What We Do Together Matters.

Essex Partnership University
NHS Foundation Trust

MENTAL HEALTH UNIT

# Therapeutic Acute Inpatient Operating Model for Adults and Older Adults

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# Foreword

Firstly, I would like to acknowledge and thank all the authors, contributors, stakeholders, system partners and our 'lived experience voice' and involvement for collaboratively developing the EPUT Therapeutic Acute Inpatient Care Operating model.

In Essex and nationally mental health services are striving to provide safe, quality care and support for people with mental health conditions, neurological differences and psychosocial disabilities who require mental health inpatient services.

The NHS Long Term Plan (2019) and the NHS Mental Health Implementation Plan (2019 – 2024), set out ambitious, funded plans to transform mental health services, which significantly supported crisis, community pathways and specialist services. However, during implementation the COVID-19 pandemic began, which had a major impact on health and social care systems, including mental health. With the addition of the current cost of living crisis and a growing population in Essex by 10,000 people every year, inpatient mental health services in Essex have experienced the following challenges - sustained rises in acute demand, acuity and complexity, barriers to discharge for adults (18+) and older adults (70+) which impacts on high average length of stay and need for out of area placements.

Over the past couple of years in EPUT we have developed a resilient, experienced, knowledgeable, passionate and compassionate Mental Health Urgent Care and Inpatient Care Unit Leadership Team (Essex wide) that is led with care by myself as Director of Mental Health, Deputy Medical Director and Deputy Director of Quality and Safety with operational leaders, professional leads, workforce/HR, finance and transformation partners to focus on and manage the above challenges.

In 2022/23 during COVID –19 recovery we were very concerned about the national workforce challenges including high use of temporary staffing in mental health inpatient services, which led to the commissioning of the Time to Care Programme (TTC) by the executive team at EPUT in order to make changes to release significant and quantifiable time to care for our frontline staff on Inpatient wards.

The new Inpatient Care Unit leadership team recognised during the TTC programme that the new TTC staffing model would enable us to deliver a new innovative therapeutic operating model that would enable quality and safety consistency across all wards; ensuring purposeful admission with an ambition of an average length of stay 30 days (about 4 and a half weeks), equality, shared decision making, patient centred care, therapeutic benefit, trauma informed care, more integrated working with urgent care and community services to support safe local and effective discharge; and therefore improving the experience for patients, families and carers. Better collaboration between health and care professionals, families, carers, and individuals is key.

We would like to recognise and acknowledge the hard work and progress to date that the Urgent Care and Inpatient Care Unit has made, from frontline to leadership teams by improving Quality and Safety Performance, whilst embedding lessons learnt, working with system partners, lived experience ambassadors, peer support workers, and supporting a new registered nurse workforce on a daily basis despite huge pressures.

We are now very excited and motivated to mobilise our new EPUT Therapeutic Acute Inpatient Care Operating Model during 2024/25 which will be supported by the 2024/25 investment and recruitment of the Time to Care workforce, training schedule, Standard Operating Policy, International Fundamentals of Care and new EPUT Quality of Care Framework.

We will embrace the NHS England Culture of Care Standards for mental health inpatient services (April 2024) during mobilisation of the model - creating the conditions where patients and staff can flourish.

We look forward to working with you all.
**Elizabeth Wells, Director of Mental Health, Urgent Care & Inpatient Services**

# Executive Summary

Essex Partnership University NHS Foundation Trust (EPUT) is committed to delivering high quality, safe, consistent, integrated mental health services across all our inpatient wards. In support of this aim, the new Therapeutic Acute Inpatient Operating Model for Adults and Older Adults will enable delivery of a co-produced service model that is sustainable, measurable and supports consistent quality of care across our mental health inpatient services in Essex.

It is part of the Trust's Time to Care programme of work, which will transform how EPUT delivers mental health care. This includes a new staffing model *(see appendix page 79),* which will expand the capacity and range of skills in our multi-disciplinary teams (MDTs) and enable our clinical teams to focus on delivering high quality therapeutic care that is tailored to our patients' individual needs.

**Key principles of our new inpatient operating model:**

- Personalised care and shared decision making
- Care that advances health equality and involves co-production
- Joined up partnership working
- Trauma-informed care

**Key stages of our new inpatient operating model:**

- Purposeful admission
- Therapeutic benefit
- Proactive discharge planning and effective discharge support
- Trauma-informed care

We have taken learning from the past to ensure that the care we deliver every day will continue to be guided by actively listening to people with lived experience, those that care for them, and our staff. We have also collaborated with our system partners and adopted local, regional and national recommendations that will enable the Trust to improve inpatient care and sustain high standards reliably and consistently

**Together we will:**
*Create new innovative operating model for all wards, which is integrated with place-based community models and the wider system.*

This operational model aligns with our Trust strategic priorities, corporate aims, vision, values and the Care Quality Commission's (CQC) five domains of safe, effective, caring, responsive and well-led services.

We have identified key frameworks to support its delivery and monitor its effectiveness, which are aligned to NHS England (NHSE) national guidance outlining expectations for acute inpatient mental health care for adults and older adults (2023), NHSE Getting it Right First Time (GIRFT) principles/recommendations, and the Trust's Quality of Care framework *(appendix page 78).*

The Trust's Time to Care staffing model will be a key enabler to the new inpatient operating model and ensure a standardised approach and a robust governance framework to support delivery.

# Background and Rationale

In 2019, the NHS Long Term Plan was published, together with the NHS Mental Health Implementation Plan, which set out ambitious, funded plans, to transform mental health services.

As the implementation of place-based, specialist and 24/7 community services is almost complete, there is now a need to modernise our inpatient offer for people who present as very high risk and acutely unwell, who may be detained under the Mental Health Act 1983 (MHA) or require 24/7 assessment and treatment.

This is especially important as EPUT and other Trusts have seen increased acuity and demand, which coincides with the impact of the Covid-19 pandemic and cost of living crisis in recent years.

We have drawn on numerous sources of guidance, recommendations and best practice to design a new inpatient operating model that will support the delivery of high quality, patient-centred care.

We have incorporated new NHS England (NHSE) guidance, which was published in July 2023 to support acute Trusts to review their inpatient mental health provision. This emphasises the need for people to have timely access to high quality therapeutic inpatient care, which is close to home and in the least restrictive setting as possible.

We have taken on board recommendations from a recent CQC inspection of EPUT's inpatient services, which identified a number of key areas of improvement.

We have also addressed key themes from the Lampard Inquiry, and embedded lessons from recent inquests.

# Case for Change

## Key drivers of the programme

The new Therapeutic Acute Inpatient Operating Model for Adults and Older Adults is aligned to recommendations and guidance that is most important to driving change.

- NHS Mental Health Implementation Plan with a focus on improving Therapeutic Acute Mental Health Inpatient Care by 2023-24
- NHS England Guidance for Adult and Older Adult Acute Inpatient Mental Health Services (January 2023)
- NICE guidance
- Getting it Right First Time Principles
- Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2017)
- World Health Organisation's Hospital-based mental health services: Promoting person-centered and rights-based approaches, 2021
- Royal Pharmacological Society Professional Standards for Hospital Pharmacy services
- EPUT's vision, purpose, values and strategic objectives agreed in 2021
- EPUT's care unit and Trust strategic plans (agreed in January 2023)

- Parliamentary and Health Service Ombudsman Discharge from mental health care: Making it safe and patient-centered, February 2024
- EPUT Safety Strategy – updated 2023
- EPUT Quality of Care Framework – 2023
- The International Fundamentals of Care Framework
- CQC recommendations
- EPUT Quality Framework based on NHSE MHLD Inpatient Quality Programme Scope – agreed 2023
- EPUT Time to Care Programme

# Our Trust's Strategic Vision

EPUT's core business is to provide care services. The Therapeutic Acute Inpatient Operating Model drives high quality inpatient care and is underpinned by the principles of the Trust's Quality of Care framework.

## STRATEGIC OBJECTIVES

**We have four strategic objectives to achieve our vision:**

**We will deliver safe, high quality integrated care services.**

**We will work with our partners to make our services better.**

**We will enable each other to be the best we can be.**

**We will help our communities to thrive.**

# National NHS England Strategy

NHS England has produced its first national policy document outlining expectations for acute inpatient mental health care for adults and older adults (NHSE, 2023). The guidance has been developed from other planned policy documents, extensive engagement with clinical and expert advisors, and wider stakeholder feedback.
It aims to outline what good acute inpatient care looks like and provides practical suggestions to support systems to meet the ambitions in the Mental Health Implementation Plan. The draft guidance supports planning and spending on therapeutic acute care in 2023/24 and beyond.

This guidance is embedded in the new Therapeutic Acute Inpatient Operating Model.

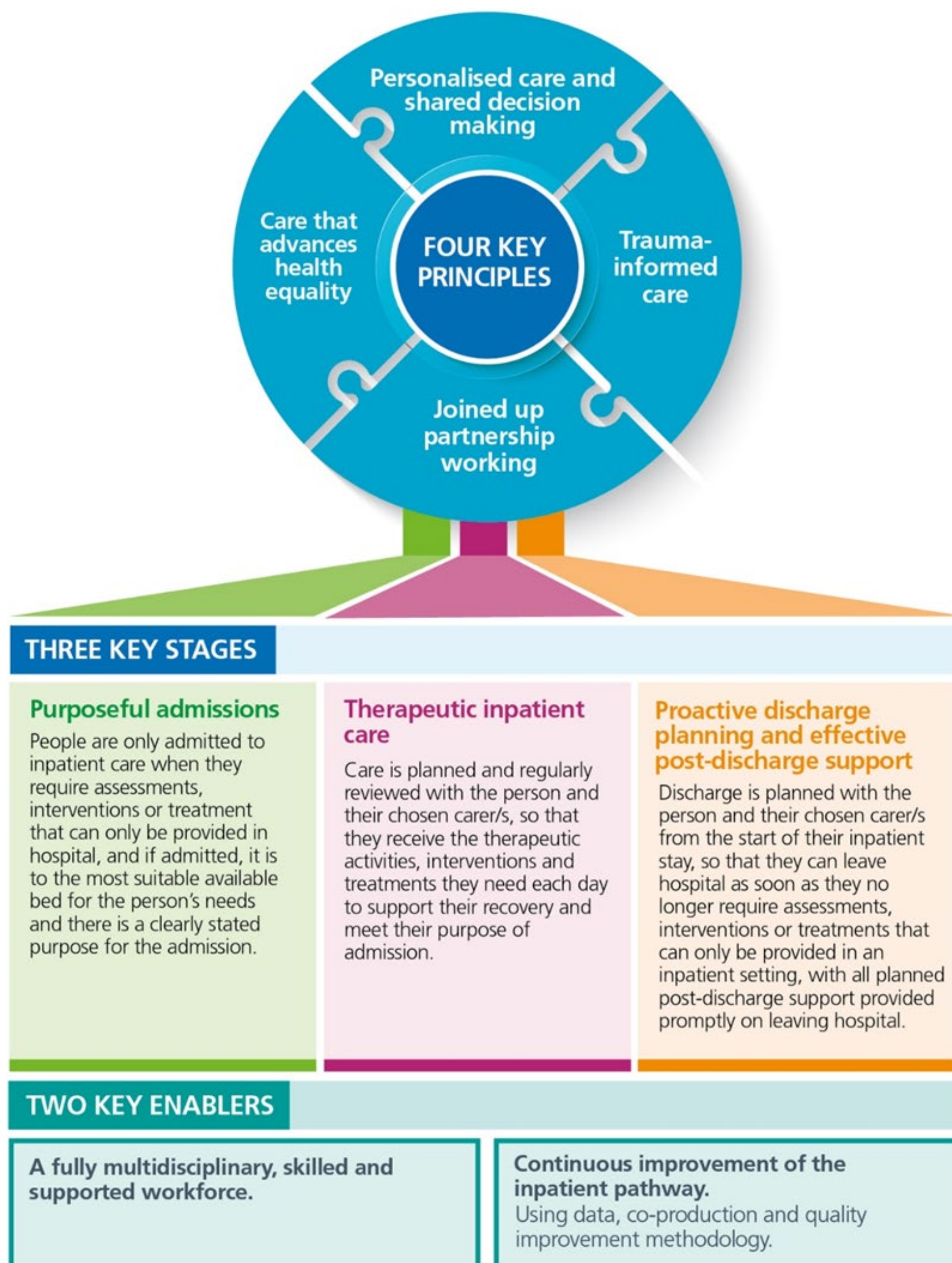
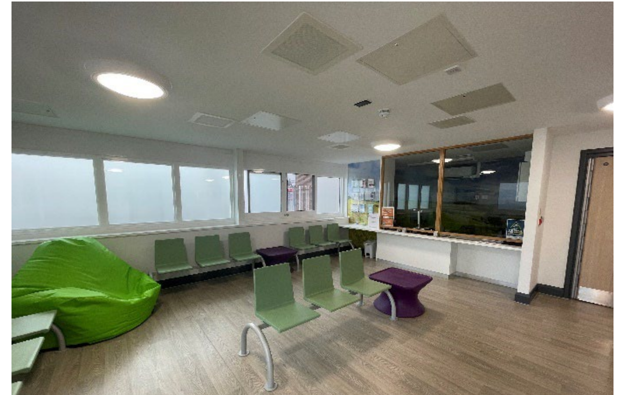



*Image from NHS England Guidance for Adult and Older Adult Acute Inpatient Mental Health Services (January 2023).*

# Urgent Care and Inpatients Care Unit Strategic Plan 2023-2028

The Trust's Urgent Care and Inpatients Care Unit provides urgent and emergency and inpatient mental health services for adults (18+) and older adults (70+). It provides inpatient care in 23 wards across Chelmsford, Colchester, Rochford, Harlow, Clacton, Basildon, Thurrock, and Epping.

The care unit operates a Trust-wide rehabilitation unit and two nursing homes, as well as community-based urgent care services including mental health liaison teams based within the five acute hospitals in Essex, crisis response services and home treatment teams



*Urgent care centre, Basildon, Essex*

## Urgent Care and Inpatients vision

- Work in partnership with our service users, their families and supporters.
- Modernise inpatient services to deliver excellent outcomes.
- Increase our skills and capacity to provide high-quality therapeutic care.
- Reduce inequalities in health outcomes.

### We will deliver safe, high-quality integrated services

- Develop and implement clear clinical pathways within our services.
- Further develop place-based alternatives to admissions.
- Implement family and social network-based approaches.

### We will enable each other to be the best we can be

- Release Time to Care and develop our managers.
- Introduce peer support workers on every ward.
- Promote a caring, learning and empowering culture.

### We will work together with our partners to make our services better

- Build a new partnership with services users, families and supporters.
- Drive transformation of urgent and acute mental health services.
- Develop shared education and learning modules.

### We will help our communities to thrive

- Improve health outcomes for people with serious mental illness.
- Improve equity of access, experience and outcomes.
- Provide good quality work opportunities for our communities.

# CHAPTER ONE

## Purposeful Admission (including capacity and flow)

**This chapter explains our framework for admission of individuals into acute adult and older adult inpatient services.**

# Overview

This chapter explains our framework for admission of individuals into acute adult and older adult inpatient services.

Each admission will have a clearly defined purpose for assessment and/or treatment that can only be delivered in acute inpatient care and ensures that there is therapeutic benefit to each admission.

Alternatives to admission should be explored when a clear purpose for inpatient admission is not indicated and/or there is no therapeutic benefit to the admission. Community-based alternative therapeutic treatment should be explored to provide effective care, whilst considering least restrictive alternatives.

By integrating learning from individual personal experience, the NHS Long Term Plan, the NHS Mental Health implementation plan, the Mental Health Adult Crisis & Acute Care, GIRFT National Specialty Report, the NHS E acute inpatient mental health care for adults and older adults guidance, alongside clinical best practice this model seeks to ensure that all admissions remain aligned with the key principles of personalised care; that admissions are purposeful and timely and that care is joined up across the health and social care system.

EPUT recognises the important role that early trauma can play in mental health difficulties. Research has demonstrated clear links between Adverse Childhood Experiences (e.g. ACE studies) and a range of different mental health diagnoses, with trauma also typically playing a key part in difficulties which may lead to a diagnosis of personality disorder or psychosis.

In deciding if an individual would benefit from an inpatient admission and there would a therapeutic purpose, clinicians should consider their early childhood and/or recent trauma and how an admission may inadvertently repeat early experiences and care giving. The overall aim is not to inflict further harm.

Principles and processes outlined in this operating model aim to hold in mind key aspects of care we believe will reduce the risk of re-traumatisation. These include:

- Providing a sense of safety, including the physical environments where assessments and treatments are offered.
- Working collaboratively with individuals and their families, carers and support networks.
- Developing a shared understanding of an individual's presenting difficulties and associated risk, including what has happened to them.
- Sharing responsibilities in the recovery process, aiming to empower and combat stigma or social injustice associated with mental health diagnosis/treatment and need for inpatient admission.
- Offering choice and information to support decision-making.

By adhering to these principles, the model aims to optimise the use of inpatient resources whilst providing the best possible care to individuals in need of acute inpatient mental health admission.

# Objectives

The NHS England acute inpatient mental health care for adults and older adult's guidance sets out a clear vision that every person who needs acute inpatient mental health care receives timely access to high quality, therapeutic inpatient care, close to home and in the least restrictive setting possible:

- Care is personalised to people's individual needs, and mental health professionals work in partnership with people to provide choices about their care and treatment, and to reach shared decisions.
- Admissions are timely and purposeful - When a person requires care and treatment that can only be provided in a mental health inpatient setting and cannot be provided in the community, they receive prompt access to the best hospital provision available for their needs, which is close to home, so that they can maintain their support networks and community links. The purpose of the admission is clear to the person, their carers, the inpatient team and any supporting services.
- Care is joined up across the health and care system - inpatient services work in a cohesive way with partner organisations, at admission, during a person's inpatient stay and to support an effective discharge, so that people are supported to stay well when they leave hospital.

This vision is underscored by key commitments for adult acute mental health inpatient services outlined in the NHS Long Term Plan to:

- Eliminate all inappropriate adult acute mental health out of area placements.
- Reduce avoidable long lengths of stay in adult acute mental health inpatient settings (including for people with a learning disability and autism), so that people are not staying in hospital any longer than necessary.

The Mental Health Adult Crisis and Acute Care GIRFT National Specialty Report outlines the need to:

- 'Get it right first time' by ensuring equitable access to timely and effective core mental health, community care and treatment before people reach emergency need level.
- Routinely use proven flow tools, in both community and inpatients, to maximise effective use of capacity.
- Create 'easy in, easy out' services to prevent people being stranded in the wrong part of the pathway:
    - Based on therapeutic benefit not being delayed.
    - The earlier the person gets the therapeutic benefit they require the fewer secondary and tertiary harms occur.
    - Early intervention usually means the underlying condition is also easier to treat.
    - In turn, the above means that improvement is quicker, and so the intensity of input can be stepped down quicker. Hence, it is easier to step up input for next person who needs it.

