emphasises the need to integrate people's different fundamental needs; namely their physical (e.g., nutrition, mobility) and psychosocial needs (e.g., communication, privacy, dignity), which are mediated through the nurses' relational actions (e.g., active listening, being empathic). The Framework also outlines that the context in which care is taking place must support care providers to develop relationships and integrate the needs of those for whom they are providing care.

402. The Fundamentals of Care Framework was created from the expertise and experience of International Learning Collaborative (ILC) members. The Framework has continued to stand as the ILC's position paper and has been used in subsequent research and education activities by ILC members. The ILC continues to refine and improve the Framework to ensure it meets the needs of clinicians, consumers, educators, and

researchers worldwide. The International Learning Collaborative was founded in2008 and its vision is to transform care globally by valuing and prioritising person-centred fundamental care. Its mission is driven by valuing, talking, doing, owning and researching fundamental care. It has a global membership that is inclusive and diverse, with members from care professions, care recipients and their care networks, education providers, policy makers, researchers and the community.

403. As a response to negative feedback on the standards of care delivered in inpatient wards (CQC, channel 4 dispatches, incidents and complaints) a recently appointed Director of Nursing and Chief Nursing and AHP Information Officer reviewed what model of care underpinned practice, what forums were in place in EPUT that specifically focused on how patients were nursed in an inpatient setting.

404. The findings highlighted a lack of a universal approach, with examples of good practice in some areas and inconsistencies in others. In response, the Director of Nursing (DON) was provided with the Fundamentals of Care framework and information about the International Learning Collaborative to assess its suitability for mental health wards. In collaboration with the Director of the Inpatient Mental Health Care Group, the DON initiated a pilot of the framework and supported its implementation by appointing a Quality Matron to lead and oversee the work

405. The work commenced in November 2023 with inpatient matrons and ward managers, and it was agreed that first steps would be a focus on the trusted relationship with patients. The reclaiming of the named nurse for every patient has been the focus to support building that relationship and care thereafter. EPUT has become a member of the international learning collaborative and draws on evidence-based practice and research across the world. Six of the team attended the ILC conference in Oxford in June 2024 of which 5 of those continued to undertake a leadership program with mentors to support in the implementation of the framework.

406. The fundamental of care framework is a golden thread in the Therapeutic acute inpatient Operating Model for adults and older adults and is now being rolled out into other parts of the organisation. A monthly meeting supports the work and is attended by internal and external partners. The framework focuses first on the relationship, then the integration of care and the context of where that care is delivered. It is therefore meaningful and relatable to individual care settings, whilst providing a framework to support evaluation and adherence **[MK2-165: Quality together meeting November 2024].** The Trust alongside this has implemented Tendable audits that are transforming ward-based audits. A Tendable audit is a smart inspection app that replaces the manual

pen and paper audit, or inspections used to assess and improve quality across clinical areas. It provides live, automated reporting so you can immediately understand where you are doing well and where you need to improve.

407. There are 12 live Tendable audits across 49 areas relating to inpatient areas and additional audits are collected via the Electronic Paper Record systems through the compliance team, external teams, and senior walk rounds. Audit completion is undertaken by various members of ward staff matrons, compliance team, and subject matter experts. Ward managers are required to undertake all audits to an acceptable standard, which currently takes a significant part of their working week. Repetition of questions across different audits is present **[MK2 –165: Quality together meeting November 2024].** The Trust has been regularly inspected by the CQC who produce inspection reports identifying the learning and any areas of improvement that the Trust should make. These reports are reviewed by the Board and Senior members of the Trust who produce and monitor the implementation of action plans that are derived from them.

408. Care Unit Quality and Safety meetings provide a service-led forum where learning is discussed with Senior Managers. The Care Units are responsible for ensuring messages and learning is cascaded to individual teams, which can occur in handover meetings, huddles and team meetings. Agenda items:

    1. safety dashboards
    2. clinical audit reports
    3. restrictive practice assurance reports
    4. medicine management
    5. reports of any compliance or inspection visits

409. The Quality committee receives assurance reports from the Care Unit Quality and Safety meetings.

Unique service processes

410. Whilst there is similarity across the inpatient pathway referred to above there are areas of uniqueness that are service specific across the whole pathway which are now described specific to the particular unit. For ease of reading, each service is identified with subheadings for the areas where there are differences.

Secure services

411. The service is for adults over the age of 18 and only those patients who have been assessed and accepted for admission by the MDT with the agreement of the East of England Provider Collaborative will be admitted to the service. Secure services are for patients who require a level of security, which cannot be provided within other settings.

412. As referenced in the Trust's response to Rule 9 (6a) Brockfield House and Edward House. Brockfield House is a unit containing seven wards of low and medium security, and Edward House is a low secure ward.

413. Brockfield House has special boundary fencing to prevent unauthorised entrance and exit. The entrance to the unit sits beyond a gate where entrance and exits are monitored and controlled. Entrance to the unit is in the reception area and is via an airlock so that there is no unauthorised entries or movement.

414. Access to the individual wards at Brockfield House is also managed via an airlock system, which requires access to a fob, provided once training has been completed. Security includes a designated ward 'security nurse' which is in place across all secure wards.

415. Secure services comprise medium secure services, low secure services and a Community Forensic team. Since its inception, the Trust's medium secure service is a regional specialty service accepting referrals from within the region and not just Essex.

416. For secure services the Collaborative now has a major influence on the secure services. EPUT acts as the lead provider for secure services within the provider collaborative.

417. The secure services collaborative was formed in 2021 and includes secure services provided by the following organisations; Essex Partnership University NHS FT, Norfolk and Suffolk NHS FT, Cambridge and Peterborough NHS FT, East London NHS FT and Hertfordshire Partnership University NHS FT.

418. Pre 2021, NHS England commissioned specialist beds, and these were locally managed through a weekly referrals meeting.

419. Prior to 2019, the referral pathway was direct from other providers, courts etc directly to the clinical team for assessment and gatekeeping. Now these pass through a central bed management service within the collaborative to support the process and provide data analysis. It is important to say that this is the Provider Collaborative as a whole as this encompasses CAMHS, MBU within Perinatal and Secure Services.

Secure services admissions

420. For admissions, only those patients who have been assessed and accepted for admission by the MDT with the agreement of the East of England Provider Collaborative will be admitted to the service.

421. For secure services all admissions, including urgent admissions are made on a planned basis. In all cases the assessment will take place within a maximum 21 working days, wherever possible. A final written report will be shared with the referrer within 7 working days of the assessment. For urgent referral requests the referrer will be contacted in 24 hours and a response will be made following assessment. Priority is given to those in prison rather than a referral from another hospital.

422. The quality of the referral is essential, and the protocol requires detailed information from the referrer including a detailed case history and any presenting risks. Although the decision to admit remains with the MDT, secure services protocols identify the composition of the assessment team which is multi-disciplinary. This is however in collaboration with the East of England Provider Collaborative.