These national documents highlight the need for each person to work in partnership with professionals to develop a plan of care that meets their need, is personalised, timely and as close to their home as possible.

Individual personal experience has been shared throughout this purposeful admission chapter of the operating model.

**Ensuring that people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available inpatient service provision for the person's needs, and there is a clearly stated purpose for the admission.**

**'Acute inpatient mental health care for adults and older adults'**
**NHS England, 18 July 2023**

Appendix 1 *(page 83)* outlines the indicators that are monitored at a national level to measure the effectiveness of acute mental health pathways.

**Deciding whether an inpatient admission is required or the person could be supported through a less restrictive community-based acute care model**.

When people are in crisis, they require prompt access to the right support, in the best setting for their needs.

*"When I got admitted to hospital in 2018 it seemed to take way longer than necessary for me to get admitted. It was triggered by a bad reaction to LSD I took. I am unsure about the time frame it felt like 2 to 3 weeks from when I started getting ill. It would have been better if they sent me to the Linden Centre sooner because I kept getting worse to the point I tried to OD on the medication, then they sent me to Broomfield where once they knew I was OK I was admitted to linden centre. One thing they could have done when I was going in was to say where I was and why because at the time I was so confused and distressed, I thought I was being put in a prison for something I didn't do."*

For people with a learning disability and autistic people, a Care (Education) and Treatment Review (CETR) should normally take place pre-admission to understand the person's needs and determine if they could be met in the community or whether they require an inpatient admission.

For people who do not have a learning disability or autism, a holistic face-to-face assessment should be conducted to understand the person's care needs and preferences in relation to treatment. This assessment should include identifying who the person's chosen carer/s are and what their views are about the person's care. To avoid the person needing to retell their story, their clinical record should be reviewed at the earliest opportunity, ideally prior to their initial assessment, to gather information from any prior assessments and care plans and to identify any advance choices. This information should be checked back with the person and their chosen carer/s in case there have been changes.

International Fundamentals of Care standards detail that a person is to have care and treatment that is tailored to their needs and preferences. This is supported by the use of

the Newman system model in EPUT urgent care pathway team's assessment and care planning.

Based on the assessment and taking the person's wishes into consideration as far as possible, a decision should be made about whether it would be better for the person to be admitted to hospital, including admission under the Mental Health Act (MHA), or whether it would be better for the person to be supported in the community. This may be through support from a community-based acute mental health service, such as the Home Treatment Team, or crisis house, or an intensive support team.

Consideration should be given to the impact on the person's life (e.g. home/tenancy, pets, employment etc), their family and friends (e.g. children, caring responsibilities).

Given that long lengths of stay in hospital can in themselves be harmful, decision- making needs to explicitly consider whether a hospital admission is essential because the person requires assessments, interventions and/or treatment that can only be provided in hospital and could not be delivered through community-based acute services.

*'Exactly 2 years later – I went through another episode of psychosis. I would describe this experience as even more challenging and dark. It lasted for 5 weeks. This time was different because I avoided hospital admission and medication. This time I had 3 things…*

1. *More insight because I had spent 2 years healing, self-reflecting about my past experience and talking to others who had been through similar.*
2. *More support around me. My care-co and my family knew the negative impact that hospital had had on me. Everyone, including myself, was more equipped to deal with it again.*
3. *I felt it was a spiritual experience and so the treatment I used reflected this. I used essential oils daily, crystals and I worked with a highly skilled and experienced energy healer for 2 weeks.'*

Often receiving care and treatment at home or in a less restrictive community setting can lead to a better experience of care because it means that the person can more easily maintain existing routines, access to their usual support network and can stay in a more familiar location.

*'When I was admitted I felt apprehensive and scared about my environment. I was admitted by a mental health nurse who took me seriously, which I appreciate. Based on my experience of being admitted to hospital, I feel like certain aspects were adequate; however I think mistakes were made in terms of my treatment and preventative action and I went onto have a traumatic experience in hospital ultimately."*

Within EPUT, the Home Treatment teams (HTT) will provide face-to-face assessment to explore with a person (and their chosen carer/s) whether an inpatient admission is required, or if they could be supported through a community-based acute intervention. The team's expertise in knowing the care and treatment options available within community-based acute care and inpatient care support in this decision-making.

Where a person is open to a community mental health service, a referral to the HTT will be made to support in working alongside the community team in offering the person an alternative to admission. By working in close partnership with the person and their chosen carer/s and partner services, the aim is to support the least restrictive assessment and treatment available.

In a situation where the community team are considering the need for a person to be assessed under the MHA, the community team consultant who knows the person will complete an assessment and the first medical recommendation prior to the request for a second Section 12 approved doctor and Approved Mental Health Practitioner, ensuring all key information is communicated to support the assessment.

*'I had an assessment by a panel of psychiatrists. They seemed very calm but didn't say much. They suggested I come into hospital under Section 2. I agreed, because I knew something bad was happening to me and I knew I needed help.'*

Best practice supports consultant assessment and review prior to consideration for all inpatient admissions and has proven effective during periods of heightened operational pressure.

The EPUT twice daily demand and capacity call includes membership from EPUT's Urgent Care Pathway (Home Treatment Team, Crisis Service (24/7) Mental Health Liaison Teams) and inpatient and community teams, the local authority AMHP Hub Leads (Essex, Southend and Thurrock) and Essex Police to support in the multi-agency membership working collaboratively as part of one wider team.

# Agreeing a purpose of admission

Communicating regularly about presentations and demand in the community, acute hospitals and police custody, in addition to staffing/ resource capacity to meet this demand, will enable us to make more informed decision-making about the most appropriate care setting and opportunities for alternatives to admission.

The introduction of the Clinical Flow Lead and Clinical Director for Flow roles seek to ensure there is clarity and consistency around decision making in relation to whether people receive community-based acute care or are admitted into hospital. When an assessing team judge that an inpatient admission is required, the reasons should be formalised in a purpose of admission statement, which clearly articulates why an inpatient stay is needed and the aims of the admission.

The following questions should be answered:

Purposeful
Admission Statement

- What is the purpose and therapeutic benefit of inpatient admission?
- Why can this not be achieved / provided as a community alternative to admission?
- Are there likely to be detrimental or traumatic effects to an admission?
- To inform care planning, what needs to be resolved to enable care to be provided in the community?
- What is the expected duration of admission and proposed EDD?

Evidence from quality improvement initiatives has shown that when a purpose of admission is recorded, it reduces the risk of people staying in hospital longer than needed.

The intended reforms to the MHA, outlined in the draft Mental Health Bill, include new detention criteria requiring admissions to provide therapeutic benefit:

*'The treatment must have a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations, to ensure that therapeutic benefit is considered both in relation to the purpose and likely outcome of the treatment'.*

Recording a purpose of admission helps to ensure that the inpatient team is clear on the therapeutic benefit that an admission should achieve and can work with the person, their chosen carer/s and any relevant partner services to achieve it. Formalising a purpose of admission should be done for each person admitted to hospital and should be recorded in the gatekeeping assessment within the clinical record or the MHA documentation. It should be uploaded to the person's clinical record, together with an expected date of discharge (EDD). The purpose of admission and the EDD should also be shared with the person, and where appropriate, with their chosen carer/s and relevant partner services. Where an inpatient admission has been requested and there is no clearly articulated purpose for the inpatient admission, the clinical flow lead will liaise with the assessing team. An urgent meeting may be convened to enable all professionals to come together to fully understand the purpose for the admission or work together to develop a community alternative

In situations where the assessing team are unable to identify a purpose or therapeutic benefit to the admission, the Clinical Flow Lead and Clinical Director for Flow will support the assessing and community teams to develop mitigation, crisis and management of risk plans to enable a community alternative to admission to be provided for the person and their chosen carer(s).

**Appendix 2** *(page 85)* provides examples of good and poor quality purpose of admission statements (*taken from 'Acute inpatient mental health care for adults and older adults', NHS England, 18 July 2023)*

# Clinical Considerations

## Why must the treatment take place in hospital?

The following (adapted from the Admission Criteria, US Centres for Medicare and Medicaid Guidance, CMS.gov) describes the features which would fit with a plan of inpatient treatment, based on (a) the intensity of intervention required, (b) the severity of the patient's presentation, and (c) the availability of active effective appropriate treatment.

### Intensity of Intervention

The patient should need intensive, comprehensive, multifaceted treatment including 24 hours a day of medical supervision and coordination (i.e., that available in an inpatient unit) because of a mental disorder. This need may be related to:

- The need for patient safety or the safety of others.
- Psychiatric diagnostic assessment.
- Potential severe side-effects of psychotropic medications
- Assessment of behaviours consistent with an acute psychiatric disorder for which a medical cause has not been ruled out.

The acute psychiatric condition being assessed or treated by psychiatric inpatient admission should require active treatment, including a combination of services including intensive nursing and medical intervention, psychological and occupational therapy, which are not available in a non-hospital setting.

Patients should need inpatient services at levels of intensity and frequency exceeding what may be offered in an outpatient setting.

There should be evidence of failure at, inability to benefit from, or unacceptable risk in an outpatient treatment setting.

### Severity of disorder

Examples of potential features of the patient's presentation justifying admission include (this list is not intended to be exhaustive):

- Threat to self, requiring 24-hour professional observation (i.e., suicidal ideation or gesture prior to admission, self-mutilation (actual or threatened) prior to admission, chronic and continuing self-destructive behaviour that poses a significant and/or immediate threat to life, limb or bodily function).
- Evidence of planning and preparation for such behaviour, including efforts to avoid intervention from professionals when serious self-harming takes place, may also need to be taken into account when deciding if the intensity of the symptoms requires admission.
- In older adults, the presence of self-harm as part of the presentation renders the risk of completed suicide significantly higher and should also be taken into account when deciding the need for inpatient treatment. Lack of adequate social support and interaction in the community for people presenting in this way may also need to be considered around deciding if admission is appropriate to manage the presentation.
- Threat to others requiring 24-hour professional observation i.e. assaultive behaviour threatening others prior to admission, significant verbal threats to the safety of others prior to admission.

- Past history of serious risk to self or others in the context of mental health disorders, where there is recent recurrence of similar presentations to the past episodes, will also need to be considered around deciding if the severity of the presentation is sufficient to warrant admission.
- Command hallucinations directing harm to self or others where there is the risk of the patient taking action on them.
- Acute disorder/bizarre behaviour or psychomotor agitation or retardation that interferes with activities of daily living so that the patient cannot function at a less intensive level of care during assessment and treatment.
- Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient or others.
- A patient with dementia, for assessment or treatment of a psychiatric comorbidity (e.g., risk of suicide, violence, severe depression) warranting inpatient admission.
- Any mental disorder causing major disability in social, interpersonal, occupational, and/or educational functioning, that can only be addressed in an acute inpatient setting.
- A mental disorder that causes an inability to maintain adequate nutrition or self-care, and family/community support cannot provide reliable, essential care, so that the patient cannot function at a less intensive level of care during assessment and treatment.
- Failure of outpatient psychiatric treatment so that the recipient requires 24-hour professional observation and care. Reasons for the failure of outpatient treatment may include:
    - Increasing severity of psychiatric condition or symptom, including the development of irreversible long-term deficits
    - Non-concordance with medication regimen due to the severity of psychiatric symptoms or lack of insight
    - Inadequate clinical response to psychotropic medications
    - Severity of symptoms such that outpatient treatment is not appropriate.
    - Use of substances, which diminish the effectiveness of treatment to stabilise the mental disorder.

If a patient requires intensive treatment because of the severity of their symptoms, but they lack the capacity to consent (or are refusing consent) to treatment in the community, they should be admitted for inpatient care. Where this lack of capacity is secondary to a mental disorder as recognised under the MHA, then usually treatment will be on a compulsory basis under the Act as an inpatient.

## Active treatment

The available treatments should reasonably be expected to improve the patient's condition or should be for the purpose of diagnostic clarification. Treatment should be designed to reduce or control the patient's symptoms that necessitated admission, and ideally improve the patient's level of functioning.

# Presentations requiring specific assessment considerations

## People with Emotionally-Unstable (Borderline) and Dissocial Personality Disorders

These people require special consideration when being assessed for potential admission, as the nature of their disorders means that inpatient admission to an acute (non-specialised) psychiatric ward is often not beneficial and may produce a long-term worsening of the patient's condition. Generally, inpatient admission is not recommended for these people, except where there is a recent escalation in risk to an unacceptably high level, and where there is benefit in a brief admission to reduce the patient's arousal levels (and which cannot be done in the community). Alternatively, many people with these disorders have psychiatric comorbidities, which may require inpatient treatment.

## Young People

People under the age of 18 may be transferred to adult wards on turning 18 if they continue to suffer the intensity of symptoms and require the intensity of service needed to warrant inpatient psychiatric treatment. Each adult acute ward will have an identified transitions champion who will support the young person and their family/carer(s) through the transition period.

## Frail Adults

Older people who have functional mental disorders may be admitted to acute adult wards if they are not physically frail and their needs can be met appropriately in the acute inpatient ward setting.

## People with Learning Disabilities

People with a dual diagnosis of a mild learning disability and an acute mental health problem may be admitted to an inpatient mental health unit if the therapeutic environment meets their needs appropriately. Close working relationships are needed between ward staff and the Learning Disability services. For people with a learning disability, a CETR should normally take place pre-admission to understand the person's needs and determine if they could be met in the community or whether they require an inpatient admission.

Consideration should be given to the patient's communication needs and the most appropriate method of communication for the patient. It may be helpful to consider the use of easy read leaflets, as well as allowing additional time in ward reviews for patients with a learning disabilities.

When patients with a learning disability and co-existing mental health difficulties present with challenging behaviour, it may be useful for the MDT to develop 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.

Those with learning difficulties, such as dyslexia, may also benefit from being provided written materials in an accessible format.

## Patients with Substance Misuse Problems

People with mental health problems may have comorbid substance misuse issues, which require treatment concurrently with their mental health care. People whose primary

problem results from substance misuse are not normally eligible for admission to acute inpatient units. Requirement for inpatient detoxification is not a reason for admission to a mental health assessment or treatment ward.

People with mental health problems may have comorbid substance misuse issues, which require treatment concurrently with their mental health care. People whose primary problem results from substance misuse are not normally eligible for admission to acute inpatient units. Requirement for inpatient detoxification is not a reason for admission to a mental health assessment or treatment ward.

## People with Autism Spectrum Conditions (ASC), attention deficit hyperactivity disorder (ADHD) and other forms of neurodivergence

Neurodivergence is a broad spectrum of neurodevelopmental conditions, which include ASC and ADHD, amongst other conditions. People with ASC and/or ADHD and other forms of neurodivergence may at times also experience treatable co-existing psychiatric conditions, which in some cases might be suitable for intervention on a psychiatric ward (within the criteria above).
However, inpatient admission for such people without such comorbid disorders should be avoided*, as the likelihood is of extended admissions with little benefit or indeed active worsening (including institutionalisation).

Admission to an inpatient ward **purely** based on the absence of adequate social care provisions in the community to care safely for such people should also be avoided. In such cases, there would not seem to be a purpose for admission, and therefore according to the above such interventions would be inappropriate.

For people with a learning disability and autistic people, a CETR should normally take place pre-admission to understand the person's needs and determine if they could be met in the community or whether they require an inpatient admission.

When patients with autism and co-existing mental health difficulties present with challenging behaviour, it may be useful for the MDT to develop 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.

When someone with an established diagnosis of ASC is admitted to hospital, the treating team should explore if the patient has a My Health Passport in place. If not, it may be helpful for the patient to be supported to complete this. The My Health Passport can be accessed at [www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport.](www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport) This is a resource for autistic people requiring hospital treatment which was developed by the National Autistic Society. It helps autistic people communicate their needs to healthcare professionals, for example their preferred communication methods, how they experience pain, and sensory needs.

When someone with ADHD is admitted to the ward, it will be important to establish if the patient requires medication to be prescribed to help with the management of their symptoms of ADHD.

When someone with **suspected** ASC and/or ADHD and co-existing mental health difficulties is admitted to the ward, and an assessment for ASC and/ or ADHD is requested, it will be important to consider such requests on a case-by-case basis. However, consideration should be given to:

- Whether the assessment of ASC and/ or ADHD is indicated at the current time (whilst the person is an inpatient), for example to inform whether confirmation or otherwise of neurodivergence would inform onwards placements.
- whether it is more appropriate for the patient to be assessed in the community post-discharge
- Whether the patient's mental state is currently stable bearing mind that such assessments should not be completed when a patient is acutely unwell, as it may not give a clear reflection of the person's needs and difficulties.
- Diagnostic assessments of ADHD and/or autism carried out whilst someone is an inpatient will be done in accordance with the relevant NICE guidelines.

Even in the absence of a diagnosis, professionals supporting those who report experiencing difficulties consistent with neurodivergence, should consider making reasonable adjustments where possible. Reasonable adjustments may include making adaptations to the ward environment and/ or the ward routine, e.g. 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 (as long as this is in keeping with the person's risk assessment). A sensory assessment by Occupational Therapy may also be helpful to further understand and support the needs of patients who are neurodivergent.

(*N.B. this guidance fits with the direction of travel of mental health law, with the new draft Mental Health Bill suggesting that detaining patients solely because they present with developmental disorders such as ASC is not appropriate.)

### People with eating disorders

Where people with eating disorders have treatable co-morbid psychiatric conditions that meet the criteria stated above for inpatient treatment, then admission may be appropriate.
However, admission to a general adult (non-specialist) psychiatric ward purely for the management of a person's eating disorder is not appropriate and should be avoided.

If a patient is rendered severely physically unwell by poor dietary intake secondary to an eating disorder (or indeed any mental health disorder), then they should be admitted to a medical ward and stabilised before consideration is given to psychiatric inpatient admission.

Non-specialist psychiatric wards are not appropriate for the admission of patients requiring re-feeding, as this is a process which requires specialist expertise around nursing, occupational therapy and dietetics, and also the availability of intensive (sometimes daily) physical monitoring (including serial blood tests and ECGs), none of which are available on a general psychiatric ward. Hence, admissions for this reason should again be avoided.

**Checklist for professionals deciding if inpatient admission is warranted**

(To be discussed, agreed and shared (as far as possible) with the person being considered for admission, the person's carers, and other involved professionals.)

1. **Is the admission purposeful?**

2. **Why must the assessment/treatment take place in hospital as opposed to another setting?**
   - ✓ Presence of sufficient severity of disorder
   - ✓ Required intensity of intervention for this presentation of the disorder
   - ✓ Availability of active treatment likely to be of therapeutic benefit in hospital

3. **What needs to happen for the person to be ready for discharge?**

## Challenges to purposeful admission faced by the wider emergency care pathway / community provision.

Home Treatment Teams undertake the gatekeeping of all in-patient admissions. They identify the following challenges, or alternatives, to admission:

- Lack of meaningful crisis plans being developed or available, for those known to services. Blanket statements referring a person to Emergency Department when in crisis.
- Rationale for reason for admission being to 'maintain a person's safety' with lack of clinical detail.
- Lack of clear expectations of the purpose of admission.
- Pressure on lack of beds resulting in patients awaiting admission in inappropriate settings.