423. The outcomes of assessments, with the opinion and recommendations of the assessor / assessing team, will be updated at each referral meeting and minuted accordingly. The East of England Collaborative for Adult secure services have standardised the referral process across secure services **[MK2 –166: SSOP03 Secure Services Patient Assessment Protocol; MK2-167: Collaborative Guidance for the Completion of Secure Referrals].**

424. Upon admission, the secure services follow a similar process of assessment for each admission **[MK2-168: SSOP02 Admissions to Secure Services Protocol; MK2-169: Secure Admissions Checklist; MK2-170: Admissions Physical Health Checklist Form].**

425. Following admission to secure services the unit's social workers would first meet the patient on admission, unless they were too unwell to do so. The social workers see the patients at the ward round every two weeks. They would also see the patients whenever there is an identified need for issues such as benefits, family visits, looking at accommodation needs or whenever the patient requests to meet with them. On admission the social workers would undertake their assessments with the patient when able for the Care Act and the Mental Capacity Act using the appropriate Trust template **[MK2-171: Care Act Assessment Form – March 2024; MK2-172: MCA – Mental Capacity Act Assessment Form]**.

Secure services involvement with family and carers

426. For secure services the social workers hold a Carers Forum every 8 weeks and for carers of patients in Brockfield House and Edward House this is via Microsoft teams. There is a different topic every eight weeks, the agreement made with the family, and Carers that attend is that no individual cases are discussed due to confidentiality. At each forum, the speaker gives an overview of their role or the subject that they are covering and there is the opportunity for anyone to ask questions. The family and Carers also can email any questions after the forum has finished or make any requests to what they would like at the next forum **[MK2-173: Flyer for Virtual session on 06.11.24 Carers Forum].**

427. The social workers send newsletters to Carers from Brockfield House in January, May and October and held a face-to-face event in December 2023 for patients and their Carers **[MK2-174: Carers matter newsletter October 2024].** However, Edward House does not have a social worker.

428. The activity coordinators for secure services offer a range of activities for patients. **[MK2-175: Brockfield House Activity schedule**].

429. Each of the secure units have welcome information for patients **[MK2-015: Brockfield House Welcome Pack; MK2-016: Edward House Welcome Pack - MK2-01: and 220**]. These details for families and patients on how the unit operates, Brockfield House. The Brockfield Patient Information Booklet was written by patients for patients **[MK2 – 177: Brockfield Patient Information Booklet]**.

430. Subject to consent from the patient, the Service actively engages with families and the patients support network. Families are invited to ward rounds and CPA meetings. The service also writes to families with information about the patients care team **[MK2-178: Letter to Carers/Families].**

431. Although there are similarities between secure services and other mental health inpatient services, there are differences due to the nature of the service. For sexual safety and behaviour, the service has developed a specific policy for secure services that reflects the specific circumstances of a secure environment for patients **[MK2-179: SSOP60 Sexual Health and Behavioural Guidance].**

Secure services comorbidities

432. As detailed above, secure service caters for a range of diagnostic groups and comorbidities. This is covered by a range of Trust policies and secure services has

specific policies including **[MK2-180: SSOP53 Control of Substance Misuse in Secure Services].**

433. Brockfield House has a Band 7 Physical Health Lead to oversee and coordinate on physical health conditions. In addition, the unit has RGNs who support the band 7 RGN in monitoring, assessing and managing physical health conditions.

Secure services assessments

434. Planned assessments are undertaken during the patient's pathway including admission and discharge. A key component of risk assessments in secure services is assessing the risk of violence (HCR-20) **[MK2-181: SSOP63 Secure Services Structured Clinical Risk Assessments Protocol].**

435. The psychological services within the secure units aim to create holistic pathways of care from inpatient to community care that improves service-user outcomes in partnership with families and other services in EPUT where appropriate. The service partnership working and values collaboration and joint working with both internal and external stakeholders, including EPUT's Specialist Community Forensic Team (SCFT). The Standard Operating Procedure for Secure Psychological Services (SSOP72) is shown at **[MK2-040].**

Secure services searching

436. Searches in secure premises enables the prevention and detection of potential and actual security breaches. The overall aim of such measures is to provide and maintain a secure and therapeutic environment for all, whilst promoting a safe environment within which to deliver care. The service employs a range of searches detailed in the policy **[MK2-182: SSOP22 Searching a Patient, Patient's Property, Visitors Protocol].**

437. Searching an individual or their property can be experienced as an intrusive procedure. The Secure services policy aims to guide staff in undertaking the search procedures with efficiency whilst minimising discomfort or distress to individuals and maintaining their dignity throughout the procedures employed **[MK2-182: SSOP22: Searching of Patients, Patient's Property, visitors and Areas Protocol].** This policy has been in place since 2009 with minor changes to reflect the evolution of this service and the change in environment and social changes such as mobile phones.

Secure services coercive treatment

438. As a secure service, there are occasions where the use of handcuffs on escorting patients is required. The Mental Health Act 1983/2007 Code of Practice details the use of handcuffs as a form of mechanical restraint applied to patients detained within the secure services. The use of handcuffs is exceptional and strictly limited to the purposes and criteria stated in policy and procedural guidelines. Handcuffs are never to be used as a first-line response or standard means of managing disturbed or violent behaviour within the secure service unit or wards.

439. The use of handcuffs takes fully into consideration the safety, dignity, needs and human rights of patients and the safety of Trust staff and the public. No member of staff is permitted to take responsibility for applying handcuffs and managing the handcuffed patient unless they have received appropriate training **[MK2-183: SSOP31 Protocol for the Use of Handcuffs in Escorting Patients].** This policy has been in force since 2010 with minor changes since that time.

440. Due to nature of the service, there are a range of patient related policies such as Mobile phones (SSOP35), e-cigarettes (SSOP20), patient possessions (SSOP11), access to computers and digital equipment including televisions and tablets (SSOP32) **[MK2-184-87: Secure Services Policies].**

Secure services leave

441. Leave in secure services is governed by several protocols, forms and in the case of restricted patients by the ministry of Justice **[MK2-188: Leave Protocol for Secure Services; MK2-189: S17 Daily Leave Risk Leave Assessment].**

442. Leave of absence from the ward can also involve staff escorting patients. The types of escorting and requirements for escorting within the unit or within the grounds as well as in the community is detailed in the service leave protocol **[MK2-190: Escorting Guidelines (Appendix 1 of SSOP15 Leave Protocol].**

443. Secure services are by their nature, controlled environments and the management of risk/risk assessments is a key component of the protocols in place within the units. The service provides a therapeutically focused environment for patients undergoing rehabilitation. The balance between maintaining a therapeutic setting and managing risk is exemplified by the management of sharps and tools. These include items such as knives, razors, scissors, cutlery, spades, gardening tools, needles, tweezers, and nail clippers—all of which carry the potential to be used for self-harm or as weapons to harm others. **[MK2-191: SSOP14 Protocol for Patients use of sharps and tools within secure services].**

444. An initial care plan within secure services is created within 72 hours of admission. Care plans are jointly owned with the patient. The Trust also utilises 'my shared pathway' which forms part of the six-monthly CPA review **[MK2-192: My Shared Pathway]** The Service has regular community meetings (monthly), has an established user forum and daily morning meetings.

Secure services monitoring and evaluation

445. The service has regular clinical and compliance reviews in addition to clinical audits. As part of the collaborative arrangement, the service has completed a self and peer review [**MK2-193: Review Summary Medium and Low Secure services 2024].** This summarises the views of the service staff, patients, carers and the peer-review team about the service's strengths and weaknesses. The review identifies areas of achievement and makes recommendations for future action.

446. Secure services have a range of core indicators that are regularly reviewed as part of the Trust's Accountability Framework. These are detailed in the service specifications [**MK2-252: Adut Low Secure Services Specification; MK2-253: Adult Medium Secure Services Specification]**

Rainbow Mother and Baby Unit

447. The Rainbow mother and baby unit (MBU) is based at the Linden Centre, Chelmsford and has 6 beds.

448. The capacity of the unit had previously been five beds (since opening on the 7 October 2010) and increased to six beds following extension to the building on the 11 October 2021.

449. Prior to the opening of the Rainbow unit, there were mother and baby beds on Galleywood Ward in a two bedded wing in the North of Essex and in the South two beds attached to acute wards on the Rochford site, until this was closed in early 2000s. It is believed these changes took place for safety reasons and the Trust's joining the Peri-natal Quality Network.

450. The Rainbow unit provides specialist inpatient services for mothers who either experience severe post/peri-natal mental illness; have a severe and enduring mental health illness and experience a deterioration in late pregnancy, or; are at a high risk of experiencing an acute relapse and for whom appropriate and safe care would be better managed in hospital **[MK2-194: Perinatal Service Specification].**

451. Mothers can be admitted during their third Trimester of pregnancy (from 28 weeks) until their baby is aged up to 12 months to receive the appropriate treatment for themselves, whilst maintaining the close Mother/child relationship.

452. Admission to the unit will primarily provide inpatient care through specialist commissioning to patients from the East of England known as the Collaborative. The collaborative arrangements have been in place since September 2024. Prior to formation of the collaborative, requests for admissions were made directly to the ward team. into the team.

453. The referrals can however be accepted from anywhere within the United Kingdom and beds will be allocated dependent on appropriateness, the clinical need and the risks **[MK2-41: POP1 Mother and Baby Operational Policy].**

454. Referrals will only be accepted for the purpose of a mental health admission and therefore should be made by a mental health Professional. The MBU has a leaflet for referrers for guidance **[MK2-195: Referrers leaflet].** A nationally agreed referral from for Mother and Baby units is used **[MK2-196: MBU Universal Referral form].**

455. Pre-admission, a risk assessment is carried out to determine if it is safe and in the best interests of the child to accompany the mother to the unit.

456. All new mothers on admission are welcomed and orientated to their surroundings, followed by a physical and mental health assessments, and a risk assessment, which forms part of the admission process **[MK2-18].**

457. Ethnicity and diversity is respected and information/guidance is made available in a language or form that is accessible and recognises the full range of ethnic and cultural differences.

458. As with other Trust services, full disabled access is available on the unit for Mothers, visitors and children. If a mother is admitted with her own personal mobility aid to the unit, arrangements can be made for the appliance to be safety tested prior to use on the unit.

459. The unit also has a bedroom that can accommodate the needs of women requiring bariatric equipment. However, bariatric patients will be subject to an assessment by the team due to limitations in the use of mechanical aids in the room.

460. For those women who have an identified mental illness or are deemed at risk of developing mental illness, clinicians consider any existing advance directives or advance decisions made by the mother. When a pregnant woman is admitted prior to

giving birth and is deemed as having capacity, she is encouraged to record her wishes for her future care and treatment both in respect of her birth plan and psychiatric care.

461. The mother's wishes and treatment plans are documented on the appropriate forms and shared with the local Obstetric Team and Midwives as appropriate.

462. Ward staff will offer, when appropriate to speak to all new admissions or family members to advise regarding what to expect/bring for admission.

463. The unit can arrange to accommodate visits to the unit to allow mothers and their partners (where appropriate) an opportunity to view the environment and speak to the staff about any questions or concerns prior to an admission. These visits are pre-planned with the nurse in charge and will only take place if clinically safe and appropriate on the day **[MK2-197: Partner and carer leaflet].**

Admission

464. On admission, staff will meet mother or visitors in the reception area and escort them onto the unit. The unit has its own separate entrance so there is no mixing with other client groups.

465. The decision to admit mothers to the unit will be based on MDT discussion, risk assessment and clinical need. The mental health practitioner wishing to make a referral for admission must discuss the patient with the MBU before offering admission to the patient. Referrers will ensure that the mother is consenting to an admission where appropriate and that all parents with legal Parental Responsibility (PR) have consented to the baby being cared for within the unit, unless there are legal or safeguarding reasons to prevent this.

466. Parental responsibility is distinct from legal parentage and is defined by the Children Act 1989 as "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and [their] property". It is possible for someone to have parental responsibility for a child without being their legal parent, and for a legal parent to not have parental responsibility.

MBU assessments

467. A full nursing, medical and risk assessment of mother is carried out on admission which includes risk to self, others and baby. A body map and handover regarding the baby is taken and a baby care plan developed collaboratively with mother around the needs, routines of baby. All risk assessments are recorded on the trust electronic patient records (Paris- was historically called Carebase). The assessment includes:

a. The reasons for admission of mothers or mothers-to-be;

b. Who has made the decision;

c. Identify key worker responsible for the care and safety of mother and baby;

d. Confirm the capacity of the mother to consent to admission. Where a mother may lack capacity to consent to admission, the MCA is followed and where appropriate use of the MHA is considered;

e. Legal status of each mother i.e. informal or detained and ensure procedures around the MHA are followed and documented and all patients are aware of their rights;

f. Full records of Baby must be maintained covering all aspects of the Baby's care;

g. All involved with primary and community care of the Baby to be informed of
    i. 'admission' and progress to discharge stage;

h. The Baby is a visitor to mental health services and is not a patient in their own
    i. right;

i. The nurse will check any property that has been brought into the unit and any prohibited items that may be a risk to patient or baby;

j. Electronic patient records Paris template **[MK2-025**];

k. My care, my recovery care plan **[MK2-151];**

l. My leave;

m. My Care My safety plan **[MK2-152].**

468. Medical responsibility for the mother during admission will be with the designated Perinatal Consultant Psychiatrist. Medical Responsibility for the baby remains with the mother's General Practitioner until the baby is registered with them following registration of the birth.

469. Baby's legal status while on the unit is as 'dependent guest' and therefore is not admitted as a patient. A dependent child is not classified as a patient but is recognised as a child who has health and care needs, which cannot be met entirely by his/her mother.

470. Baby's daily progress report will be entered under a separate heading within Mother's electronic health care record however Baby's individual records e.g. health checks, weight, baby care plan will be held within a file on the ward within the nursing office.

471. A full nursing, medical and risk assessment of Mother will be carried out on admission which includes risk to self, others and baby. A body map and handover regarding the baby is taken and a baby care plan developed collaboratively with Mother around the needs, routines of baby. All risk assessments are recorded on the trust electronic patient records (Paris)

472. As detailed above, a welcome pack [**MK2-018]** is provided to mothers on admission with key information regarding their admission and process' on the unit and a member of staff will explain this to them. Mothers will be allocated a Keyworker and Co-workers to lead in their care whilst on the unit. Mothers/babies will be allocated a Nursery Nurse who will work with mothers to support and guide on baby's care and needs.

473. New admissions will be assessed by the ward doctor or on call doctor if out of hours within four hours of arriving on the unit and will be reviewed by the perinatal consultant within one working day.

474. Medical staff are based on the unit and the Consultant Psychiatrist is on the unit Monday to Friday and is always made aware of new admissions. The on-call Consultant is also available for advice at weekends when not on call. Junior doctors will complete assessments and request support from the Consultant on more complex cases.