Where operational pressures 'black alert' principles are implemented, the wider crisis teams identify the following as strengthening the decision making regarding admission:

- Professionals meetings for those high intensity users.
- Clinical Patient flow lead and Clinical Director for Flow and Capacity providing scrutiny and clinical oversight scrutinising the rationale for admission.
- Black alert principles being embedded in practice. Consultant involvement and strengthening the decision making for admission.

## Arranging prompt access to the most suitable inpatient provision for the person's needs.

It is expected that when someone requires an admission, they will receive prompt access to the most suitable inpatient service that is available for their needs and begin receiving inpatient support as swiftly as possible.

Each person pending admission will be discussed on the twice daily demand and capacity call and decisions made about the most suitable inpatient ward to meet the individuals' needs. Community based teams will inform the call of the intervention and support in place for each individual as an alternative to admission whilst pending admission.

Clinical decisions about priority for admission will be made by the Clinical Flow Lead, Clinical Director for Flow or the Chair of the Call. This will be informed by the clinical presentation for each individual pending admission and the rationale for decision-making documented.

The Bed Management team will enter the detail of all people presented for admission onto the Surge Management and Resilience Tool Set (SMART), entering progress updates and admission information. The SMART tool is available to all EPUT staff via the intranet, provides required information for clinical teams, and also supports in out of hours decision making. (Implementation in Progress).

The EPUT admission pathway is for individuals assessed as requiring informal admission will be admitted to an Assessment Unit during which, informed by the purpose of admission, a thorough assessment of the persons mental health presenting need is completed, and plans developed to facilitate discharge to community services implemented. The intention is that this will be completed as swiftly as possible to enable a person to return home supported by the appropriate community services.

Delivering personalised care requires those providing inpatient mental health care to work as equal partners with the person and their chosen carer/s to reach shared decisions about the next steps in the person's care. It also involves recognising that even when in crisis or acutely unwell, people are experts in their own lives and have valuable contributions to make about the support that they need both before, during and after their hospital stay. It is important that clinical teams attend to the expectations of each person and their family/carers by ensuring the care is clear, achievable and realistic and by ensuring that the individual's thoughts, views and expectations are captured in their My Care, My Recovery document.

On occasion, the outcome of admission to an assessment unit might be the requirement for a person to be transferred to a treatment ward for ongoing intervention. In this circumstance, the purpose of admission and the intended therapeutic benefit of the treatment ward admission will be clearly defined by the assessment unit MDT alongside the person and their chosen carer(s).

Once the purpose of ongoing admission is clear, the assessment unit leadership will liaise with the Bed Management team and inform them of the need for a transfer of care to a treatment ward. This information will be reviewed on the daily demand and capacity calls with a view to earliest transfer. The Clinical Flow Lead/Chair will maintain oversight of all opportunities to transfer care and will ensure people are placed as close to their home/usual residence as possible.

Other than in exceptional circumstances, it is usually best for people to be admitted to their local acute inpatient mental health service, so that they can more easily maintain contact with friends, family and local community care teams.

There are a small number of circumstances in which it is appropriate to admit someone out of their local area, such as if Psychiatric Intensive Care (PICU) is required or if urgent admission is required and there is no available bed in their local area. In this case, the person will be admitted to a suitable bed to meet their needs with a view to returning to their local area as soon as possible, unless there is a good reason not to (e.g. it will disrupt continuity of care, or they want to remain in the current hospital setting).

If someone is experiencing an unacceptably long wait for an inpatient bed and this has not been resolved through routine processes such as bed management meetings, then system-wide escalation protocols should be followed in line with the EPUT Operational Pressures Escalation Level (OPEL) Framework.

Where admission to an Out of Area Private (OoAP) provider is being considered, authorisation is to be obtained from the Mental Health Inpatient and Urgent Care Director/ Associates, who will seek assurance on the quality of the proposed provider via CQC reports and local quality visits prior to admission. The Discharge Coordination team will be informed of all individuals admitted to an OoAP to enable communication and liaison with the provider, facilitate care coordinator engagement, and support oversight of the purpose of admission, clinical progress and progression to discharge.

## Key Purposeful Admission Actions to take place within 72 hours of admission

Key actions within 72 hours of admission

- Develop a care plan aligned to purpose of admission statement
- Establish an expected date of discharge (EDD)
- Understand any barriers to discharge that require resolution and agree actions to adress.
- Identify what needs to be in place for discharge to occur.
- Develop individualised crisis plan that outlines resources and supports available to enable person and chosen carer(s) to manage any future crisis.
- Where ongoing treatment admission is indicated, alongside the person and carer, clearly articulate the purpose and theraputic benefit of the treatment admission and propose the likely duration.

# Training and Development

To support the delivery of this purposeful admission chapter of the EPUT operating model for acute inpatient and urgent care, the following training needs have been identified with training resource developed:

- International Fundamentals of Care Standards
- Newman Systems Model
- Care Planning with a focus on purpose of admission
- Flow tools: R2G & Safer Care Bundles
- Neurodiversity

# Summary

**'Ensuring that people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available inpatient service provision for the person's needs, and there is a clearly stated purpose for the admission.'**
*(Taken from 'Acute inpatient mental health care for adults and older adults', NHS England, 18 July 2023)*

The new inpatient operating model emphasises the need for a clearly defined purpose for each inpatient admission. This should be established as early as possible in the process and discussed/agreed with the person, their chosen carer(s) and all treating professionals.

Included in this purposeful admission chapter are the clinical considerations for presentations and features that would fit with a plan of inpatient treatment informed by intensity, severity of presentation and availability of effective treatment. Presentations requiring specific assessment considerations are outlined with identified resources and tools available to support e.g. Admission checklist (adapted from Mersey Care's BPD Admission Checklist) suggested for use when assessing patients with Personality Disorders and parameters for the admission.

This chapter also outlines an approach and the supports available when there is no clearly defined purpose to admission and/or when there is no therapeutic benefit to inpatient admission. Solely admitting someone for the supposed management/containment of risk they present to themselves or others is not sufficient, if there is no therapeutic benefit to be achieved by admission. Indeed, in some cases and specific mental disorders, admission produces a deterioration in the patient's condition. This may result in an **increase** in their risk in anything other than the very shortest term. Equally, admitting someone for the rationale of 'reducing risk' where there was no treatment, which would actually reduce the risk presented by the patient, would logically result in the need for indefinite stays in hospital.
Professionals are **not** expected to provide ineffective or actively harmful interventions. Treatment should be **reasonable, appropriate and proportionate**. Where professionals are faced with levels of risk, which they regard as unacceptable, and where there does not appear to be any effective treatment available to moderate the risk, the person's case can be escalated to the Clinical Flow Lead and the Clinical Director for Flow. Then a multidisciplinary case review can be convened among relevant professionals (from both the acute and community services) to reach a consensus on appropriate further management.

Arranging prompt access to the most suitable inpatient provision for the person's needs is addressed throughout this chapter with systems and processed outlined.

The key flow actions to support purposeful admission are outlined and are to be completed within the first 72 hours of each inpatient admission:

- Develop a care plan aligned to the purpose of admission statement.
- Establish an expected date of discharge, informed by individual needs.
- Identify what needs to be in place for discharge to occur.
- Understand any barriers to discharge that require resolution and agree actions to address.
- Develop an individualised crisis plan that outlines resources and supports available to enable the person and their chosen carer(s (to manage and future crisis.

- Where ongoing treatment is indicated, alongside the person and carer(s), clearly define the purpose and therapeutic benefit of the treatment admission and propose the likely duration.
- Proven flow tools have been highlighted to support in ensuring that each admission remains purposeful (e.g. Red to Green; Safer Care Mental Health Flow Bundle). The meeting structure to maintain oversight of progression to discharge, including the routes for escalation of constraints to discharge at Ward, Trust and System Level outlined.

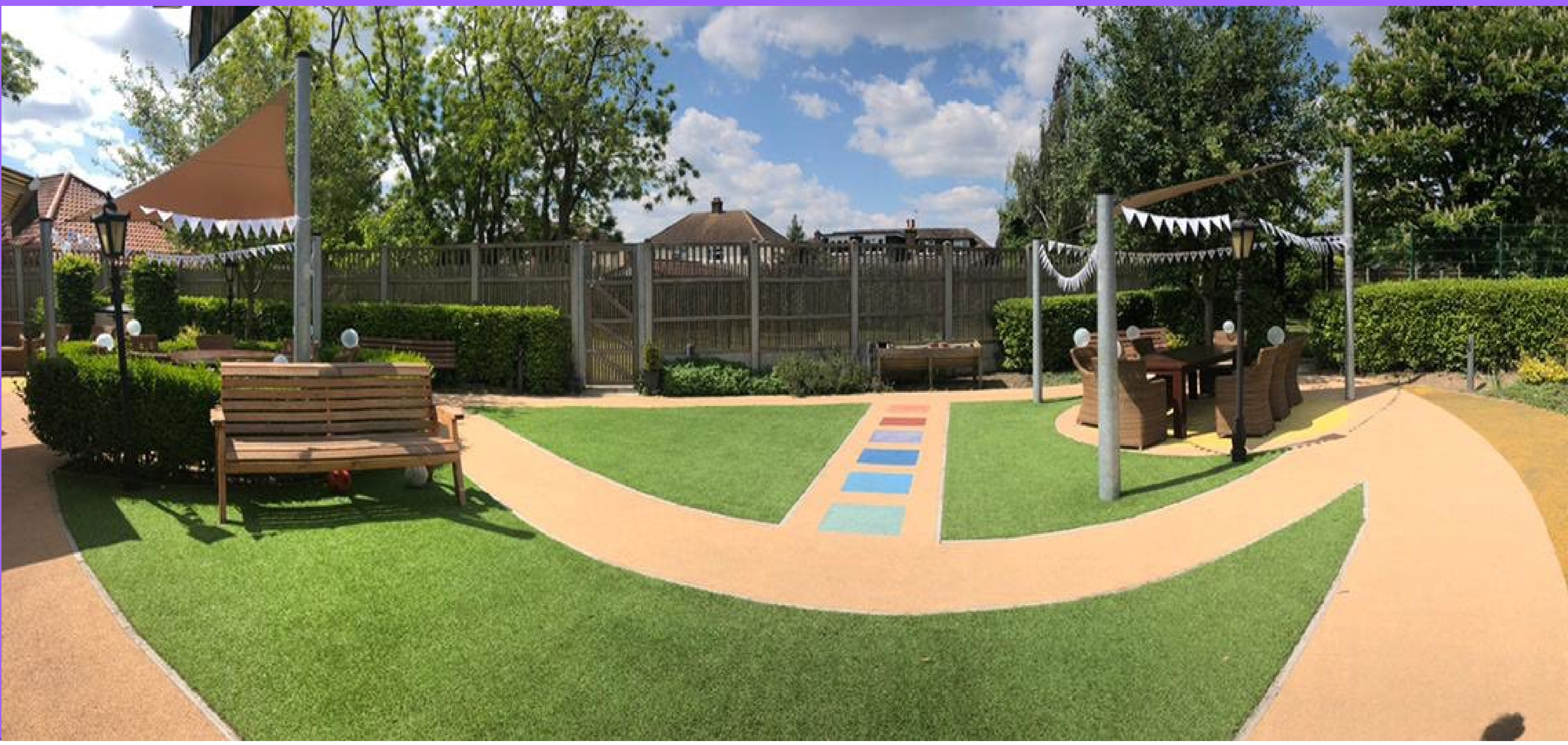
Lastly, to support the delivery of this purposeful admission chapter of the EPUT operating model for acute inpatient and urgent care, the following training needs have been identified with training resource developed:

- International Fundamentals of Care Standards
- Newman Systems Model
- Care Planning with a focus on purpose of admission.
- Flow tools: R2G & Safer Care Bundles.
- Neurodiversity

# CHAPTER TWO

# Therapeutic Benefit

**This chapter covers some of the key areas we will focus on to deliver high quality, therapeutic inpatient care.**



# Overview

This chapter covers some of the key areas we will focus on to deliver high quality, therapeutic inpatient care.

Key principles:

- Care will be planned and regularly reviewed with the person and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.
- Purposeful care in a therapeutic environment supports people to get better more quickly and reduces avoidable time spent in hospital.
- Once a person has been admitted to hospital, they should receive care that delivers therapeutic benefit throughout their inpatient stay.

# Care Formulation and Planning

Care is planned and regularly reviewed with the person and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission including:

- Purposeful care in a therapeutic environment supports people to get better more quickly and reduces avoidable time spent in hospital (supported by the Red to Green approach).
- Delivering therapeutic activities and interventions.
- Optimising medication regimes.
- Reviewing and updating care plans to ensure they meet the purpose of admission.
- Every ward to have a MDT meeting where all disciplines are represented. The purpose of inpatient admission, current presentation including risk, as well as the client's history profile and its impact on their mental health, behaviour, and engagement is discussed. Suggestion to consider a unified approach across all services and for consideration to adopt the 5P formulation, which details triggers to admission and is initially discussed in the MDT meeting to explore the individual's difficulty and successively link theory to practice. This framework will summarise all information gathered from assessment and allows the client to understand from their experiences from psychological prospective.
- The International 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. 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.
- Ensure that any concerns around substance or alcohol use and smoking are covered, discuss options that are available and agree achievable goals. Short term and long-term treatment must be considered and interventions offered to reduce any symptoms of withdrawal and support abstinence.

# Reviewing and Updating Care

Patient's care plans that are co-created with the patient and are personalised to their needs will be reviewed and updated with the patient on a regular basis. Families and carers are involved in this process to ensure shared decision making with the patient are the centre of their care.

Our aim is to ensure that the care that is provided advances health inequality by ensuring the patients care plan is co-produced with the patient at the heart of the inpatient care. Our inpatient wards will have lived-experience workers to assist the nursing teams in understanding mental health inequality and ensuring we are meeting the needs of our patients, families and cares from all diverse communities.

Our aim is to ensure that our system partners and community services are involved in the reviewing and updating of care to ensure joined up partnership working.

By embedding CQC actions, and any serious incidents will raise awareness and show learning from previous incidents whilst also building processes into teams to enable them to learn from incidents. Consider how the safety dashboard can be used alongside learning from Datix to form areas of support.

Implementing the International Fundamentals of Care, we will be achieving parity of esteem by tackling mental health issues with the same priority as physical illness to embed new behaviours into practice.

# Delivery Therapeutic Activities and Interventions

**'Care is planned and regularly reviewed with the person and their chosen carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day, to support their recovery and meet the purpose of their admission'.** *(Acute inpatient mental health care for adults and older adults, NHA England, 2023)*

**'Planning with patient & carers, community teams, including Crisis and Home Treatment, discharge coordinators and system partners. Review of support required and reduction of potential barriers to ensure safe discharge and transition of care.**

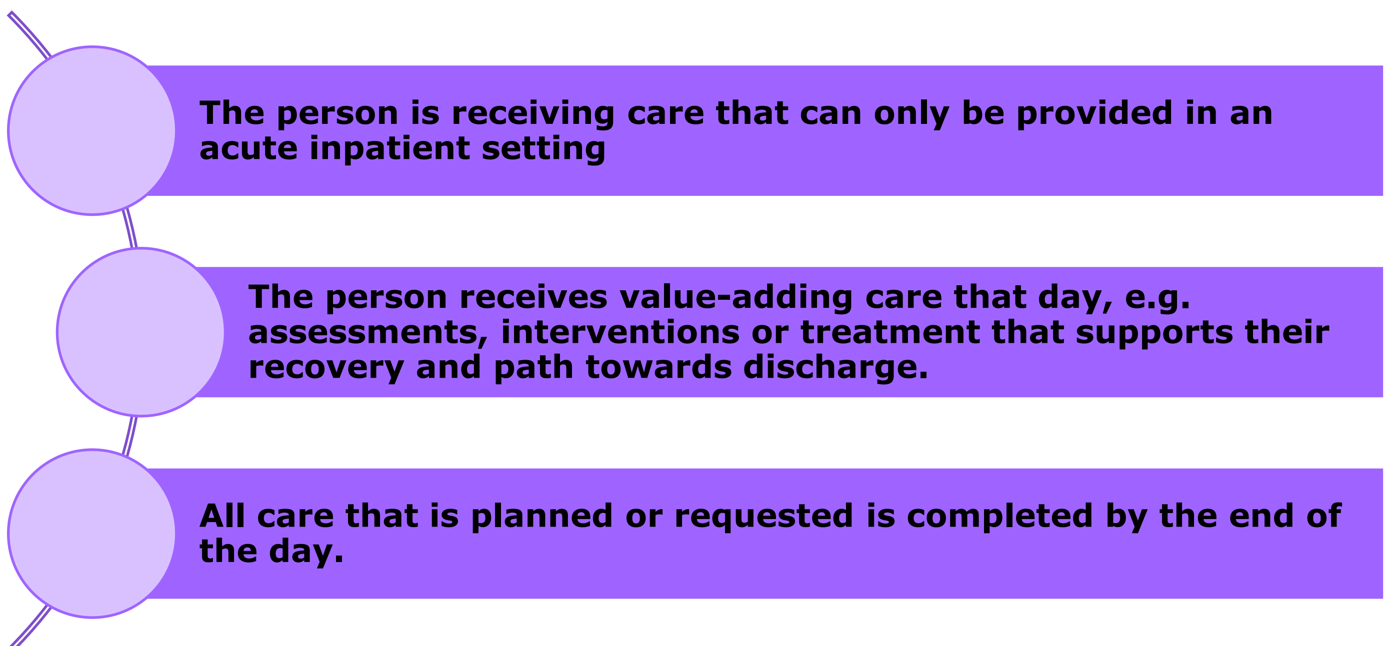
# Maintaining focus on the purpose of admission

The Red to Green approach is a helpful tool that can be used to support the allocation of tasks that are needed to deliver a person's care plan (including ensuring that people receive the activities and interventions they need to recover), and to facilitate a timely and successful discharge from hospital.