475. The key worker or nurse in charge ensure that the mother has a basic understanding of what will happen in the facility, her responsibilities for her baby and herself and is orientated to the environment. The keyworker or nurse in charge need to ensure that any medication prescribed for the mother is administered in accordance with the agreed In-Patient procedures while considering the current feeding arrangements for baby, i.e. breast/bottle.

476. All mothers are referred to and supported by the unit's link perinatal midwife or health visitor as appropriate. All expectant mothers are referred within one working day to local midwifery service and will be seen by the unit's link midwife and registered for maternity care at Broomfield Hospital in Chelmsford, Essex.

477. Baby's daily progress report will be entered under a separate heading within mother's electronic health care record however baby's individual records e.g. health checks, weight, baby care plan will be held within a file on the ward within the nursing office.

478. The principal tasks of the team are observation, assessment and treatment. The allocated nurse is required to write in the mother's health and social care record documenting their observations and clinical interactions about the mother's behaviour,

mood, mental state and response to her baby on each shift. The allocated nurse with support from the team is also responsible for documenting the care given to the baby.

479. All mothers have a comprehensive risk assessment as part of the admission process, which considers any perceived risk to baby. Mother's observation levels will be based upon this risk assessment, however all new admissions should be nursed on at least level 2 observations (4 checks within the hour) for the first 48hrs to ensure a heightened level of monitoring and support. If a mother and baby is admitted from an alternative MBU observation level should be assessed individually considering care package, parenting ability and risk already demonstrated/assessed within an MBU setting [**MK2-041: POP1 Rainbow Mother and Baby Unit Policy].**

480. Historically all mums on admission were placed on level 3 observations but this practice was reviewed approximately four years ago and considered to be an unnecessary restrictive practice. This was updated at the rewrite and update of the unit's operational policy in 2022 **[MK2-041: POP1 Rainbow Mother and Baby Unit Policy].**

481. Staff have access to specialist knowledge on perinatal psychiatry, including mother infant relationship, interaction, attachment and child development. The Trust Pharmacist provides advice on the use of medication during pregnancy and lactation.

482. Nursing risk assessment and care plans are prepared for mum and baby including liaison with multi agency professionals involved and with the carer(s)/partner who holds parental responsibility. All mothers have a comprehensive risk assessment as part of the admission process which considers any perceived risk to the baby.

483. The MDTs risk assessment may stipulate the conditions under which a mother may be alone with her baby. In practice, the nurse in charge and/or junior doctor will decide when those conditions have been met. These decisions are recorded in the patients' health and social care records. The Unit encourages fathers/partners to be as involved in their child's care as possible unless clinicians have concerns in them doing so.

484. Should a patient's illness or behaviour threaten the safety of other patients, their own safety or safety of babies, then an assessment will be conducted to review the most appropriate, safest environment for treatment to continue. Due to level of risk, it may be deemed necessary for a period of treatment within an alternate setting including possible transfer to a psychiatric intensive care unit, subject to the availability of a bed.

485. All concerns regarding the mother's ability to look after her baby safely are documented. There may be reasons why the MDT may consider the mother is a risk to her baby or that admission to the MBU may not be the most appropriate place for admission to

continue. The decision to separate a baby from their mother may be based on one serious event or an accumulation of less serious events.

486. The decision to separate a baby from their mother is made in a multi-agency safeguarding children process when it is deemed that there is a significant risk of harm (S47 of the Children's Act 1989) to the child. The relevant local authority will be involved. Removal takes place either through court proceedings or the recommendation of a child protection plan, the latter being followed by court proceedings to determine the child's legal status if they are to remain separated from the mother. This process can take place pre-birth if the risk is assessed as significant harm to an unborn baby with the recommendation that the baby is removed at birth.

487. The unit caters for all types of patient conditions physical health care issues, physical disabilities and neurodiversity. For people with a learning disability and autistic people, a Care Education and Treatment Review (CETR) should normally take place preadmission to understand the person's needs and determine if they could be met in the community or whether they require an inpatient admission.

488. A CETR or CTR assessment is part of NHS England's commitment to transforming services for people of all ages with a learning disability and autistic people. There are two versions of the Care and Treatment Review:

- One for children and young people which is called a Care, Education and Treatment Review (CETR)
- One for adults which is known as the Care and Treatment Review (CTR)

489. Both the CTR and CETR are meetings to check that a person's care and treatment is meeting their needs. A CTR or CETR may be held for anyone with learning disabilities, autism or both who may be at risk of being admitted to hospital, or who is already in a specialist learning disability or mental health hospital.

490. When patients with autism and co-existing mental health difficulties present with challenging behaviour, the MDT will consider the development of a Positive Behaviour Support Plan together with the patient. This process can help increase understanding of the patient's triggers, warning signs, more and less helpful ways of responding and alternative ways of coping [**MK2-198: Positive Behaviour Support Plan template].**

491. A range of psychological therapies and activities are available within the Perinatal service including similar to outlined previously. In addition, the specific psychological interventions for MBU include:

a. Watch wait and wonder therapy - is an evidence-based approach which helps the practitioner focus on the quality of the parent-infant relationship. The parent is encouraged to become a better observer of their child, to think about what lies behind the child's communications or play, and to follow the child's lead or cues.
b. Baby massage-baby massage is the gentle, rhythmic stroking of your baby's body using your hands.
c. Yoga- therapy is the application of yoga practices to alleviate physical and mental health conditions with the view of promoting self-care and encouraging overall well-being.

492. The unit has access to activity co-ordinators and schedules to support mother and baby in a range of activities [**MK2-199: Therapy Timetable; MK2-200: Movement psychotherapy group].**

493. As with other services mothers may be prescribed medication, and the administration of medication is carried out in accordance with Trust policies and procedures. All Mothers will be given information in regard to risk: benefit of taking medication during pregnancy or while breastfeeding to allow them to make an informed decision. Medication would only be enforced during pregnancy or breastfeeding in exceptional circumstances and if believed that the risk of not medicating was greater than the risk of medicating, and would only be given in accordance with The MHA or Capacity Act.

494. Method of baby feeding (breast/bottle) should be considered when prescribing medication as breast feeding may be contra indicated. Breast feeding should be supported and assisted in Mothers who chose this option wherever possible and medication should be adjusted where possible to facilitate this. The method of baby feeding must be documented on the front of the mother's medication card and baby's if applicable. Any baby requiring medication during admission has a separate medication chart.

495. As with other services, the minimum qualification to administer medications are Registered Clinicians or Registered Mental Health Nurses on unit. Patients are monitored daily by junior doctors for treatments given or more frequently if needed. If a patient is receiving care from any other medical specialists the unit doctors still hold oversight and are supported by pharmacists. The unit receives peer support from the medicines management group.

MBU observations and coercive treatment

496. The MBU follow the Trust policy for Therapeutic Engagement and Supportive Observations **[MK2 –029]** but manage these differently for when mother is on her own and when she is handing her baby.