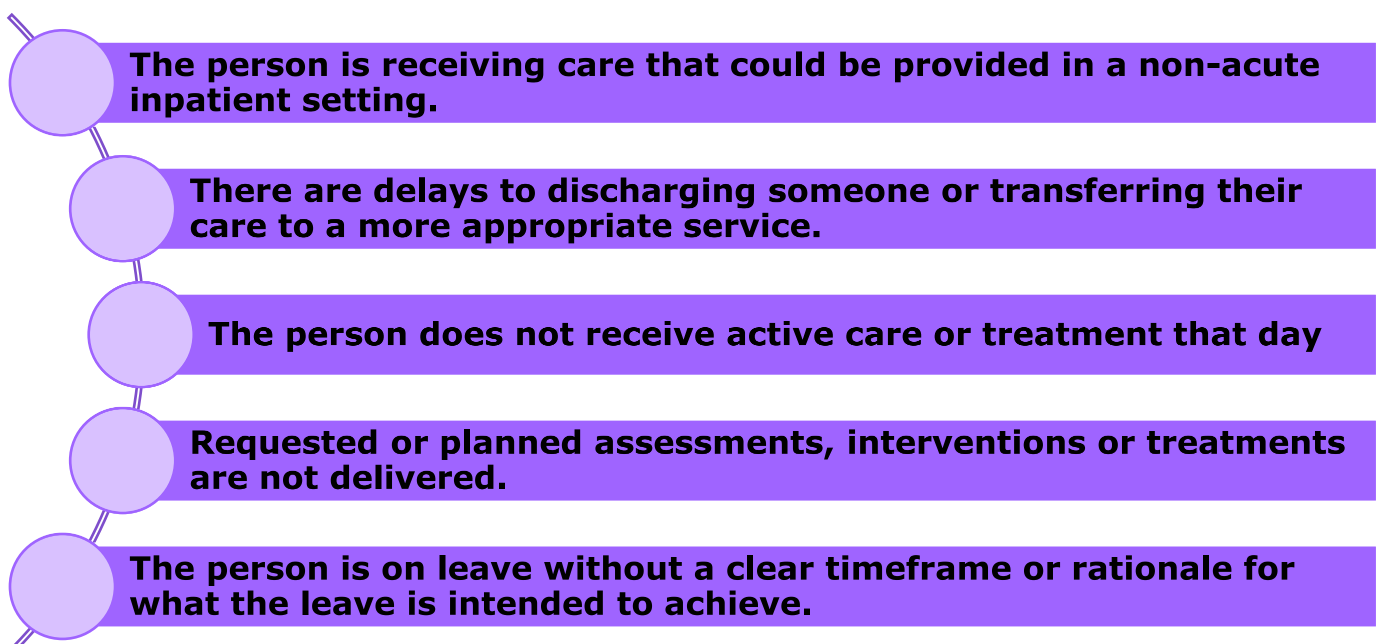
Under this approach, a 'red day' is recorded when a person receives little or no value-adding care, while a 'green day' is recorded where a person receives care that supports their progression towards discharge.

A green day does not mean the person is ready for discharge. It means that they are receiving the care and treatment that they need to progress their recovery and there are no barriers or delays to them accessing this support.

**A green day can only be recorded if ALL of the following criteria are met:**



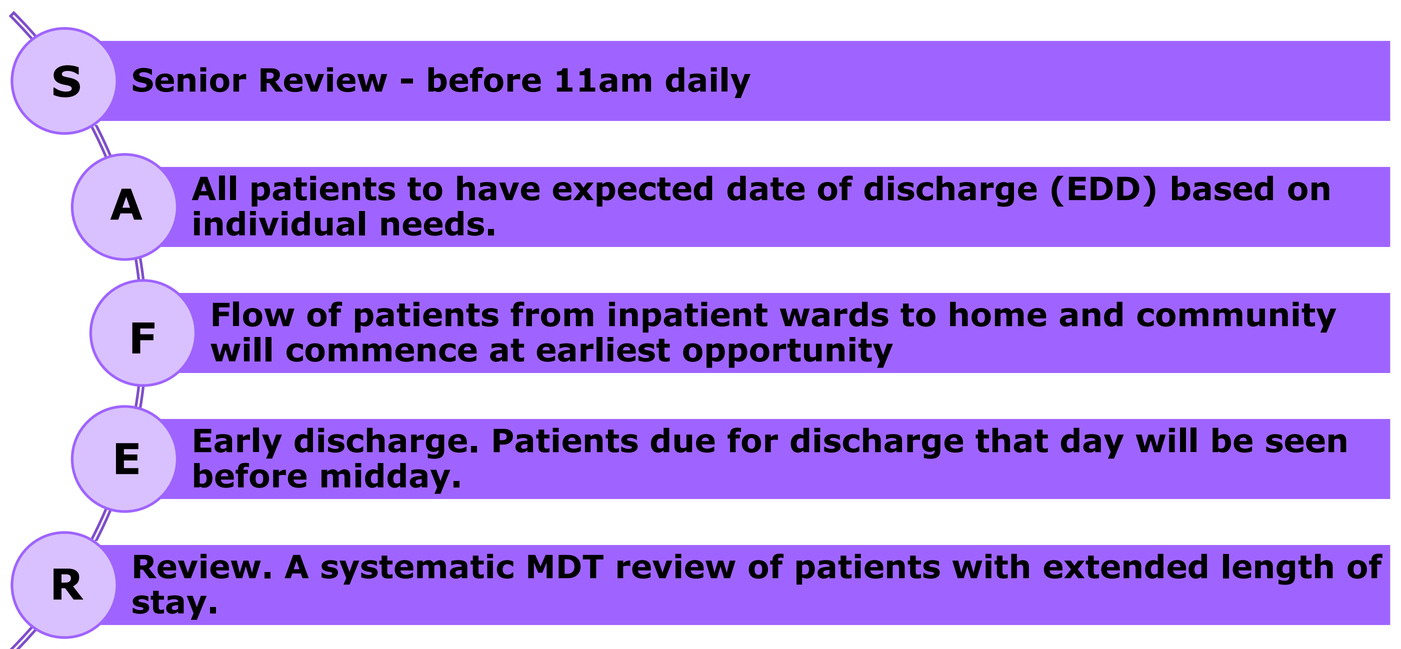

**A red day should be recorded if ANY of the following criteria are met:**



If a Red to Green or care planning review shows that the purpose of admission is close to being met, and/or the person will soon no longer need care that can only be provided in hospital (for example, they could leave hospital with support from a Crisis Resolution Home Treatment Team), additional focus should be given to planning their discharge and post-discharge support.

# Safer Mental Health Patient Flow Bundle

The Patient Flow Bundle draws together five principles which when delivered together, support the smooth management of a patient's care and timely discharge. This enables teams to ensure discharge planning is happening in parallel to the treatment/care plan. (see appendix 4 *page 89*)



# Oversight of purposeful admission through the pathway

The following meeting structures supports the oversight of purposeful admission:

## 1. Patient Review and Discharge Planning Meeting

Chaired by community and inpatient leadership, the membership of the weekly meeting hold:

- Oversight of progression on clinical treatment pathway.
- Oversight of EDD and Length of Stay (LOS).
- Ensure that all admissions remain purposeful and are focused on progression towards earliest discharge.
- Barriers to discharge and challenges experienced in community care are shared and understood.
- All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed.
- Clarity and agreement for post discharge follow up arrangements and discharge plans.
- Identification of patients clinically ready for discharge and experiencing delayed transfer of care requiring escalation within wider health and social care system.
- To hold one another to account for delivery of actions and agree escalation actions as needed.

## 2. Consultant Flow meeting

This meeting offers a space for ward and home treatment consultants to escalate individuals on their wards where there is insufficient progression to discharge. It offer peer consultation and advice on treatment for people who have an extended length of stay and remain in treatment, in addition to escalating those who are clinically ready for discharge but are experiencing barriers to discharge.

## 3. Essex System Delayed Transfer of care meeting

This meeting has responsibility for escalation and resolution for all individuals who are clinically ready for discharge (CRFD) and experiencing a delayed transfer of care from mental health inpatient services where there is a system level constraint preventing timely and safe discharge.
EPUT's senior leadership teams and representatives from health and social care commissioning and local authority partners will work together to seek resolution to barriers preventing timely discharge.
The meeting follows the principles set out within the NHS Improvement Multi-Agency Discharge Events:

- Capture the progress of each patient along their agreed pathway.
- Highlight, challenge and unblock delays.
- Support safe and timely discharges.

EPUT locality joint inpatient and community review and discharge planning meetings are established in each adult locality offering senior oversight on progression to discharge and an escalation structure to support delay avoidance. Meetings are informed by Red to Green methodology and address ward and Trust level constraints. System constraints are escalated to the Essex Delayed Transfer of Care Meeting. Individuals for discussion to be forwarded to System delay membership group in readiness for Fri AM meeting to enable all to attend prepared.

- Time slots for discussion will be clustered around LA/CCG/ICS boundaries to make best use of time. Action log to be maintained including owner and timeframe for delivery of action.
- All system partners to hold one another to account for delivery of agreed actions. Meeting to report updates to EPUT Senior oversight huddle and Mental Health Urgent Care and Inpatient Care Unit/ Accountability Framework.

# The International Fundamentals of Care Principles

The International Learning Collaborative's (ILC) International 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.

**The International Fundamentals of Care Framework outlines three core dimensions for the delivery of high-quality fundamental care:**

1. **A trusting therapeutic relationship between care recipient and care provider**
2. **Integrating and meeting a persons' physical, psychosocial and relational needs**
3. **A context of care that is supportive of relationship development and care integration**

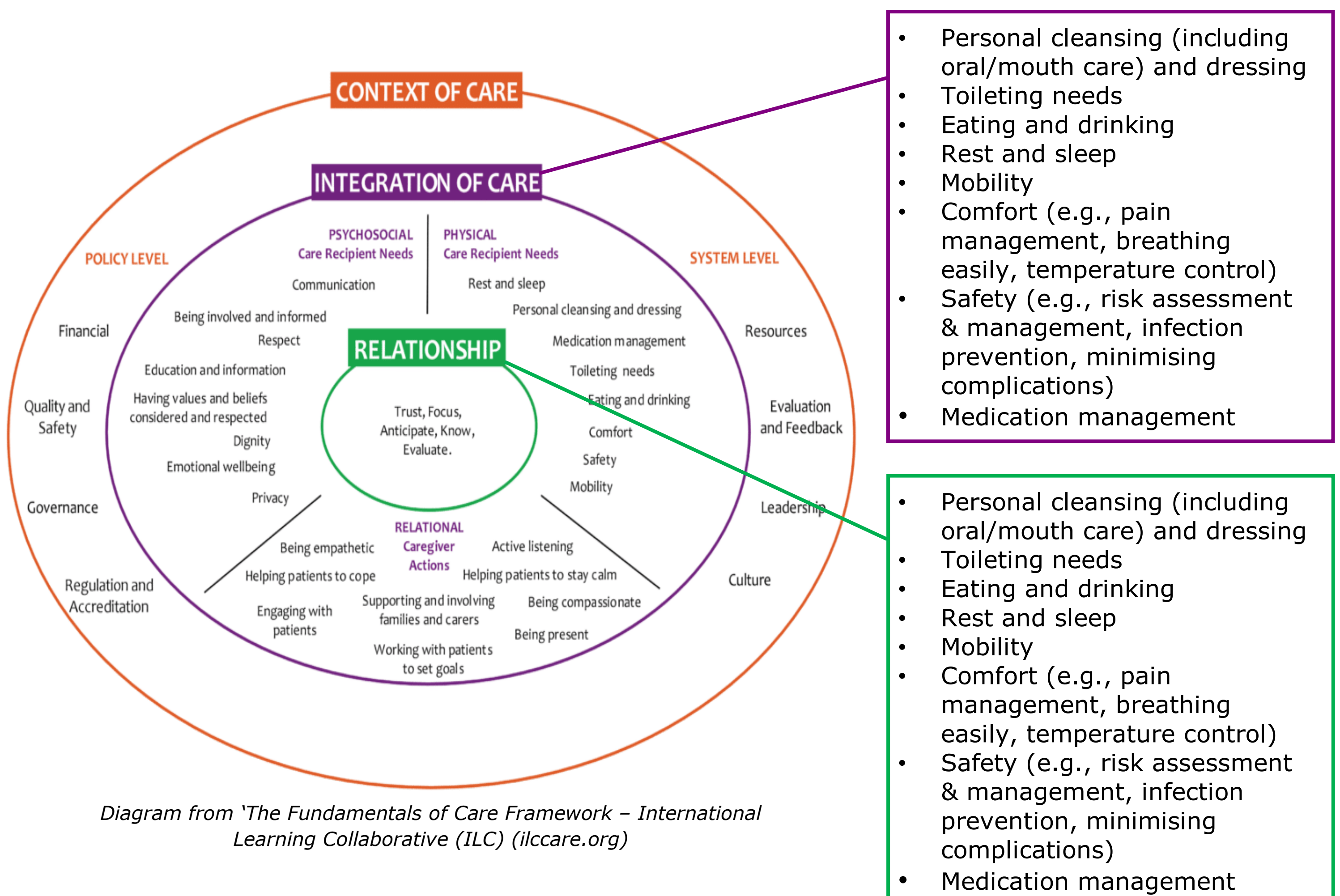



*Diagram from 'The Fundamentals of Care Framework – International Learning Collaborative (ILC) (ilccare.org)*

# Pharmacy and Medicines Optimisation

## Clinical Pharmacy

- Prompt pharmacy-led medicines reconciliation on admission with resolution of discrepancies.
- Timely access to medicines throughout to minimise missed and delayed doses.
- Pharmacy professionals routinely involved in ward rounds and MDT meetings to maximise outcomes from medicines, optimise doses, reduce risks associated with medicines (falls, adverse effects, antimicrobial resistance), encourage medicines use in line with national/local guidance, simplify regimens where possible and support de-prescribing where appropriate.
- Pharmacy involvement in discharge planning to provide clinical advice and facilitate timely supply.
- On-ward presence to improve accessibility to advice on choice, use and handling of medicines.

## Enhanced Adherence

- Support the use of patient's own medicines where these are suitable.
- Support patients to self-administer medicines throughout their stay (e.g. insulin) and prior to discharge (all medicines) to identify and resolve problems with medicines-taking, provide practical support, and improve adherence.
- Referral to the Community Pharmacy Discharge Medicines Service to minimise medication errors involving transfers of care.

## Patient Focused

- Provide regular group education sessions to improve understanding of the role of medicines in recovery and discuss beliefs, expectations and past experiences associated with medicines.
- Opportunity for 1:1 individualised discussion with a pharmacy professional about their medication regimen to support adherence.
- Provide information about side effects, interactions, and how to take medicines, to support shared decision making.
- Medication counselling shortly prior to discharge including advice on how to get information if needed post-discharge.
- Access to a pharmacy helpline to provide information post-discharge about medicines.

# The Therapeutic Environment

Therapeutic environment

Positive Health Outcomes

Offering opportunities for social interaction

Meeting sensory & cognitive needs

Promoting recovery & wellbeing

**Physical Space**

- Units should feel pleasant and comfortable, and feel safe but not institutional.
- Create spaces that encourage social interaction, which may range from small, quiet spaces, to larger, open-plan communal areas.
- A simple layout, with direct access and communication routes, identifiable focal points and clear signage.
- Appropriate choice of materials, furniture and fittings.

**Light, colour and texture**

- A focus on natural light or design solutions intended to increase or decrease the amount of light in the building in order to promote a pleasant and restful environment.
- Glare and shadow should be minimised.
- Colour and texture may help to differentiate spaces and support wayfinding.

**Noise**

- Minimise noise and promote a sense of calm and safety. For example, soft closing doors and consider whether alarms (fire and safety) could be linked to staff alarm pagers. This can avoid provoking anxiety reactions.
- Good sound insulation for areas where confidential discussions may take place.

**External areas and landscaping**

- Access to fresh air and outdoor spaces play a significant role in supporting well-being and recovery.
- Open grassy areas, herbs, textured plants and shrubs that attract wildlife can alleviate stress.
- Raised flower beds could incorporate seating areas and support therapeutic activities
- Incorporate space for outdoor activities, such as gardening, ball games, walking and resting.
- Level access from unit to external space and shading provided in external areas.

# Complementary and Alternative Therapies

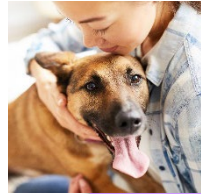
Complementary therapies are used alongside conventional medical treatments to enhance overall well-being. They are not intended to replace standard medical care but to complement it.

## Essential Oils

A holistic practice that involves using concentrated plant extracts called essential oils, for therapeutic purposes.

The aroma of these oils is inhaled or absorbed through the skin to promote physical, emotional, and psychological well-being.

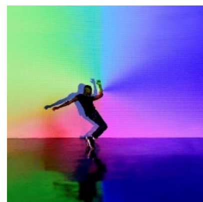
The olfactory system, linked to the brain's limbic system, is thought to influence emotions, memory, and certain physiological functions.



## Pet Therapy

Pet therapy involves the use of trained animals to facilitate therapeutic interactions between individuals and the animal.

**Emotional and Physical Benefits:** Interactions with therapy animals have been shown to provide emotional and physical benefits. This can include reduced stress, anxiety, and depression, as well as improvements in mood, social interactions, and even physical health markers such as blood pressure.



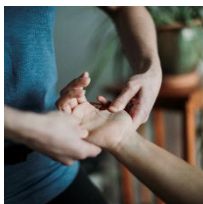
## Emotional Expression

Emotional expression healing refers to therapeutic processes or practices that focus on the healthy expression and processing of emotions to promote well-being.

The approach centres on acknowledging and expressing emotions as a vital step in emotional healing, encouraging individuals to confront and release pent-up feelings rather than suppressing them.

Emotional expression healing encompasses a range of therapeutic modalities, talk therapy, music therapy, dance therapy, mindfulness, and yoga.

Alternative therapies are used in place of, rather than in addition to, standard medical care. Individuals who prefer non-conventional approaches to healing and have scientific evidence supporting their effectiveness choose them.



## Reflexology

Reflexology is a complementary therapy that involves applying pressure to specific points on the feet or hands.

Reflexology is rooted in the idea that energy flows through the body along specific pathways. By applying pressure to reflex points, practitioners aim to stimulate and balance energy flow, promoting overall well-being.

Reflexology often promotes relaxation, alleviates tension, and supports the body's natural healing processes.

We do not currently practice these therapies by aspire to.

## Somatic Breathing

Deep and rhythmic breathing enhances oxygen flow to the brain, promoting alertness, concentration, and mental clarity.

Techniques like diaphragmatic and alternate nostril breathing are known for their positive impact on cognitive function

# Peer Support

Peer support involves individuals with similar experiences providing emotional, informational, and experiential support to one another. Peers share common challenges, allowing for a unique understanding and connection based on first-hand experience.

Peer support fosters a sense of empowerment as individuals work together collaboratively. It emphasises mutual respect and shared decision-making, recognising that those with lived experiences can be crucial in supporting each other's journeys toward recovery or personal goals.

*EPUT Inpatient Peer Support Team*

# Consistent daily care

Our new inpatient operating model will ensure each person receives the following daily care as standard.

### Daily

- Individual Care Plan (underpinned by international fundamental of care principles)
- Dedicated 1to1 time with a MH professional
- Mutual help community meetings
- Contact with medical team with medical intervention
- Risk assessment/risk management planning and evaluation
- My Care, My Recovery (patient family voice tool to support joint planning)
- Individual therapeutic programmes (activity/coordinator groups)
- Family/carer support meeting and daily conferencing
- Patient centred care with their involvement at all times
- Daily Board Rounds
- Making every contact count - supports physical health and optimises medical input
- Concerns regarding substance and alcohol use is covered, goals are agreed and are achievable, relevant signposting to services e.g. Tobacco Dependency Scheme to embed new behaviours – reduce smoking and support lifestyle change
- Optimising medication regimes

# Adults with a learning disability and autistic adults

Health and care services are required to identify and record the specific needs of each person with a learning disability and any 'reasonable adjustments' they require, so they can be cared for safely and effectively. Reasonable adjustments are changes made by organisations to make it as easy for people with a disability to use services as it is for people who do not have a disability. (Caring for adults with a learning disability in acute hospitals. hssib.org.uk/patient-safety-investigations/caring-for-adults-with-learning-disabilities-in-acute-hospitals/)

Admissions to acute mental health inpatient mental health services should align with NHS England's guidance for acute inpatient mental health care for adults and older adults (/www.england.nhs.uk/publication/acute-inpatient-mental-health-care-for-adults-and-older-adults/) which includes key actions which need to take place for adults with a learning disability and autistic adults. (www.england.nhs.uk/long-read/national-guidance-to-support-integrated-care-boards-to-commission-acute-mental-health-inpatient-services-for-adults-with-a-learning-disability-and-autistic-adults/#appendix-5-things-that-need-to-happen-for-an-adult-with-a-learning-disability-or-autistic-adult-during-their-inpatient-journey)

During a mental health hospital stay care is personalised and addresses inequality
Care should be personalised to people's individual needs, and mental health professionals (including learning disability team members and social workers) should work in partnership with people to provide choices about their care and treatment, to reach

shared decisions, and to have choice and control over the support they receive to enable independent living upon discharge. Care should take into account the person's diverse cultural and spiritual needs (www.england.nhs.uk/publication/acute-inpatient-mental-health-care-for-adults-and-older-adults/), recognising that people's identities and experiences are multifaceted, and that being a member of multiple groups that experience inequalities may compound poorer experiences of care.

Services should actively identify and address inequalities that exist within their local inpatient pathway, alongside people representing affected groups and communities. This must include ensuring that people are not prevented from accessing or receiving good quality acute mental health inpatient care simply because of a disability, diagnostic label, or another protected characteristic.

People with a learning disability and autistic people should be admitted to inpatient care on the same basis as other people. People's needs should be evaluated on an individual basis and decision making as to the most suitable hospital inpatient setting should be clearly evidenced and undertaken in a co-productive manner with families and the person themselves.

Admission to mental health acute inpatient care should be to allow for the assessment, intervention and treatment of a serious mental health problem that requires support that can only be safely provided in an inpatient setting. Other community options such as intensive support teams or community home treatment teams should have been exhausted. Admission should be at the time it is needed, to the most suitable bed for the person's needs, and when there is a clearly stated purpose for the admission.

Training and development- We will have a competent and confident workforce regarding how to care for our patients with a learning disability and autistic people.

The Oliver McGowan training Programme is being rolled out to every member of staff within EPUT over the next three years (2024- 2026).

- Currently around 90% of EPUT staff have completed part 1 of both tiers.
- The Tier 2 face-to-face training day is now open to all EPUT staff, with Comms and specific emails to directors sent out. It will also appear on the relevant staffs' training trackers by this time next week.
- We will be working with key directors linked to inpatient services and PICU to ensure their staff are able to book on training dates over the next 6-9 months as a priority.
- As part of the lead trainer role, they will be supporting services to help them make the necessary reasonable adjustments in their areas of work.

A training needs analysis will be identified against each chapter of the inpatient operating model and this will include learning disability and autism.

# Cultural and Spiritual needs

Care will be personalised to people's individual needs, and mental health professionals (including learning disability team members and social workers) should work in partnership with people to provide choices about their care and treatment, to reach shared decisions, and to have choice and control over the support they receive to enable independent living upon discharge. Care should take into account the person's diverse cultural and spiritual needs (www.england.nhs.uk/publication/acute-inpatient-mental-health-care-for-adults-and-older-adults/), recognising that people's identities and experiences are multifaceted, and that being a member of multiple groups that experience inequalities may compound poorer experiences of care.

# CHAPTER THREE

# Proactive, Safe, and Effective Discharge/Transfer Planning

**This chapter reflects the recommendations made by the Parliamentary and Health Ombudsman's report on Discharge from mental health care: making it safe and patient-centred (February 2024).**

# Overview

During our stakeholder involvement groups, people with lived experience highlighted that the word 'discharge' does not always support recovery. We have therefore added 'transfer' to our heading to reinforce that care continues in the community, ensuring a safe and effective transfer of care.

This chapter reflects the recommendations made by the Parliamentary and Health Ombudsman's report on Discharge from mental health care: making it safe and patient-centred (February 2024).

### MDT transfer and discharge planning

The new operating model will make sure transitions of care consider a patient's full condition and situation, and an MDT will be involved in discharge planning and delivery. This team will include representatives of the different points in a patient care pathway. This will create a 'safety net' of care around a person when they leave an inpatient setting. MDT members will be treated as equal partners in an individual's care.

Each transition of care should include or state the reasons for excluding:

- The current inpatient mental health team.
- Other medical specialities involved in an individual's physical health care
- Occupational therapists
- Dieticians (for example, for individuals with a diagnosed eating disorder)
- The community mental health team or a representative from primary care
- The crisis response or home treatment team
- Voluntary and community sector partners involved in support services
- A mental health social worker, where relevant
- A local authority representative responsible for housing, where relevant.

A patient's care plan on discharge will clearly reflect each of these teams' involvement.

### 72 hour follow up

When someone is discharged from inpatient mental health services, they will have a follow-up appointment within 42 to 72 hours of leaving hospital. This is usually led by the community mental health team or home treatment mental health team and is informed by evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health.

A 'crisis contingency plan' will also be in place on point of transfer/discharge to support their individual needs. For example, 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.

When the mental health liaison team is discharging someone from an emergency department to their home, they should confirm or rule out a follow-up call or appointment with a crisis mental health team, care coordinator or primary care provider within 72 hours. This applies the principles of safe transitions of care and discharge to emergency admissions and assessments.

### Nominated person to be involved in discussions and decision-making around transitions of care

In the absence of reform to the MHA, guidance should state that people are asked to name a nominated person who they would like to be included throughout the planning

and transition of their care. As set out in the draft Mental Health Bill, this nominated person would replace the 'nearest relative' role and could be a close relative, carer or another trusted person. They should be able to advocate for the individual's wishes and concerns. Healthcare professionals should listen to the nominated person's views and record them alongside the views of the person who is having their care transferred.

Other people including family members and carers should still be informed and updated on discharge plans.

**Culture of Care Standards for mental health inpatient services (NHS England April 2024)** will support transfer and discharge as they are rolled out in 2024 making sure that:

- The views and experiences of individual patients, their families, carers and nominated person are held in balance with any clinical perspective in making decisions about transitions of care.
- Staff support and encourage people to use this right and, in the case of someone being detained under certain sections of the MHA, listen to the views of an individual, their family and carers before making a clinical decision.
- People are empowered to give feedback about their or their loved one's care and staff proactively seek out their feedback.
- When things go wrong in care, the people affected are supported to make a complaint and know that this will be responded to in an honest and compassionate way. Where necessary, services must effectively signpost and support people to take their complaint to the appropriate organisation, such as the Parliamentary and Health Service Ombudsman, Local Government and Social Care Ombudsman, Care Quality Commission or Mental Health Tribunal.

# Case Study

The following sections will include a case study of a fictional patient called George to describe how the new inpatient operating model will enable effective discharge planning.

George's discharge from inpatient care is planned with him and his chosen nominated person from the start of his inpatient stay, so that he can leave hospital as soon as he is clinically ready for discharge and no longer requires assessments, interventions or treatments that can only be provided in an inpatient setting. Planned post-discharge support is provided promptly on leaving hospital.

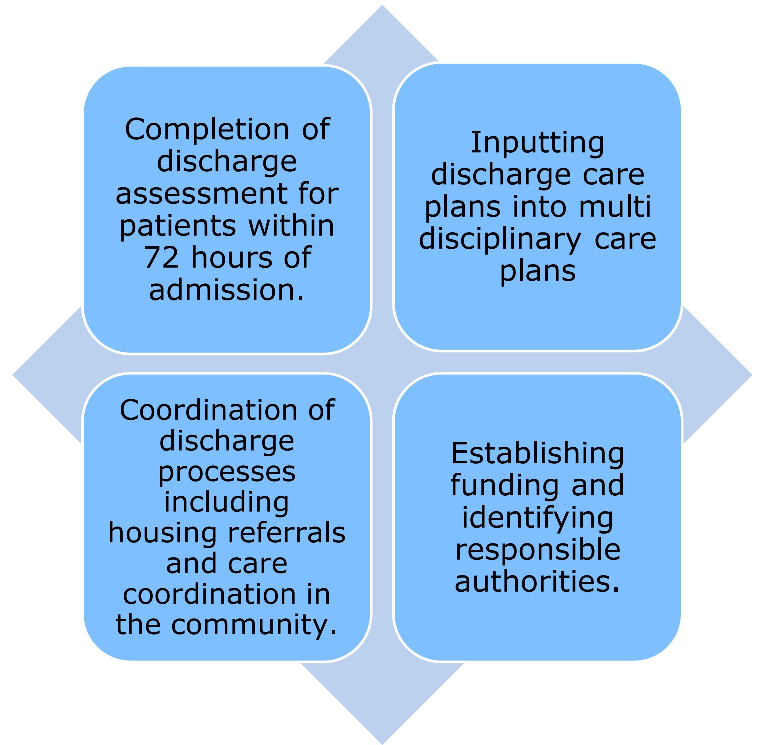
## Care Formulation and Planning

Police detained George under Section 136 of the MHA. He was assessed, agreed informal admission, and transferred to an assessment unit bed from the Health Based Place of Safety. Following admission, a further MHA assessment was required and he was subsequently detained under Section 2 and identified for transfer to an EPUT acute inpatient ward.

Within 72 hours of admission a comprehensive care plan will be completed which will include all the identified needs. Discharge coordinator assessment will feed into this multi-disciplinary care plan clearly identifying the barriers to discharge (if any and interventions required) or discharge destination.

## Discharge Coordination Role

George was assessed by the discharge coordinator using the initial screening tool, and then a more comprehensive assessment was completed.
George was assessed to have no accommodation as was sleeping rough before admission.
Any barriers to discharge are identified.
A discharge plan was devised, and recorded on George's care Plan.




| | **Issues Identified** (Please circle) | | **Full MHAU Discharge Coordination screening required** | | **Discharge Coordination Team action required?** (To be completed following daily review with team lead) | |
|---|---|---|---|---|---|---|
| **Accommodation/Housing** | Yes | | Yes | | Yes | |
| **Care / Support** | Yes | | Yes | | Yes | |
| **Finances / Benefits** | | No | | No | | No |
| **Asylum / Immigration** | Yes | | | No | | No |
| **Any other issues identified as potential barrier to discharge** | | No | | No | | No |
| **Current / historic drug / alcohol issues?** | Yes | | Yes | | Yes | |

**Initial discharge plan:**

- Gain signed consent from George
- Duty to Refer (DTR) to local housing authority
- Refer to Move On Facilitator
- Referral to First Episode Psychosis (FEP) for assessment and allocation
- Referral to Dual Diagnosis Team
- Confirm in receipt of all benefits entitled to
- Confirm Immigration status/right to remain.
- Contact family to try and re-establish links

Admitted, deteriorated, detained under MHU S2 then upgraded to S3.

→ Care deficits noted, discharge plan reviewed.

→ Care Act Assessment, OT assessment, mental health nursing needs assessment (MHNNA) completed.

→ Care and support needs and 117 health and social care needs identified. To be presented to 117 panel rather than Social Care Funding Forum (SCFF).

→ Deemed clinically ready for discharge (CRFD), now Trust level delay.

→ Care Co-ordinator (Co) and MDT prepare application and Care Co presents to 117 panel. Need agreed, now System Level delay.

→ Service Placement Team (SPT) source placement. Escalated through System delay call weekly.

→ Placement sourced, funding agreed, George is discharged.

Time is spent getting to know George as a person. What does he want his life to look like after discharge? You discover George is feeling anxious because he cannot picture where he is going to live and he is worried he has no support and not going to get better. Together and through discussion, you create a "Toolkit for Recovery", helping George become aware of what he as an individual finds supportive, along with other goals he can aim for.

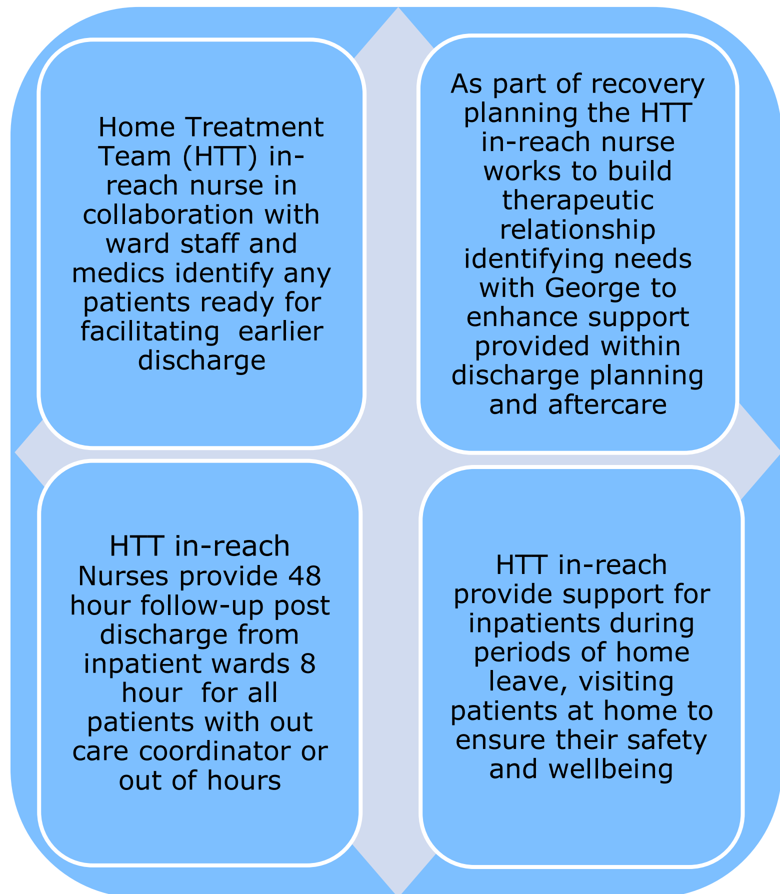
To inspire George, staff can complete a spider diagram to share the things that help to maintain steady mental health and overall well-being.

At the end of the exercise George shares his optimism for recovery, then takes his "Toolkit for Recovery" back to his room for further reflection.

This offers support, direction, purpose and above all hope for recovery post discharge.

## Role of Home Treatment team in inpatient services

The Home Treatment Team in-reach nurse attends the ward MDT meeting working towards wraparound support for George during discharge planning. George is currently detained under section 2 of the Mental Health Act. Prior to admission George was sleeping rough and has no current.




## Clinically ready for discharge and estimated date of discharge

All patients will have access to a MDT to review them daily in assessment units and weekly in treatment wards. During review an assessment on whether that they are clinically ready for discharge is completed.

The review will be documented clearly to ensure that discharge options including supported early discharge by Home treatment teams.

Home treatment teams will attend MDT review and ward reviews to support early discharge.

## Discharge planning meetings

**Locality meeting**:

- All admissions remain purposeful and are focused on progression towards earliest safe discharge.
- Barriers to discharge and challenges experienced in community care are shared and understood.
- All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed.
- Clarity and agreement for post discharge follow up arrangements (within 48hrs) and discharge plans.
- Identify delayed transfer of care patients requiring escalation within wider health and social care system.
- To hold one another to account for delivery of action s and agree escalation actions as needed.

**Agreed actions for George:**

- Referral to First Episode in Psychosis (FEP) for allocation
- Referral for Dual Diagnosis support (Drug & Alcohol)
- Contact safeguarding re any open case, under Multi Agency Risk Assessment Conference
- Care Act Assessment
- Mental health nursing needs assessment (MHNNA)
- Occupational therapist (OT) / activities of daily living (ADL) assessment
- Psychology assessment/formulation
- Duty to refer to local Council
- Funding Support Tool
- Care and Support Plan
- Financial Assessment

## System escalation

**System Escalation**:

- Essex System delayed transfer of care meeting has responsibility for escalation and resolution of all individuals who are Clinically Ready for Discharge and experiencing a delayed transfer of care from mental health inpatient services where there is a system level constraint preventing timely and safe discharge.
- The meeting follows the principles set out within the NHS Improvement Multi-Agency Discharge Events (MADE): Capture the progress of each patient along their agreed pathway. Highlight, challenge and unblock delays. Support safe and timely discharges.

- George was reported at the escalation meeting following need being agreed at 117 funding panel.
- Service placement team are sourcing placement within the Supported Accommodation Pathway.

## MDT ward review and discharge planning

**Ward Review**:

Initial ward review was completed for George. Reason and purpose of admission are explored and decision made regards whether he can be supported in the short term, on the assessment unit (AU), or requires transfer to a treatment bed. Due to multiple factors, it is decided George requires another Mental Health Act Assessment, as he has deteriorated since admission, and now lacks insight and capacity to consent to treatment. As well as treatment pathway, discharge planning is started.

**Discharge planning:**

It was decided George requires transfer to treatment bed so no EDD was set as he would not be discharged from AU.

Other factors considered during the initial planning were:
Accommodation status, care and support needs, psychological and emotional needs, benefits, immigration status, recourse to public funds, is there dual diagnosis with either drugs and alcohol and/or learning disability & autism, forensic issues, any legal restrictions in place, any open safeguarding, known to, or restricted by, Ministry of Justice?

## Using the Red to Green approach

Embedding the **Red** to **Green** approach to deliver a person's care plan (including ensuring that people receive the activities and interventions they need to recover), and to facilitate a timely and successful discharge from hospital. Under this approach, a '**red** day' is recorded when a person receives little or no value-adding care, while a '**green** day' is recorded when a person receives purposeful care that progresses their recovery and path to leaving hospital.

Further detail on what constitutes a **red** and **green** day is as follows:
All reds to be escalated to MDT.

*Equipment at the Hub, Derwent Centre*

## Discharge planning

An overall BRAG rating will be applied following initial screening on admission. This will highlight the complexity of discharge planning and barriers to discharge.

A discharge BRAG rating will be shared with inpatient, community and system partners involved in the patient's care (as appropriate) to enable actions needed to resolve barriers to discharge to commence early.