497. When observation levels are assessed on the MBU pregnant women or those up to 6 weeks postnatal will automatically be rated as Amber as per Trust policy until they have received their 6-8wk post-natal check and clearance, during this time under no circumstances can the mother be placed in Prone position and any physical intervention should be to a seated or kneeling position only. Staff should utilise the use of the safety pod wherever possible. If the mother during this time throws herself to the floor staff should immediately release any holds in place and ensure an immediate medical review takes place**.**

498. The use of seclusion is avoided and only undertaken in exceptional circumstances and if necessary, the unit uses the facilities of the Psychiatric Intensive Care Unit (PICU) room on site. If seclusion is used, this is for the minimum time and in line with the Trust's Seclusion and Long-Term Segregation Procedure [**MK2-146: CLPG41 Procedure for the use of Seclusion & Long-Term Segregation]** A contingency plan for the care of the baby is put in place. The seclusion of the mother prompts an urgent MDT review in relation to the possible increased risks and future management.

499. Following any physical intervention staff offer the patient a debrief to allow them time to discuss the incident, explore any contributing factors and offer reassurance and support. If necessary and appropriate this will be offered to other patients on the unit that may have been affected**.**

500. The safety of the mothers and babies and the staff on the unit is paramount. To ensure and assist in the management of this, all entrance and exit points require staff to access. The unit main entrance is operated by a fob and code system to restrict the ability of people accessing the unit inappropriately or a vulnerable patient or baby exiting the unit unplanned.

501. The unit is equipped with a non-recording intercom system with a camera at the main entrance, allowing visitors to notify staff of their arrival. Staff can view the entrance via a monitor located in the main nursing office. Access to the unit itself is controlled by an internal door operated by fob entry only.

502. All ward staff have trust photographic identification badges which are always worn. Staff ensure they check the identification of any person visiting the unit and view professional identifications as relevant.

503. All patients, either detained or informal, are informed of their legal rights and how to request and exit the unit. The unit assess and discuss any requests made giving consideration to legal status of the mother, baby and mothers' capacity.

504. The unit acknowledges there may be occasion where Mothers have the legal right to leave but it may not be possible for them to leave with baby due to baby's legal status or due to safeguarding concerns. The team act to always safeguard the baby whilst ensuring that they respect mother's wishes where safe and possible but taking appropriate action in line with MHA, MCA and Children's Act when needed.

505. The baby, whilst in the nursery, is separated from others and staff have an override key for their use. The unit have fewer blanket rules as the laundry is kept open, the garden is supervised when is use, and the main kitchen has supervision fob access and door to stop baby going in.

MBU leave

506. The MBU acknowledges there may be circumstances where it is not possible to predict or pre-plan an episode of leave. However, the unit will work to ensure all leave is pre planned and agreed with the MDT and exceptions to this should only be under exceptional circumstances.

507. The unit ensures that community teams and other agencies i.e. GP, Health visitor, midwife, social care are informed of all planned periods of leave as necessary and relevant.

MBU discharge and follow up

508. All discharge plans incorporate multi-agency involvement, including midwifery, health visiting and social care as appropriate. Staff ensure all agencies and relevant family members (with patient consent) involved in the MBU's care are made aware of and invited to weekly care reviews and discharge planning meetings. If it is not possible for community services to attend the meetings, staff will liaise and inform services via telephone and/or email of any relevant outcomes.

509. The principles of Care Programme Approach apply to all MBU admissions, and discharge planning starts at the point of admission. Referral for community support is made within the first week of admission. Every effort is made by the unit to ensure allocation of an appropriate community-based clinician to lead on planned transition arrangements between the inpatient MBU and community-based care.

510. Discharge planning takes into account the full range of needs for both mother and baby, and may involve referrals or signposting to other agencies and voluntary sector services. Upon discharge, all patients are provided with information on who to contact in an emergency or if they require further support. Every effort is made to ensure that mothers discharged from the service have an allocated care coordinator whom they have met prior to discharge. However, the unit recognises that this may not always be possible due to local area arrangements.

511. All relevant parties are informed of the patients discharge and a pre-discharge checklist is completed **[MK2-041 POP1, Appendix 9]** All patients discharged from the MBU are informed and invited to contact the MBU post discharge for support. At the point of discharge all patients are given an initial (24hr) discharge summary, the ward scans and email a copy of this to the GP at the same time.

512. If a patient wishes to self-discharge against medical advice, staff consider any risk factors to the mother and/or baby and any safeguarding concerns. Staff take appropriate action taking into consideration with MHA, MCA or Children's Act and ensure this is comprehensively documented on the electronic patient record.

513. If a mother wishes to self-discharge with her baby and it is not felt appropriate or possible to use the MHA to prevent her, staff will consider any child protection/safeguarding concerns. If no formal order is in place in regard to the Children's Act, but staff feel that baby would be at risk if they left, this should be explained to the mother wherever possible, and consultation should take place immediately with Social Care. Staff should not allow the baby to leave until plans are in place. If it is felt that the baby is or would be at immediate risk staff call police for assistance via (9)999 for consideration of a PPO (Police Protection Order).

514. The standard membership of the weekly MBU MDT which takes place the day before the patients care reviews varies according to the needs of the mother but in principle the membership consists of the medical team, the clinical lead, registered mental health

nurse, nursery nurse, psychologist, occupational therapist, activity coordinator and the therapist working with the patient.

515. The MBU, like other Trust service provisions, is monitored through internal and external scrutiny and its collaborative arrangements, however it adheres to the Perinatal Quality Standards **[MK2-201]** and is part of the peer group network.

Adults and older adults

516. The adult and older adult units are spread across multiple sites in the Trust and details can be found in rule 9(6a).

517. Each ward has designated 'security nurses' who are responsible for managing environmental aspects of the patient's experience on a shift-by-shift basis. Entry and exit points for the units are monitored and controlled by intercom and the door release access.

518. In older adults the wards are divided into those for acute mental health admissions (functional wards) and those for people with moderate to severe dementia in crisis (organic wards).

519. The criteria for any inpatient within adult services is for age 18 plus and for older adults aged 70 and over, and those between the ages of 65 and 70 provided the patient has a frailty score of 5 and above. Frailty score is determined using the Rockwood Frailty scale and is a measure of frailty based on clinical judgement and designed to grade the degree of frailty following a comprehensive assessment. The Rockwood Clinical Frailty Scale (CFS, 2005) is a semi-quantitative tool used to estimate an individual's degree of frailty on a scale of 1 (very fit) to 9 (terminally ill). Patients who score a 5 or higher are considered as frail and the degree of frailty will correspond to the degree of dementia [**MK2-202: NHS England Rockwood frailty scale].**

520. The Trust has several older adult organic wards and is where patients are admitted when they have diagnosis of dementia. Early onset dementia patients however may be admitted to an adult ward depending on their clinical needs and how young they are. The decision is made based on individual clinical factors.

521. Informal patients who are consenting to their admission are admitted into the assessment unit. Generally, adults aged 18 plus are admitted into the assessment unit but this could include older adults depending on their expressed preference or their

presentation. If the patient meets criteria for admission to an older adult ward generally, they will go directly to an older adult ward.

522. The Trusts Assessments Units cater to the assessment and treatment of informal patients, however, pressure on treatment bed has, at times resulted in detained patients being admitted to such units. The assessment units have been functioning since 2005 in South Essex and in North Essex since 2017.

523. If a patient is detained under the Mental Health Act, they are admitted to a treatment ward in their local area, provided a bed is available, and if not, are admitted to the nearest available bed.

524. In a small number of cases, it may be appropriate to admit a patient outside their local area—for example, when Psychiatric Intensive Care (PICU) is needed or when an urgent admission is required, and no local beds are available. In such instances, the individual will be admitted to a suitable facility that meets their needs, with the intention of returning them to their local area as soon as possible. However, this may not occur if there is a valid reason, such as the potential disruption to continuity of care or the patient's preference to remain in the current hospital setting.