In the case of our fictional patient George, a BRAG rating may look like the below.

| BRAG | Trigger | Action | Owner |
|---|---|---|---|
| | **No Accommodation Issue.**<br><br>**Person to return to home address agreed with no additional care and support needs.**<br><br>**No Financial issues.** | **Discharge planning with Person and chosen carer(s)** | **Ward and Care Co./ HTT** |
| | **Mainstream housing need with clear local connection.** | **Duty to Refer to identified council/housing** | **Ward Team / DCT** |
| | **Person has accommodation and enhanced support required to support returning.** | **Carers Assessment Review community MH and SC support plan and enhance as required.** | **Care Co.** |
| | **Care and Support plan requires review and minor amendment.** | **Review and update to care and support plan, presentation to funding panel for agreement of need and sourcing of amended provision.** | **Care Co.** |
| | **Person requires support with finance/ benefits – no concerns re capacity.** | **Support in signposting to benefits/ financial advice** | **Ward/ Care Co.** |
| | **Mainstream housing need with no identified local connection or no Council accepting duty to house.** | **Clarification of why council refusing duty or discharged duty.** | **Care Co and DCT** |

| | | | |
|---|---|---|---|
| | | **ECC move on facilitator to support options for appeal.**<br>**Escalate to Essex housing growth/ strategic homelessness lead as needed (Rod Cullen).** | **Ward/ Care Coordinator** |
| | **Supported accommodation need or package of enhanced care needed.**<br>**Full assessment of care & Support required and resubmission for funding and provider.** | **Full assessment of need: MHNNA/ ADL/ Care and Support Plan/ Financial Assessment/ Funding Support Tool/ Risk Assessment.**<br>**Presentation to funding panel: SCFF / S.117/ CHC** | **Care Coordinator**<br><br>**Care Co/ Service Placement Team/ Brokerage.** |
| | **Appropriate housing in place although assessed as uninhabitable.** | **Sourcing of appropriate provision.** | **DCT** |
| | **No Recourse to Public Funds/ Accommodation.** | **Clarify immigration status with Home Office.**<br>• Open application or appeal – liaison with HO<br>• No application – liaison with local refugee action / RAMA.<br>• Complete Human Rights Act Assess if indicated.<br>• S.117 rights or care and support needs under Care Act may override and place duty on Local Authority to support. | **Care Co/ DCT/ Ward** |
| | **Person lacks capacity regarding care and support needs/ Finances/ Tenancy** | **Mental Capacity Act Assessments to be completed**<br>• Best Interest Meetings<br>• Court of Protection. | |
| | **Highly complex housing / Care and Support need** | | |

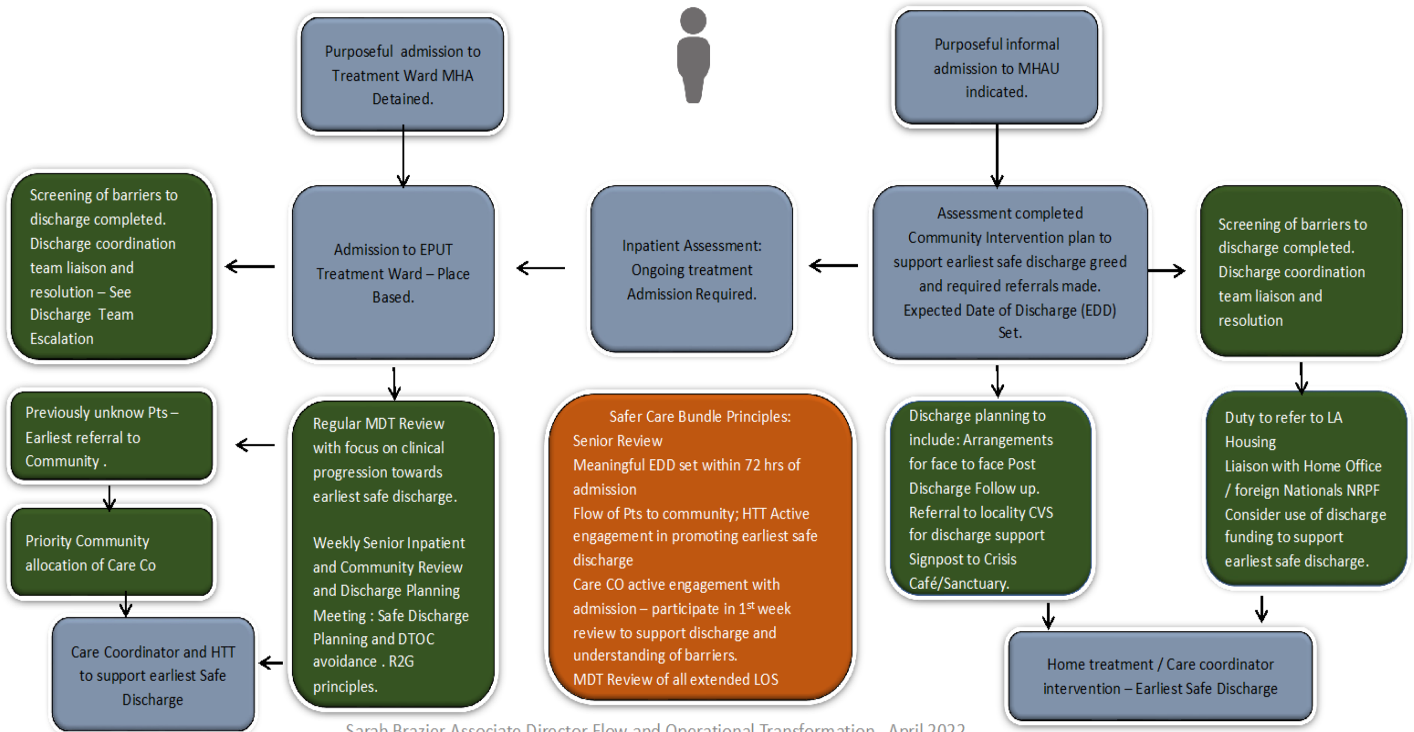
| | | | |
|---|---|---|---|
| | **Multiple housing providers unable to manage complexity/acuity of person presentation.**<br><br>**No appropriate community provision commissioned / sufficient resource unavailable.** | **Multi agency meeting to establish level of need and identify appropriate accommodation provider.**<br>**Identification of MH provision to support.** | **DCT/ Care Co/ Multi Agency.** |

# Mental Health Admission and Discharge Principles

- All admissions are to have clearly defined purpose for admission. This will include clear goal(s) for admission episode and explain why care and treatment cannot be provided within the community as an alternative to admission.
- All admissions into inpatient services are to be at the right time, in right place and of the right duration.
- Screening on barriers to discharge are to be completed immediately on admission and repeated if the patient's circumstance changes.
- It is essential that care coordinators and the Home Treatment team are involved early to support progression to discharge and earliest safe discharge.
- Safe Care Bundle Principles to be in place for every admission:
    - Every Person to have Daily Senior Review
    - Meaningful EDD to be set within 72 hours of admission and shared with individual and family/carers
    - Flow of patients from inpatient to community to begin at the earliest opportunity. Home Treatment team actively engaged in promoting earliest safe discharge. Prompt referral to community services if the person is previously unknown to services.
    - Care coordinators to actively participate in first week review, to support discharge planning and understanding of barriers.
    - MDT review of all extended LOS-review of all patients with extended LOS 28+ days.
- Red to Green Improvement Methodology is designed to ensure all days spent in hospital are value-added to help facilitate safe, effective care and expedite appropriate discharge.
    - Green Day**:** Patient receives an intervention that supports their clinical journey
    - Red Day: A day with no added value and the patient no longer needs to be in that environment to receive care/patient would not be admitted if presenting today.
- Locality joint inpatient and community patient review and discharge planning meeting to be in place weekly with Senior Chair to ensure progression of actions to support earliest safe discharge.
- Consideration of community support available from community and voluntary sector partners and use of discharge funding to support earliest safe discharge.

- Delayed discharge meeting to be held weekly, to include social care leadership team and health and social care commissioners to progress and resolve multi-agency barriers to discharge
- Escalation of delayed transfer of care where progression is hindered to be communicated with locality Associate Directors and Associate Director for Social Care for whole system review and resolution

**Discharge Pathway**



**Timeline - Assessment Units**

| Team | Pre admission | Admission | Within 24hrs | Within 48hrs | Within 72hrs |
|---|---|---|---|---|---|
| **Home treatment** | Face to face gatekeeping: explore opportunities for alternative to admission. | Comprehensive clinical handover to admitting Assessment Unit. To include clear purpose for admission and indication of admission duration, understanding of barriers to discharge. To inform initial inpatient care plan | Response to ward requests to HTT assessment to support earliest safe discharge | Respond to ward requests for HTT assessment to support earliest safe discharge. | Active participation in Assessment Unit MDT with view to supporting earliest safe discharge. Arrangements for completion of post discharge following up agreed with individual. Liaison with locality HTT as required (Trusted Assessor) |
| **Discharge Coordination Team** | | | Active participation in daily clinical meeting. Identification of priority patients for screening barriers to discharge. | Complete screening for barriers to discharge. Actions required identified and actions. Consideration of use of discharge fund to support earliest safe discharge. | Actions required in action. Consideration of use of discharge fund to support earliest safe discharge. |

*For patient transferred from Assessment Unit to treatment ward, handover of barriers to discharge to occur between discharge coordination team and shared with ward team and care coordinators.

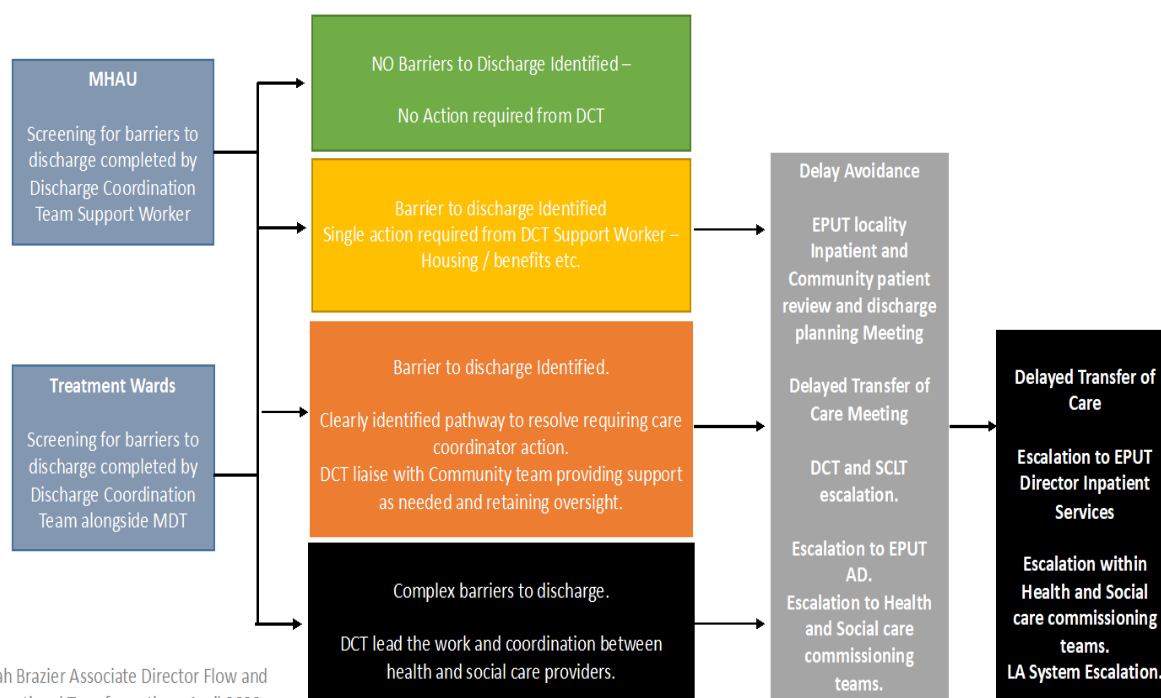
*Sarah Brazier, Associate Director Flow and Operation Transformation. April 2022*

**Timeline – Treatment Wards**

| Team | Pre admission | Admission | Within 1 Week | Within 2 Weeks | Ongoing to discharge |
|---|---|---|---|---|---|
| **LA AMHP HUB** | Liaise with HTT to participate in MHA Assess | Comprehensive clinical handover to admitting Treatment Ward. To include clear purpose for admission and understanding of barriers to discharge. | | | |
| **Home Treatment** | HTT to support MHA Assessment. Explore opportunities for alternative to admission. | | Respond to ward requests for HTT assessment to support earliest safe discharge. Liaise with locality HTT as required (Trusted Assessor) | Respond to ward requests for HTT assessment to support earliest safe discharge. Liaise with locality HTT as required (Trusted Assessor) | Respond to ward requests for HTT assessment to support earliest safe discharge. Liaise with locality HTT as required (Trusted Assessor) |
| **Discharge Coordination Team** | | | Active participation in ward clinical meeting. Identification of priority patients for screening barriers to discharge.<br><br>Complete screening for barriers to discharge – to be repeated if individual circumstance change.<br><br>Actions required identified and actioned. Consideration of use of discharge fund to support earliest safe discharge | Active participation in Weekly Join Inpatient and Community review and Discharge Planning Meeting.<br><br>Support to ward and care coordinator to resolve barriers to discharge and lead most complex. | Active participation in Weekly Join Inpatient and Community review and Discharge Planning Meeting.<br><br>Support to ward and care coordinator to resolve barriers to discharge and lead most complex |
| **Community Team** | Consultation with clinical manager and consultant prior to request for MHA Assessment to ensure all least restrictive alternatives in place | | Care Coordinator active participation in 1st MDT Ward Review. Share information re: barriers to discharge and actions in progress to address. | Active participation in Weekly Join Inpatient and Community review and Discharge Planning Meeting.<br><br>Actions identified to resolve barriers to discharge in action | Active participation in Weekly Join Inpatient and Community review and Discharge Planning Meeting.<br><br>Arrangements for completion of post discharge follow up agreed between care coordinator and individual. |

*Sarah Brazier, Associate Director Flow and Operation Transformation. April 2022*

## EPUT Discharge Coordination Process




## Delay Prevention and Escalation

### Patient Review and Discharge Planning Meeting – Adult Treatment Wards

Each adult inpatient locality hosts a senior action focused meeting for EPUT inpatient and community teams to ensure:

- All admissions remain purposeful and are focused on progression towards earliest safe discharge (inc. Expected date of discharge and review of all 28+ day extended length of stay)
- Barriers to discharge and challenges experienced in community care are shared and understood.
- All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed.
- Clarity and agreement for post discharge follow up arrangements (within 48hrs) and discharge plans.
- Identify Individuals who are a delayed transfer of care requiring escalation within wider health and social care system.
- To hold one another to account for delivery of actions and agree escalation actions as needed.

This meeting is informed by the NHS E Improvement Red to Green methodology ensuring all Ward and Trust level constraints are raised and actions for resolution implemented.

### Essex System Delayed Transfer of Care Meeting

- Individuals identified as experiencing a system level constraint impacting on timely discharge to be escalated to the Senior whole Essex System Delayed Transfer of Care Call.
- Meeting to be chaired by EPUT Associate Director Flow and Operational Transformation or Clinical Matron Patient Flow in absence.
- System Partners including EPUT SCLT, Local Authorities, CCG to be in regular attendance with additional members in attendance as required.
- System Partners to be informed of those for discussion requiring a system response to facilitate discharge prior to meeting to enable preparation.
- Meeting Action Log to be maintained and circulated.
- To hold one another to account for delivery of actions and agree escalation actions as needed.

Sarah Brazier Associate Director Flow and Operational Transformation. April 2022

**Daily Prevention and Escalation Meetings -**

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| **Adult Mental Health** | **11am – 12pm West Essex** Inpatient and Community Senior review and discharge planning meeting.<br><br>**1.30 – 2pm** Senior Oversight Huddle | **2-3pm South Delayed Transfer of Care Escalation** Meeting, including EPUT Social Care Leadership and Health and Social Care Commissioning Teams<br><br>**3.30-5pm Basildon** Inpatient and Community Senior review and discharge planning meeting<br><br>**4-5pm Rochford** Inpatient and Community Senior review and discharge planning meeting | **3.30-5pm Chelmsford** Inpatient and Community Senior review and discharge planning meeting | **1.30-3pm North East Essex** Inpatient and Community Senior review and discharge planning meeting<br><br>**1.30-2pm** Senior Oversight Huddle | **10.30am – 12pm Essex System Delayed Transfer of Care Escalation** Meeting, including EPUT Social Care Leadership and Health and Social Care Commissioning Teams<br>• Phase1- Adult DTOC to commence 29/04/2022<br>• Phase 2 – include Older Adult |
| **Older Adult** | **1.30 – 2pm** Senior Oversigh Huddle | **10-11am South Essex** Patient LOS and discharge planning meeting | | **10.30-11.30am Mid Essex** Patient LOS and discharge planning meeting<br><br>**1.30 – 2pm** Senior Oversight Huddle | **11am – 12pm West Essex** Patient LOS and discharge planning meeting<br><br>**12-1pm North Essex** Patient LOS and discharge planning meeting |

*Sarah Brazier, Associate Director Flow and Operation Transformation. April 2022*

Essex Partnership University
NHS Foundation Trust

## Delayed Transfer of Care – Escalation Framework:

| OPEL ALERT STATUS | OPEL 1 – GREEN | OPEL 2 - AMBER | OPEL 3 – RED | OPEL 4 – BLACK |
|---|---|---|---|---|
| Number of Patients Fit for Discharge* | 14 | 15-18 | 19-22 | 23+ |

*Informed by SMART OPEL Alert Status Triggers

**OPEL 1 - GREEN**

**Patient flow management:**
Barriers to discharge for all patients are understood and actions are in place to resolve.
There is good progression to discharge with focus on delay avoidance.
EPUT Inpatient and Community Ward and Trust level (R2G) constraints are in action.
Weekly Delayed transfer of care meetings to resolve system constraints are in place; to include EPUT operational teams, Social Care leadership and Health and Social Care commissioning.
**Monitoring and Oversight:** Locality senior inpatient and community review and discharge planning mtgs, Senior oversight Huddle.

**OPEL 2 - AMBER**

**Mitigation of escalation:**
All actions as OPEL 1.
Escalation to EPUT Service Managers (Inpatient and Community) for resolution of internal constraints.
Escalation to Social Care Leadership Service Manager for resolution of Local Authority Constraints.
Escalation to EPUT Locality Associate Director (Inpatient and Community) for System escalation.

**OPEL 3 - RED**

**Actions taken at Level 2 have failed to return the system to level 1 and pressure is worsening. Urgent Action and Support required from across the system by all partners.**
All action as OPEL 1 and 2
Escalation to EPUT Directors (Inpatient and Community) for Director to Director escalation with system leads.
Escalation to Social Care Leadership Associate Director for resolution of Local Authority constraints
Implement planning for specific locality Multi Agency Discharge Event (s).