525. PICUs as referred to in rule 9 (6a) are nationally recognised clinical units for patients who are acutely unwell and require increased levels of care. This requires them to have increased security protocols in comparison to general mental health inpatient wards.

526. For informal admissions, patients will be assessed by the clinical teams in the community and decision made whether enhanced community provision can be offered or whether admission is necessary. If admission is required, appropriate gatekeeping teams in the Urgent Care Pathway, such as Crisis Resolution Home Treatment teams, Crisis Response Teams, Urgent Care Department and Dementia Intensive Service/Team (for patients with dementia/frailty) will be contacted.

527. For patients requiring formal admissions (i.e. under the Mental Health Act), the assessments are completed by the Local Authority Approved Mental Health Professionals (AMHPs) and Section 12 approved doctors. AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the MHA. They are responsible for coordinating the assessment and admission to hospital if an individual is sectioned. The AMHP service transferred into the Local Authority between2018-19. Section 12 approved doctors are those approved by the Secretary of State under section 12(2) MHA 1983 where they are

described 'as having special experience in the diagnosis or treatment of mental disorder'.

528. When the decision is made that a patient requires admission a request is made for the bed, specifying the type of bed that is required. Under the MHA, the AHMP is the decision maker once the relevant recommendations are made pre–admission by section 12 approved doctor. The paperwork is provided to bed management team (an administrative team) which is then forwarded to the identified inpatient ward. The AMPH usually accompanies the patient and provides a handover to the inpatient team.

529. The urgent care pathway is for crises and the crises response team (CRS) provide a four-hour response. The Crises home treatment team and Accident and Emergency (A and E) liaison team have a policy **[MK2-203: MHOP33 Operational Policy Mental Health 24/7 Crisis Response and Home First Service]** for the 24-hour response. This is currently being reviewed alongside the three Integrated Care Boards for the entirety of the urgent care pathway.

530. The Mental Health Urgent Care Department (MHUCD)in Basildon provide a 24-hour response. [**MK2-204: MHOP30 Mental Health Urgent Care Department Operational Policy].** A and E liaison and crisis team respond to 111 calls made for home assessments and inform the decision for if attendance is required at the MHUCD. During working hours patients contact the team that usually coordinates their care for management of their condition, and it is not expected that the service would refer patients to the MHUCD. All parts of the pathway have consultant psychiatry access for a complex case for any medical view.

531. The bed management team in EPUT provide an administrative function and are not involved in making clinical decisions. The team gather information around referral requests and present them to the clinical inpatient team. This system was put in place in 2017 following a review of the corporate administration services and combined the functions of the admission and discharge processes into one team to look at the pressures across the whole system. The admission process has always been clinically led by senior clinical managers and is discussed twice daily in the SITREP meetings.

532. Clinical decision making on bed placement will take into consideration the availability of a bed, acuity on the receiving wards and number of patients on higher levels of observations. In deciding on the bed, views of the patients and family members are taken into consideration. A patient may have had a negative experience on a particular

ward and the particular ward may not be considered suitable for the patient. The preferred option is to admit the patient to a bed in the local area, but this may not be possible due to limited availability of a local bed.

533. In 2016, an inpatient director was appointed across the NEP in the North. Prior to that senior leaders would hold a clinical bleep for the area covered and would take the admission details. Post-merger, a single director for inpatient services was appointed for all adult and older peoples' wards in EPUT. In early 2020's the Trust transitioned into a Care Unit model and inpatient services for adults and older people became a care unit.

Discharge and follow up: older adult

534. The person's discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require inpatient care, with planned post-discharge support provided promptly on leaving hospital.

535. Each Older Adult ward has an unregistered Discharge Coordinator, who is a member of the inpatient multi-disciplinary team, line managed by the ward manager. Following Time to Care transformation programme, an Agenda for Change band 7 and band 6 practitioner are being appointed to provide support to the Older Adult wards with the most complex cases and include the implementation of an escalation process that can support resolution for barriers to discharge and system level challenges.

Discharge and follow up: adult

536. Previously there was a discharge support team divided into North and South areas and resourced, with Agenda for Change band 7 and a band 3 in the South, and band 7, band 6, and band 3 in the North. These staff were responsible for covering all inpatient treatment and assessment wards.

537. These were later supplemented by the addition of social workers under a Section 75 contract from Social Care A screening tool was used to look at barriers to discharge focussing on areas such as accommodation and housing. Care and support needs, finances and benefits, asylum or immigration status, substance misuse and other relevant factors.

538. Following Time to Care, there is now a band 6 allocated to each hospital, the two assessments units, and Psychiatric Intensive Care Units The screening tool is now

updated and includes Learning disabilities/Autistic Spectrum Disorder, Safeguarding, Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conferences (MARAC), and includes an initial discharge plan as part of the process.

539. Agenda for change (AfC) refers to national pay system for all NHS staff, except for Doctors, Dentists and most Senior Managers. There are no fixed criteria for when the discharge coordinators become involved, as a rigid practice would not be practical. Due to the limited team capacity, the team currently engages with more complex discharges.

540. The decision to involve discharge coordinators depends on several factors, including whether the individual is already engaged with services, whether they are under the care of a community team or other organisations already providing support, actions taken to address discharge barriers, and the outcomes of the screening process. This may result in a referral for care coordinator allocation or signposting to appropriate support services. [**MK2-205: Initial Discharge Screening and Plan; MK2-206: North Discharge Coordination Initial Screening Record].**

541. EPUT discharge coordinators navigate a very complex landscape that includes working under three Integrated Care Board's, three Local Authorities, and more than thirteen different housing authorities. There are further complexities of joint working with Learning Disability teams, physical health teams, Leaving and Aftercare teams, safeguarding, police, probation, and a host of others, due to increasing complexity of the cohort of individuals being supported,

542. At times challenges can arise in identifying relevant responsible Integrated Care Board/Local Authority, who hold the after care responsibility for detained patients following their discharge. There is the London and surrounding counties impact, which presents further challenges. There are Out of Area Patients, who are in various localities across the country, requiring oversight and input from EPUT.

543. The discharge coordinators are likely to benefit from the implementation of the new operating model and the multiple work streams that are ongoing with system partners to improve discharge pathways. The initial screening by the discharge coordinators in collaboration with patients, family and carer ambassadors, will lead to identification of any local or system barriers early on in the admission process and identification of actions to address those barriers.

CAMHS

544. Child and Adolescent Mental Health Services Tier 4 (CAMHS Tier 4) are a specialist service commissioned by NHS England since April 2013. This marked the first occasion where all elements of CAMHS inpatient services were commissioned nationally, providing an opportunity to implement standards consistently across the country **[MK2-207: NHS England Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report].**

545. EPUT operates two Child and Adolescent sites: Poplar ward in Rochford and St Aubyns Centre in Colchester. Poplar Ward a 13 bedded, mixed acute short stay ward which opened on the 23rd of February 2009. Young people are admitted between the ages of 13 to 18 to the child and adolescent units. **[MK2-250: Tier 4 CAMHS PICU Service Specification; MK2-251: Tier 4 CAMHS Service Specification]**

546. As referenced in Rule 9 (6a) CAMHS wards provide short term inpatient care for patients who cannot be treated in the community but do not require enhanced security or procedural measures that other wards do. Each ward has 'security nurses' responsible for the environmental factors of a patient's experience on a shift-by shift basis. Entry and exit points for the units is monitored and controlled by intercom and door release access.