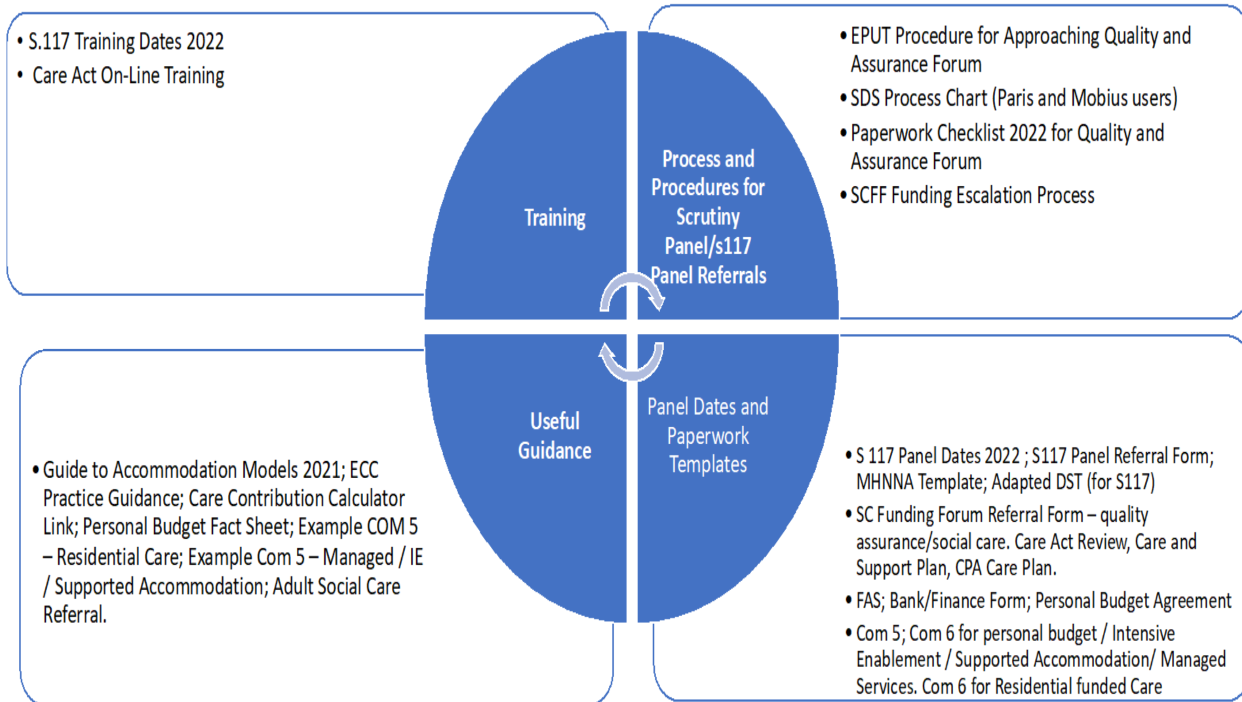
**OPEL 4 - BLACK**

**Severe pressure and failure of actions. Decisive action must be taken to recover.**
All Actions as OPEL 1, 2 and 3
Escalation to EPUT Exec. Team for System Exec. escalation.
Urgent Multi Agency Discharge Event to ensure system engagement with need for urgent resolution.

Sarah Brazier Associate Director Flow and Operational Transformation. April 2022

**Panel Processes, Actions and Timeframes:**

**Information, Guidance and Paperwork available: Input.eput.nhs.us/TeamCentre/sc/Pages/sds.aspx**



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**No Recourse to Public Funds. Discharge Pathway protocol in development:**

To Include:

- Introduction and rationale
- Eligibility and legal frameworks
- Care Act
- Access to Care and Support
- Insurmountable Repatriation
- Pathways:
  - No ongoing needs identified
    - Confirming immigration status
    - Disengaged Consulate
    - Unable to source links in Home Country
    - Refusal of repatriation
  - Ongoing Needs Identified
    - Lack Capacity, Refuses repatriation
    - S.117 rights and funding
    - Safeguarding issues identified
- Financing of Repatriation
- Contact Information Glossary

Sarah Brazier Associate Director Flow and Operational Transformation. April 2022

## Post Discharge

The National Confidential Inquiry into Suicide and Safety in Mental Health has found that there is an increased risk of patients admitted to mental health inpatient care dying by suicide within three days of discharge from hospital. To ensure that patient have the right follow up the Trust has a robust follow up procedure, which includes a telephone call from the discharging team within 24 hours of discharge. Guidance for further follow up is available for all staff.

When a person is discharged, they may receive short-term intensive home treatment from the Home Treatment team to facilitate discharge, and it is expected that they will receive ongoing support from a community-based mental health team. Section 117 aftercare is available to people who have been detained under section 3, 37, 47, 48 or 45A, or have been placed on a community treatment order or conditional discharge. If someone is entitled to Section 117 aftercare, notification of their admission should be made to the local authority.

In the case of our fictional patient George received a telephone call from the ward the day after his discharge. Due to his 48 hours after discharge following on a week HTT attended his accommodation and completed a face to face meeting. His care coordinator met with him on the Monday at his temporary placement.

## Discharge Partners

Local experience suggests that housing is not always considered early enough in the discharge process, resulting in some people remaining in mental health hospitals for longer than necessary, or being given unsuitable housing arrangement that may create a higher risk of breakdown.
Housing needs assessment form template will be used to support all referral for housing

EPUT Discharge coordination team will develop joint protocol, which sets out how local partners will work together to ensure that planning for people's future housing needs start as early as possible after admission to hospital and is undertaken in a fully joined-up way, in close co-production with the person and any family or loved ones.
This will include ensuring that referral forms are in place to deliver on patient accommodation needs – Brick by brick NHS resources.

## Medicines and Discharge Planning

On the day of discharge George's medicines weren't ready as the team had made some last minute changes and he hadn't had a blood test, which was needed for the medicine to be supplied.

He usually had supervised methadone daily, so a new prescription also had to be arranged via STaRS so that it was ready for him at the community pharmacy. As it was Friday it would not be ready until Monday and he could not go home until this was sorted out.

George had medicine changes during his stay, he wasn't sure what all his new medicines were for, or when to use the "PRN" ones and was worried about how he would get them one eh left hospital.

Ensure any issues with medication are during medicines reconciliation, including medicines that may need special arrangements such as clozapine, methadone or long-acting (depot) antipsychotics.

Changes made to medicines just before discharge should be avoided as this can lead to unnecessary delays and there is less ability to monitor the patient once discharged.

Make sure all monitoring is up to date and any adverse effects managed.

Offer all patient a medication consultation at discharge to go over their medicines and the process for after discharge. Refer to, or communicate with, services that may be supportive or needed at discharge. Make sure all medicines are considered, not just those for physical health, especially if that have changed.

Allow patients to have more input into their medicines so that they are prepared at discharge. Quantities of supplies at discharge can be individualised based on the risk of harm and non-adherence, consider giving original packs of medicine if safe to do so.

## Barriers to Discharge: Initial Screening Record

| **Patient Name** | | **Patient ID (PARIS/MOBIUS)** | |
|---|---|---|---|
| **Date of Admission** | | **Expected Date of Discharge** | |
| **Assessment Unit Pathway** | | **Treatment Ward Pathway** | |

| **Purpose of admission** | |
|---|---|

| **Barriers to discharge** | **BRAG** | **Further Screening required by DCT and by when?** | **Action required by? (DCT/ Ward/Care Co/ System).** |
|---|---|---|---|
| **Accommodation/ Housing** | | | |
| **Care and Support** | | | |
| **Immigration/Asylum** | | | |
| **Finance/ Benefits** | | | |
| **Other: Please detail below** | | | |

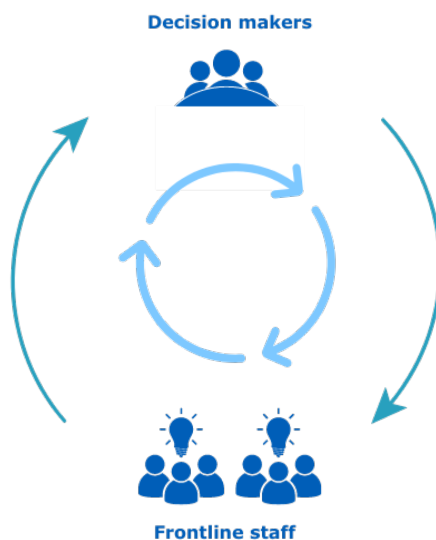
| **Overarching Discharge Planning BRAG** | | **Required actions communicated** | **Date:** |
|---|---|---|---|

| **Screening completed by:** | |
|---|---|
| **Role:** | |
| **Date:** | |

## Ensuring a culture of sustainable change, with measurable results

Lasting change is underpinned by clarity of communication to ensure people understand the purpose of change, as well as removing barriers and creating opportunities for changes to practice and behaviour.

- Our communication channels need to enable us to deliver clear and empowering messages on the purpose of change:
- inspirational, inclusive Trust-wide messages on key priorities;
- focused operational communications covering purpose and staff's role in the change, and;
- a communication mechanism to ensure accessible and digestible essential messages.




**The environment and tools available should support those delivering the change and minimise barriers they will face:**

- focus on the experience of those adopting the change, including equipment & processes;
- training available at the start of a change and for additional improvements, with a clear mechanism to access help.

**We need to measure the impact of change, and incorporate staff ideas and feedback through iterative improvements:**

- those delivering the change play a key role in designing the practical steps to make it happen;
- giving the space for changes to be trialled, tested and measured, and
- strong feedback mechanisms to quickly identify and respond to issues faced and make adjustments.

# CHAPTER FOUR

# Trauma Informed Care

**This chapter outlines what trauma informed care is, and why EPUT are aspiring to be 'trauma informed'.**

# Moving towards becoming Trauma Informed

This fourth chapter has a different quality to it. Whilst the previous three chapters detail the three key stages of the new inpatient operating model, being trauma informed is one of the four key principles alongside: tackling health inequalities; a focus on personalised and shared care; and joined up partnerships (NHS Acute Inpatient Mental Health Care for Adults and Older Adults, 18 July 2023).

Becoming trauma informed is one of three golden threads running through all of our inpatient change, together with initiatives from the International Fundamentals of Care Framework and the Culture of Care Programme.

The road to becoming trauma informed is not a protocol driven, tick box approach. Change has to be at an organisational level and begins with leadership, as it requires a cultural shift. To this end, EPUT is preparing to undertake a Trust-wide initiative to become a Trauma Informed Trust and this inpatient work will form part of this.
As will be outlined, this is a huge cultural change for an organisation: balancing a medical approach (focused on using symptoms to guide diagnosis to determine medical treatment) with a trauma informed approach focused on what has happened to someone (trauma) and how they are coping.

This will be complicated as mental health care remains dominated by a medically focused MHA and NICE guidance. However, anticipated updates to the MHA will direct mental health care towards a focus on trauma informed care, choice and collaboration for service users. In anticipation, focusing on trauma informed care now offers EPUT an opportunity to be among the forerunners of NHS organisations transforming mental health services in this way.

The inpatient operating model aims to adopt Trauma Informed Care (TIC) on all wards for working age, and older adults, as well as in Urgent Care pathways in and out of hospital (e.g. Crisis teams, Home First, Urgent Care Emergency Department, Transitions services). All of the information outlined applies across all populations, however a very brief overview of issues specific to older people is included in Appendix One *(page 92).*

This chapter outlines a definition of TIC, followed by EPUT's current position with regards TIC and the planned changes including a consideration of what this cultural change might mean in mental health services.

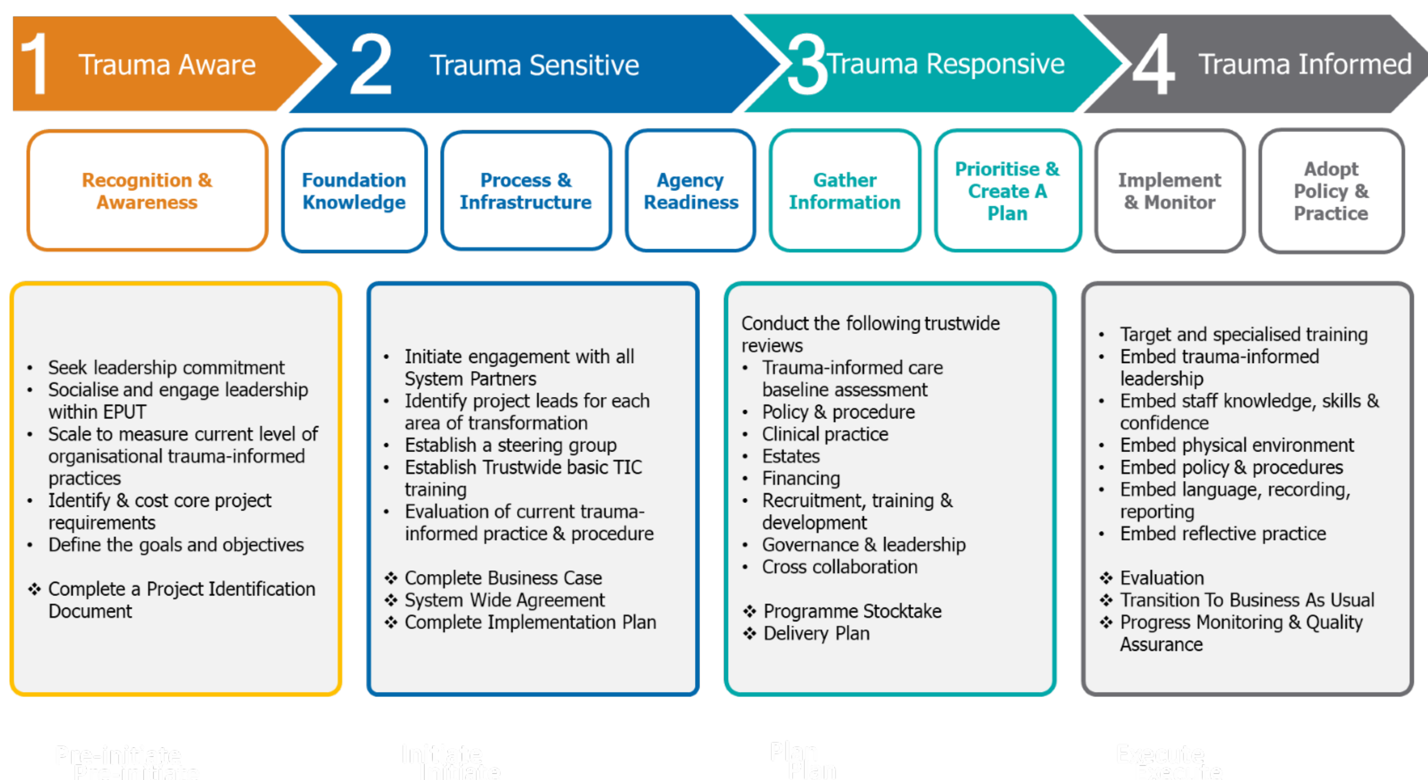
Please note, in order to give a brief overview, complex topics will be referred to or described extremely briefly.

# What is Trauma Informed Care and why is EPUT aspiring to be Trauma Informed?

Trauma informed practice is underpinned by a fundamental shift from thinking 'What is wrong with you?' to considering 'What happened to you?' (The Power Threat Meaning Framework, Johnstone & Boyle: 2018 or overview 2020).

Rather than being a specific service or set of rules, trauma informed approaches are a culture focussed on promoting recovery and resilience and preventing re-traumatisation.

The ambition is to increase staff awareness of how trauma can impact people and communities, and prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing (in line with the new MHA). This will entail reviewing and transforming clinical practices, staff support, organisational procedures and service user engagement. It encompasses transformation of policy, practice, procedure and delivery.




Becoming a trauma informed organisation is an ongoing process, not a one-off event. Engagement at the most senior levels of organisation is essential for the successful implementation of trauma-informed practises.

It is important that EPUT creates a safe environment for both physical and emotional safety (for staff and service users), through intentionally and comprehensively incorporating trauma informed principles and practices into the organisation's structure, service delivery, and culture.

The proposal is for the Trust to use the Oregon tool[3] in guiding change (reproduced above). The table shows how an organisation can move from being Trauma Aware, to Trauma Sensitive, to Trauma Responsive and finally Trauma Informed. At any point a service/organisation can pause in its development. This inpatient initiative could become a pilot in this Trust-wide transformation. This can be used as a guide to note where the service is at, in its development. The first challenge is to become Trauma Aware.

# Why be Trauma Informed?

A systematic review estimated that half of all people in contact with mental health services have experienced physical abuse, and a quarter have experienced sexual abuse (Mauritz et al, 2013).

For some, there is a direct relationship between the trauma they have experienced, and the distress or symptoms that have led them to need hospital care. It is important to note here that use of the word 'trauma' is not a coded reference to those with a Personality Disorder diagnosis, for example, research indicates that up to 90% of those with psychosis have experienced trauma(s).

The guidance from NHS England: Acute inpatient mental health care for adults and older adults adds "when people are admitted to hospital, and particularly when a person is detained under the MHA or is subject to a restrictive intervention, it is often accompanied by feelings of loss of power and control, and can be traumatic. It is therefore important that services work to ensure that the support that is offered in hospital is underpinned by a trauma informed approach, both in terms of the way that care pathways are organised and how care is delivered". We need to move from services that can further induce trauma, to services that reduce trauma.

Given the prevalence of trauma in the inpatient population and the frequent experiences of traumatisation in that environment, a different approach is needed.

TIC is associated with improved mental health outcomes, greater patient satisfaction, and significant reductions in violence, substance abuse, containment-related injuries, seclusion and restraint, and use of sedative hypnotics in acute inpatient settings. It is associated with improved staff satisfaction through less incidents and therefore less stress and trauma for staff, alongside benefits felt from changes in leadership and organisation culture.

# Where we are at – what do we need to do to change/adapt?

NHS Mental Health services developed along a path set by physical health services. This served a great purpose in recognising and legitimising people's mental health experiences. However, the physical health paradigm has also meant a reliance on medical models of mental health. A pharmaceutical industry has built up around the treatment of mental health, and this has played a significant part in alleviating distress. Latest figures show the NHS spends £520 million per year on mental health medication[4]. Other forms of intervention are now recognised to be effective, and cost effective, with less harmful 'side effects'. Clearly when people are distressed, medication has a role to play in reducing emotional pain, but this can now be better balanced against other forms of intervention and treatment.

Inpatient wards, (where patients may be restricted by law underpinned with medical terminology), have become the last upholders of this medical model approach. However, with new insights from research, anticipated changes to the Mental Health Act, guidance from NHS England, and the growth of Multi-Professional Approved Clinicians, the scene is set for inpatient wards to redress the balance of what is on offer to service users.

The main difference in these approaches is that where Psychiatry see symptoms that lead to diagnosis and usually medical treatment, a *trauma informed* mind-set looks at what

has happened to this person and asks '*what if these symptoms were actually ways of coping with what has happened to them*?'

Although a medical approach legitimised mental health problems, this archetype is also partly why people think mental health problems relate to an inner illness, rather than an understandable reaction to experiences. In fact many of the thoughts, feelings and behaviour seen in mental health relate to how people are trying to keep themselves safe, based on their previous experiences (e.g. as outlined in the Power Threat Meaning Framework).

In addition, sometimes it seems easier, or suits the system (political systems, family systems, psychiatric systems, pharmacological industry etc.), to focus on individuals and their 'faulty' internal mechanisms, (to be treated) rather than look at the problems in the system itself – the impact of trauma, the impact of abuse of power, daily exposure to stress and threat etc.

So in contrast to the current mental health assessment and treatment model which predominantly focuses on the ill or disordered human requiring treatment; TIC (Trauma informed care) still keeps a focus on the individual, but recognises the impact of trauma upon them, and uses that knowledge to inform assessment, formulation and treatment.