547. Longview opened pre 2000 at the Turner Village site in Colchester, Essex and closed on the 18th of June 2012. On the same day, the new St Aubyn Centre, was opened in Colchester, Essex. Longview was initially an 11 bedded acute, mixed unit but did not provide Psychiatric Intensive Care. In 2012 Longview transferred to St Aubyn Centre, Colchester and opened as a 15 bedded short stay acute mixed unit.

548. Larkwood Psychiatric Intensive Care Unit opened as a new Psychiatric Intensive Care Unit (PICU) alongside Longview at the St Aubyn Centre on the 1st of June 2012, as a 10 bedded intensive mixed sex unit. CAMHS PICUs provide services to young people with an acute mental health disturbance that cannot be treated in the general CAMHS units and have increased security protocols.

549. The service holds a daily multidisciplinary referral meeting for admissions, Monday to Friday, across all EPUT CAMHS units. Referrals are currently received through a central email inbox linked to the provider collaborative, which has oversight of admissions and is involved in the decision-making process. Patients requiring prioritisation for admission across the East of England are managed through the provider collaborative and the patient flow team, who oversee bed availability and flow.

550. Referral forms are still reviewed by the service but over a period of time processes have developed to include the provider collaborative in the discussion who have been part of the meeting since December 2024.

551. The practice of a referral meeting has been in place since 2015-16. In the period before this, the process was ad hoc, and the crises mental health team were the point of referral. This would follow an assessment being undertaken in the Accident and Emergency Department by the crises team to decide if admission was necessary and then ward referral took place with a plan to admit.

552. At this point the units had a short-term crisis bed to manage flow due to admission beds being full. In 2021 the short-term crisis bed was changed to a 72-hour bed pathway, with most patients coming through ending up being transferred to longer term beds.

553. Decision making on admission has always been made by senior clinical team members with the oversight from multi-disciplinary team. On the rare occasions, when the team has deemed the admission to be clinically inappropriate, external factors have influenced the final decision. In most cases, this has involved legal directives through the Courts. In other instances, when an admission has not demonstrated a clear purpose for admission, external pressures such as patient's dissatisfaction with their current placement has influenced the push for admission.

554. It is preferable to pre-plan the admission and agree in advance. However, acknowledging that emergency admissions do take place, a new protocol was put in place in 2021 for decision making for out of hours admission, regarding who can decision for admission. The protocol for out of hours included reviewing any barriers to prevent the admission. Risks are RAG rated using a RAG system and if the risk is high, the wad may be considered unsafe for admission. **[MK2-208: Blank Poplar daily RAG ratings for admissions].**

555. Admissions onto the generic adolescent units (GAU) are for young people whose current level of mental health risks and presentation can no longer be managed safely in the community. The focus of the admission is to rapidly stabilise these risks so that young people can be safely discharged back into the community for the remainder of their mental health treatment.

556. Admission on the PICU aims to stabilise risks sufficiently so young people can be stepped down to their local GAU for further inpatient treatment. The PICU pathway is 6 weeks.

557. The units follow the same admission processes as other Trust inpatient services with modifications to suit the younger patients it cares for. A welcome pack is provided that is modified to suit the younger audience it is meant for, and are available in long, short and easy read versions **[MK2E019-021 and 047-048: Easy Read documents].**

558. The service access interpreters and translation services through Language Empire to aid any language barriers **[MK2-209: Language Empire EPUT Online Portal User Guide]**. The service has accessed support for individual patient needs including deafness, patients with mobility issues requiring their wheelchair and patients with a range of physical health issues and physical disabilities. The team adapt service to meet individual patient needs, accessing specific support to provide the episode of care.

559. The service has developed Easy Reads with the support of the psychology team that have produced literature to help the patients understand the psychological treatments and care they provide [**MK2-210 to 217].** Assessments are similar on CAMHS admissions to other services in that they include: medical assessment, psychology initial assessment, nursing assessment, MDT assessment and Teachers' assessment from the education unit when they start working with a young person.

560. The team work with a provisional diagnosis that is reviewed in ward rounds and CPA meetings. The approach to assessment and working with young people differ from other services in the way that patients may have different assessments and present differently at their age where there are concerns for autism. These are then collated and discussed in a care meeting.

561. In some cases, formulation or professionals' meetings may be held to discuss clinical observations. Where diagnoses are complex and require detailed assessments, such as in cases involving Autism Spectrum Disorder, follow-up meetings with the family are arranged based on the outcomes of these discussions. For more straightforward diagnostic queries, discussions typically take place during ward rounds or Care Programme Approach (CPA) meetings with the patient, family, and professionals. These outcomes are then documented in the clinical notes and communicated to relevant staff.

562. In all cases the team will assess patients as individuals, create formulations with the patients along the way as well as diagnosis and use approaches like PBS to focus on individual needs. Care is provided for needs led as opposed to diagnosis led **[MK2-198: Positive Behaviour Support Plan template].**

CAMHS interactions and staff roles

563. Formally, the patients would meet with each professional they're involved with once a week, and then informally every day they have contact and the option to request extra meetings. The CAMHS wards are designed in a way where the nursing office is in the middle of the lounge so that the patients have ready access to nurses and the therapists.

564. The CAMHS Inpatient Psychological Therapies team are part of a comprehensive multidisciplinary team across the service. Young people are allocated a care pathway(s) dependent on their presentation at the point of admission and agreement about what assessment/treatment is required to enable discharge and support recovery [**MK2-218: CAMHS Psychological booklet].**

565. The care pathway determines all the MDT interventions that the young person and their family are offered, including the role of the psychological therapies team. The care pathways are informed by Service Specifications for CAMHS inpatient services, CQC recommendations, NICE guidelines, and the latest evidence and best practice.

- Current care pathways are;
- Core – Psychiatric Intensive Care Unit and General Admission Unit;
- Emotion Dysregulation;
- Trauma;
- Disordered Eating/Eating Disorder;
- Neuro-divergent;
- Psychosis.

566. Care pathways are regularly monitored and reviewed with young people and their families, and within the psychological therapies and multi-disciplinary teams. Young people can be moved to another care pathway at any point during their admission if clinically indicated **[MK2-219 to 224: Care Pathways].**

567. Dependent on the care pathways selected the CAMHS Inpatient Psychological therapies team offer their direct interventions via:

- Individual assessment, formulation and treatments, including providing post discharge recommendations.
- Parent/carer/family assessment, formulation and treatments, including providing post discharge recommendations.

- Group interventions (young people and parent/carers), including providing post discharge recommendations.

578. The following therapeutic models are currently available in the service:

- Systemic Psychotherapy;
- Cognitive Behavioural therapy including trauma focused CBT;
- Dialectical Behavioural Therapy;
- Creative Arts Therapy;
- EMDR models.

568. The team also provide psychological thinking to non-direct work including multidisciplinary team formulations, CPA reviews, ward reviews with community professionals, section 117 planning meetings involving the patient and their family or carer with consent and the ward and Care, Education and Treatments Reviews (CETR).

569. The psychiatrists join the morning meetings and often attend informal activities with the young people, and form part of various group activities. The psychiatrists spend considerable time in meetings with patients and families.

570. Each morning the team have an MDT handover that the psychiatrists attend. This leads to a list of patients needing to be seen that day shared out across the medical team. If a patient needed a medical review, it is done that same day and will be with a consultant, if that needs to happen.

CAMHS observations

571. Since 2021, CAMHS introduced that no more than three patients on level 2 observations can be allocated to one member of staff and has subsequently been included in the Standard Operating Procedure [**MK2-42: COP1].**

572. The team undertake physical observations using the national Paediatric Early Warning System (PEWS) which is a tool rolled out by NHS England for tracking the deterioration of children in hospital to apply consistency in how deterioration is recognised.

Coercive treatment

573. The CAMHS service have changed the word from drop or rub down to pat resulting from engagement with their patients and their feelings to the use of the words. Uniquely for CAMHS parental responsibility and control results in parents asking for restrictions in place and the team respond to this individually. Changes have taken place over the

scoping period to the use of mobile phones and access to social media gained from learning and is continuously reviewed owing to the restrictive practise elements **[MK2-225: COP04 Inpatient Mobile Phone and Internet Use Protocol].**

574. The service assesses restrictions on items permitted in patients' rooms on an individual basis. High-level observations are also recognised as a form of restriction, as are limitations on leave, particularly within the framework of the Mental Health Act (MHA).

575. The units manage visitors to the ward in line with Policy [**MK2-042: COP1 CAMHS Inpatient Operational Policy]**, particularly with children, reviewing parental responsibility and the age of visitors and any safeguards needed for under eighteens. An agreed visitor list for a patient is made, that is individual to the patient referenced in the operating policy **[MK2-042: COP1 CAMHS Inpatient Operational Policy].** This is acted on if a particular court order or instruction was in place where a parent wasn't allowed to have contact. This is recorded in the patients care plan and that parent wouldn't be allowed on the ward or have telephone contact.

576. If a patient was in Long Term Segregation external scrutiny is requested, example being an external consultant psychiatrist from another CAMHS ward and a case manager to review. The EPUT safeguarding team are notified and included in the process [**MK2-146: CLPG41 Procedure for the use of Seclusion & Long-Term Segregation].**

577. Following an episode of segregation debriefs with patients takes place and a medical review by the consultant or RC. The patient undergoes physical, emotional, and psychological checks and the team are alert to secondary trauma from coercive practice. The therapy team carry out assessments and therapy for trauma that relates to coercive events and reviews are made in MDT discussions. More recently, restrictive practices have become a regular agenda item at weekly community meetings, where open discussions are held with all young people about how these practices affect the ward environment and dynamics [**MK2-226: Community meeting blank template].**

578. The team aim to offer individualised trauma-informed care and is a focus for all the therapy teams that have been trained to provide trauma focused work. Restraint will always include pre, debrief with the individual after restraint, and immediate physical checks or eye checks.

CAMHS Leave

579. The team's uniqueness from other services is that families will always be included and involved in all episodes of appropriate leave owing to their parental responsibility. Patients are assessed for their risk of absconding when the decision is made for them

to be escorted to and from the education block or if they can go on their own. The service is unique in that it manages patients leaving the unit to attend education. The education team will take patients out for Physical Education 1-2 times a week, once off site and the other on the ward. The education team provide sessions for archery, shooting acts, throwing and other activities. The unit has a programme of visits and educational activities **[MK2227: Poplar Activity Timetable].**

CAMHS risks balanced with therapeutic care

580. The service continually reviews and discusses whether they can reduce observations or increase leave for a patient when balancing between risk and therapeutic benefit. Patients are risk-assessed for various aspects of their care, including access to different areas of the ward, participation in specific parts of the programme, and even room changes. All such decisions are guided by individual risk assessments.

CAMHS care planning

581. Any Positive Behaviour Support (PBS) care plans are kept in the nursing office and on staff boards so that's they are available to staff temporary workers to view for a patient. The PBS is an approach used for naging different levels of distress, and a plan is made so that issues are managed consistently at home, on the ward and in the Community [**MK2-198: Positive Behaviour Support Plan template].**

582. The CAMHS service have formed a medical peer group that arranges medical cover arrangements and something similar is in place for the education team who are linked for their head-teacher.

CAMHS sharing between agencies

583. The service liaises in the same way as other Trust services but uniquely they contributed to a joint audit with Essex Local Authority. It was a year long audit on complex cases and discharges and the learning shared from the Local Authority was developed into a shared care plan between all agencies.

584. The service is unique in its work with Children in Care where parental responsibility if often with the named social worker for the child in the Local Authority of residence.

CAMHS Involvement of the patient

585. The service gives patients care questionnaires in an easy read form about how they are experiencing their care over the past week. These are reviewed, and the data is collated every three months by the psychology team who produce a report evaluating the

feedback they receive from the patients **[MK2-049: Easy Read Care Questionnaire; MK2-228: Results of Care Questionnaire for SAC and Poplar Care Q report].**

CAMHS contact with families

586. The service may engage with a patient's family for reasons beyond inpatient care, such as involvement in safeguarding or child protection proceedings, which are routinely addressed when relevant to a patient on the unit.

587. A family can request meetings with the consultant, other senior members of staff or with the nursing team and there are many informal contacts, which is encouraged when visiting or contacting the unit.

588. Many parents and young people are offered family therapy assessments from family therapists in the service whilst some don't have family that can be accessed in that way. All parents get invited to the online weekly parent care group **[MK2-229: St Aubyn Centre Online Parent/Carer Group Feedback]** run by the psychological therapist team with contributions from the MDT **[MK2-230: Larkwood Parent and Carer booklet; MK2-231: Longview Parent and Carer booklet].**

589. The service provides parents with communication feedback forms for when their child is a current patient and for discharge so that they can raise any concerns and provide feedback on their experience of their child receiving care [**MK2-232: St Aubyn Centre Current Parent/Carer Communication Feedback; MK2-233: St Aubyn Centre Discharged Parent/Carer Communication Feedback].**

CAMHS Second Opinions

590. CAMHS adopt the same principles and processes as the other services for when a second opinion is asked for. However additionally for CAMHS, a complex case panel is provided through the provider collaborative, so although not a formal second opinion, it's somewhere where the service can take a case to a clinical panel and discuss.

CAMHS monitoring and evaluating practice

591. The service participates in Five Pillars framework Quality Reviews where quality metrics are reviewed and evaluated for effectiveness. Additionally, case manager visits take place to review service provision by observation using the Five Pillars as the five cornerstones of holistic mental wellness **[MK2-234: Larkwood Five Pillars Quality Review].**

592. The service is part of a quality network for peer support and information for inpatient CAMHS with the Royal College of Psychiatrists programme that set and monitor standards and share good practise for transforming care.

593. The service has undergone external reviews as part of NHS England's Transforming Care programme and contributes to the Trust's participation in national practice audits. This includes involvement with the Prescribing Observatory for Mental Health, which focuses on specific areas of mental health prescribing. The service actively engages in these audits to review and monitor compliance.

594. For CAMHS, the education units on site are inspected by Ofsted and the reports produced are reviewed in the same way resulting in action plans that require implementation and monitoring. The CAMHS service is similar to the other units in that the CQC is the formal regulator for the provision for mental health services.

Statement of Truth

The content of this statement is true to the best of my knowledge and belief.

Signed: [I/S]

Dated: 26 March 2025