# Who does have trauma informed care right?

Curiously, we have not lost these skills with other animals. Take for example an animal rescue centre, where staff have no trouble thinking about how these animals - who have often been mistreated and rejected - show behaviours which relate to their experiences. They may be overly aggressive or fearful, bark incessantly, even chew at their own legs – and staff there readily draw on a narrative of how these behaviours relate to their experiences and how they are triggered.

They understand that these behaviours are shaped by traumatic experiences. They do not blame the animal, or take it personally if it behaves aggressively or fearfully. They are open to trying to understand what are the triggers, which they share with each other at handover. For example, they might say: this animal was beaten with a stick so becomes fearful if someone carries something that even slightly resembles a stick; this animal was teased by children and had its tail pulled, so reacts aggressively if someone is behind it; this animal was mistreated in a noisy chaotic household so is triggered by sounds; this animal was punished with a hosepipe so reacts unpredictably when the kennels are cleaned; and so on.

Staff observe for signs of escalation, knowing they need to make the animal feel safe, to aid with de-escalation if it becomes threatened. Staff have no problem understanding that these characteristics are both contradictorily somewhat stable and open to change. That the dog can be lovely one moment, but when triggered may react in what might seem like unpredictable ways, but they learn to know that they are predictable – and relate to trauma. They know that if the dog feels safe, it may be able to be rehomed, but they are also realistic about the enduring impact of trauma too.

# What does it mean to have traumatised people on an inpatient ward?

Traumatised people are on the lookout for danger in order to keep themselves safe. This threat focus means they are more easily triggered to fight or flight/survival mode. In fight or flight mode, the survival instinct takes over – an automatic response, out of conscious control which prioritises running and fighting or freezing to survive a threat. This can feel like an explosion of uncontainable feelings driving behaviour (run, fight) and/or a freeze and numbing, switched off state. While this happens sophisticated (not threat focused) thinking is put on standby and logic can be offline temporarily.

The resulting behaviour can be challenging to treat in a trauma informed way i.e. thoughtfully and compassionately, especially as being on high alert/panic is so easily transmitted between people and that means staff feel the panic and their logical thinking can be compromised too.

This more trauma aware way of viewing mental health can complement traditional medical approaches and already does within the wards Multi-Disciplinary Teams (MDT: a team made up of people trained in different disciplines/professions working together). Typically staff with a psychological training already work from a trauma formulation perspective. The organisational and system challenge is about blending them, where the volume needs to be turned down for one and turned up for the other; and then in working with each patient, to work out what their preferred volume setting for different approaches would be (in keeping with the new Mental Health Bill).

# What does a Trauma Informed Service look like?

A summary and distillation of what a Trauma Informed service would look like is set out in the *NHS England Inpatient Mental Health Care for adults and older adults* (2023) and described in the three points below. It is important to note that all of this will be in keeping with the new Mental Health Bill.

1. Staff to recognise that many people in contact with mental health services will have experienced trauma. Staff should talk to the person and their chosen carer/s to understand the role that trauma has played. The staff should read what has already been written about someone on their electronic patient record (EPR), so they can being mindful not to re-traumatise someone, and give the person choice about whether they wish to discuss these aspects of their life again.
    - Give the person as much choice and control via working collaboratively as is possible – being mindful not to trigger or further traumatise by being in hospital,
    - Make shared decisions with the person about whether they need specific support to help them process any traumatic experiences that they have had.
    - The physical and emotional environment on the ward should promote feelings of safety and recovery.
    - Members of the inpatient team should work to build therapeutic relationships with people that are based on trust, respect and compassion.

2. For all of this to happen, "*it is essential that there is a positive ward culture, where the use of restrictive interventions, including restraint and seclusion, is not seen as standard practice, and where restrictive interventions are used, it is as a last resort,*

*proportionate to the situation and for the minimum time necessary. Managers should undertake regular reviews of practice, to ensure that where restrictive interventions are used, it is absolutely necessary and is applied proportionately*".

3. For this to happen, staff's own wellbeing needs support. Services should have processes in place, including reflective practice and supervision, which help team members to process their own thoughts, feelings and reactions to situations that have occurred on the ward, as well as any traumatic experiences they have had outside work.

The changes for staff on the ground will not be about more tasks and checklists, but to help them find a way to hear someone's story and their distress. Time needs to be given for staff to read notes to speak with their patients and to think about the meaning of what has happened to someone in Reflective Practice groups. These groups alongside training and supervision will help staff to chart a course between the 'all or nothing' approach that the patient themselves can be stuck in. In the pressure and demands of inpatient care, when someone's behaviour is hard to make sense of, or is contradictory and changeable, and it is hard to keep someone safe, the culture can lead to labelling someone as 'PD' and then switching off to the person, and becoming dismissive. On the other hand some staff, especially less experienced staff, can find themselves in the other extreme. They may try to rescue someone, hopeful they will be the one to make the difference, often encouraged by the patient (desperate for someone to rescue them too, but also fearful); before the complexity of the situations and difficult dynamics can lead them both become disappointed, if success isn't achieved or sustained.

It cannot be emphasised enough that if staff feel traumatised, they themselves will operate in a survival or flight/fight mode and be unable to think clearly and work effectively. So the first job is to help staff feel safe, so they can learn and then regulate or ground themselves, and can then help regulate and ground patients.

This is a challenge right now, as we know staff are experiencing hardship and trauma. This can include: the increased demand and acuity of admissions as acknowledged in the latest NHS guidance (July 2023); they may feel under threat from CQC inspections; fears about the ongoing Statutory Enquiry; fears about what might happen on shift today; fears about being on the receiving end of verbal and physical threats/assaults that patients are unable to contain; they may be experiencing secondary traumatisation; and managing all this whilst working long challenging shifts. However, they also have lives outside work, which we may not know about but could include challenges from the cost of living, or living abroad and away from family, to facing discrimination.

# Action planning

The table below sets out some of the actions required to start the process of being trauma informed on the inpatient wards, although these need to be considered in the context of the Trustwide initiative, and be at a system and organisational level.

| | Action | Advantages | Disadvantages | Risks to implementation |
|---|---|---|---|---|
| **Leadership** | • Leaders to engage with the Trust-wide trauma informed initiative.<br>• Leaders to take on training and understand the full implications of a trauma informed approach.<br>• Leaders demonstrate by example through the hierarchical management structure trauma informed ways of working.<br>• Use of the Oregon tool to plan change. | • Leaders will discover the advantages of a different leadership style, and how this changes relationships with staff in a positive way.<br>• Leaders see their staff pass on this more trauma informed style to their own staff and then through to patient care.<br>• Some of this style of work is already in place – but is currently piecemeal and more down to personal and individual characteristics rather than a system supported, endorsed and valued approach | • It takes time.<br>• It requires taking a different approach. | • Leaders don't feel they have the time or don't buy into the philosophy so the implementation becomes tokenistic and tick box, and therefore not trauma informed.<br>• Variation of training and isolated areas of staff training are insufficient to make fundamental changes in the organisation. Organisational support and participation of leadership throughout all services, as well as workforce and service user involvement, are critical components of effective implementation of this programme. |
| **Environment** | Review environment using existing checklists and consider:<br>• Soft close doors<br>• Minimise echoes from bangs, crashes and shouts<br>• Soothing environments<br>• Access to outside or fresh air | • If the ward is more of a trauma informed environment, then it will be less likely to trigger patients in unforeseen ways, leading to a reduction in escalations and incidents. | • Takes time<br>• Cost<br>• Managing ligature risks<br>• Staffing issues | • Requires leaders and managers, and staff to buy into the TIC mind-set, which can be difficult if the default setting is a medical model approach. If staff are stressed or challenged, they are more likely to |

| | | | | |
|---|---|---|---|---|
| | • Access to gym equipment e.g. cycling or running machines to aid with using up excess energy from fight/flight mode.<br>• Access to chill out boxes<br>• Posters to remind staff and patients | • There could be roles for new and existing staff (with training) to notice escalation issues as they are happening and then use techniques (as set out in positive behaviour plans). So use exercise equipment such as bikes and running machines to aid de-escalation (from those with a more run/fight response) or soothing and grounding techniques (breathing, mindfulness, grounding, e.g chill out box).<br><br>Gym equipment and soothe boxes are already available. What needs to happen next is the training and mind-set of how to use them to de-escalate.<br><br>This will teach patients how to de-escalate themselves with exercise or soothing. Eg. "I thought I was losing it, but after 20 minutes on the exercise bike alongside a member of staff encouraging me, I felt so much better". | | default to old and familiar ways of working. Doing something different is effortful. |
| **Staff Training** | • Training to increase understanding of the role of Trauma in mental health. See Scottish Toolkit with its five principles of safety, trustworthiness, choice, collaboration, and empowerment. | • Staff have new information and skills and find that these ways work to reduce escalations and incidents. Azeem et al noted incidents | • Takes time<br>• Cost<br>• Staff may be overwhelmed themselves and unable to take on new information. | • Not all staff engage with the training.<br>• 12-hour shifts mean staff may be over tired from the middle of a shift onwards, and |

| | | | | |
|---|---|---|---|---|
| | • Could use NHS training in part [Trauma-Informed Care - elearning for healthcare (e-lfh.org.uk)](#)<br>• Training to aid in understanding and using physical exercise and other grounding skills eg. mindfulness as a way to minimise dysregulation when triggered.<br>• All staff to be trained, to include medical staff, psychiatrists, occupational therapists, physiotherapists, unqualified staff.<br>• Training to include understanding the function of symptoms as ways of coping (see Power Threat Meaning Framework, 2018) **Appendix 2 - page 92**<br>• To appoint a Trauma Informed Ambassador Trust-wide and per shift/team/ward to act as reminder of the principles.<br>• Specific training for staff working with older people – see quick guide in **Appendix 1 - page 92**.<br>• Specific training for those working in Urgent Care, tailored to their services.<br>• Training in dialectical behaviour therapy for some staff. | reduced by one third.<br>• Can use existing NHS trauma informed e-learning<br>• Nurse Professional Educators are proposed via (TTC) and these could be lead trainers for TIC (if trained themselves). | People have to feel safe, in order to take on new information. | less likely to be able to use these skills.<br>• Risk not all staff will engage and it will be seen as a task for e.g. psychology rather than a whole MDT approach.<br>• Risk of piecemeal approach and pockets of good practice, undermining the whole endeavour.<br>• Risk that one person is responsible for TIC and becomes an unwelcome conscience or reminder to others. |
| **Staff support** | • All staff to have regular supervision. This supervision should complement the trauma informed training received, and use clinical examples to embed practice. | • The CQC notes that 28% NHS staff sick days are accounted for with anxiety, stress and depression.<br>• EPUT's Patients and Staff Safety | • Requires time away from face to face work. | • This may mean a change in culture. This may be difficult where staff have become disillusioned or burnt out, or view the job as just a way to |

| | | | | |
|---|---|---|---|---|
| | • Supervision and/or Reflective Practice groups to focus on staffs own wellbeing and emotional reactions to their work. | Incident Support Service (PSSI) service received 42 individual referrals and 29 team referrals since started[5] | | earn money in a detached way.<br>• Risk that some staff view supervision as punitive, rather than supportive. |
| **Changes to inpatient practices** | • MDTs to be part of every ward.<br>• Staff to use Positive Behaviour Plans (PBS) to aid with individual approach, to understand know what to do for each patient<br>• Staff require dedicated time for reading about new patients – which requires strong support from line management, changes in job plans.<br>• Change systems when a serious incident occurs, swap teams out, and focus on regulating staff first, so they are able to complete forms accurately.<br>• Reflection and Understanding:<br>• Posters to be displayed in communal spaces for both staff and patients to be reminded of trauma informed practice, particularly when a person or a situation may be escalating.<br>• For MDT staff (unqualified/ qualified) to be more visible and available in communal areas on the ward. For this to be valued and documentable part of clinical inpatient practice. | • MDTs will be more trauma informed and in line with changes in MHA.<br>• Staff already on-board, with all band 6 staff undertaking PBS training from January 2024.<br>• If staff have respected and valued time to read and think about the patients, they are well on their way to offering TIC.<br>• Staff and patients are more likely to feel cared for when a serious incident has occurred. The correct policies, and paperwork are more likely to be completed in a timely and accurate manner.<br>• To help remind both staff and patients, (when their thinking may be compromised by being in panic mode) of what they can do to try and de-escalate or regulate a situation.<br>• TIC indicates time to discharge reduced by 39%, and discharge to lower level care doubled. | • Time required**.**<br>• Staffing implications.<br>• Resourcing issues**.** | • Risk -these approaches can be delivered in a tokenistic, tick box style, in piecemeal fashion, which is not in the spirit of what a trauma informed approach is - a cultural whole system change.<br>• TIC has less emphasis in current psychiatric training, and as psychiatrists are still most likely to lead MDTs and be Responsible Clinicians, their personal beliefs and preferences may dictate how they practice and due to hierarchical team structures may lead other staff to follow suit**.**<br>• A trauma informed approach would be easily undone at this point. There needs to be a whole system buy in.<br>• There is a risk that improved care may make it more difficult for patients to want to leave hospital. For those traumatised in childhood by abusive or |

| | | | | |
|---|---|---|---|---|
| | | | | neglectful care, being treated in trauma informed ways may be their first experience of positive care. They may sabotage their own progress (unconsciously?) to retain access to this care. Mitigation is very clear boundaries around admission and planned discharge. |
| **Audit** | • Psychological Services staff already use ESSENCES to measure ward atmosphere scale, so use this to assess for impact of change.<br>• Audit incidents<br>• Audit restraints<br>• Audit length of stay<br>• Audit discharge destinations | | | |

In addition, the aim is to develop a resource pack for staff which will include information on many initiatives already in use, as well as new ones planned that fit with being more trauma informed. This will include the use of Positive Behaviour Plans, trauma informed passports, Reflection and Understanding sessions following serious incidents, posters on wards to help remind people of trauma informed ideas when they are in 'survival mode', alongside many of the other suggestions included in the table above.

**In conclusion**, although trauma informed work could be viewed as something that 'some on the ground, interested and motivated staff do with patients with a trauma diagnosis', this is **not** in the spirit of trauma informed care. All evidence and research predicts that piecemeal trauma informed approaches will fail unless they are part of meaningful organisational change. EPUT as an entire Trust is beginning the process of working towards becoming trauma informed and this is an organisational, system and cultural change that could take years. That is not to say that there are not pockets of excellent trauma informed work going on within inpatient services and as part of the Trust-wide initiative. As a first step, it is essential to focus on leadership, as well as staff training and staff support. Leaders leading and treating staff in a trauma informed way will help staff in turn pass on the principles to those they work with.

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# EPUT Quality of Care Framework

Quality of Care Framework, created through public, staff and stakeholder engagement, will underpin the new inpatient operating model.

- The Strategy delivery includes the introduction of the Quality Senate, Care Unit and Professional Leaders with lived experience and frontline members.
- The senate will receive inputs from various sources e.g. NICE, research, GIRFT, peer review, lessons identified, royal college etc., all considered with majority voting, then providing outputs to advisory to change education and training , digital, transformation, service change etc. and then senate ownership and accountability for all clinical guidelines.
- Quality outcomes will be defined and reviewed annually over 3 years.
- There is also a Quality Assurance Framework which has 4 parts: Quality Planning, Quality Control, Quality Assurance and Quality Improvement
- It has a layer approach at Team, Care Unit, Board and ICB level, using multiple approaches and feeds Q&S Meetings, the Accountability Framework, the CQRG Quality Committee and Regulation Evidence Assurance.

We have listened to people who we care for:

- ✓ Who want to be empowered and feel in control of their lives
- ✓ Who want sensitive communication
- ✓ who want reliable and consistent care
- ✓ Who want compassion, kindness and hope

- The strategy will build quality outcomes that meets the needs of people we care for
- The strategy delivery includes the introduction of a Quality Senate with representation by care unit and professional leaders with lived experience and frontline staff members
- The senate will receive inputs from various sources including: NICE, research, National guidance, benchmarks, peer review, lessons identified, Royal colleges, Legal frameworks
- The senate members will appraise, agree, advise and provide professional accountability for the quality of care EPUT provides through outputs, which influence education and training, digital, transformation, service changes.
- Quality outcomes will be measured and reviewed annually over 3 years

We are adopting the NHS constitution and WHO definition of quality of care. Care is evidence-based to ensure it is safe, effective and provides positive experiences.

## Delivering quality care in systems: **the seven steps**

| | |
|---|---|
| 1 | **Setting clear direction and priorities**<br>To deliver a new service model for the 21st century, which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities. |
| 2 | **Bringing clarity to quality**<br>setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities. |
| 3 | **Measuring and publishing quality**<br>Measuring what matters to people using services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform improvement and decision-making. |
| 4 | **Recognising and rewarding quality and learning**<br>Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well. |
| 5 | **Maintaining and improving quality**<br>Working together to maintain quality, reduce risk and drive improvement. |
| 6 | **Building capability for improvement**<br>Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing. |
| 7 | **Staying ahead**<br>By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy. |

Visit our website eput.nhs.uk/about-us/quality-of-care for more information.

# Time to Care Staffing Model

The table below shows a new multidisciplinary workforce as part of the Time To Care Programme which will be a key enabler of the New Therapeutic Inpatient Operating Model. New and current staff members will be expected to enroll in training that will support the new model's requirements.

| Initiative | Role | Band | Revised WTE to Recruit | Comments |
|---|---|---|---|---|
| **Specialist Therapeutic Support**<br>**Ensure each ward has an Activity Coordinator operating on minimum one short shift, 7 days per week** | **Activity Coordinators** | **3** | **54.04** | **We already have approximately 6 WTE in post so do not require equipment for all 54 WTE.** |
| **Capacity & Flow**<br>**Introduce an Integrated Patient Flow team to support the purposeful admission agenda** | **Adult Discharge Coordinator** | **6** | **4** | |
| | **Clinical Flow Lead** | **8b** | **1** | **Individual recruited into role; no equipment needed.** |
| | **Older Adults Discharge Lead** | **7** | **1** | |
| | **Patient Flow Administrator** | **4** | **1** | |
| **Leadership**<br>**Introduce Clinical Site Managers to provide 24/7 leadership capability** | **Clinical Site Managers** | **6** | **18** | **We already have approximately 6 WTE in post so do not require equipment for all 18 WTE.** |

| | | | | |
|---|---|---|---|---|
| **Specialist Therapeutic Support**<br>**Introduce Dietitian provision in South Essex and CAMHS to reduce variation** | **Dietitian** | **6** | **2.44** | |
| **Specialist Therapeutic Support**<br>**Uplift AHP provision by 22% to account for timeout, leave and training** | **Dietitian** | **6** | **17.62** | **No equipment required as this is applying an uplift to current staff already in post.** |
| | **Physiotherapists** | **3 to 7** | | |
| | **Occupational Therapists** | **3 to 8a** | | |
| | **Speech and Language Therapist** | **5 to 6** | | |
| **Patient, Family & Carer**<br>**Introduce Family and Carer Ambassadors across all wards** | **Family and Carer Ambassador** | **4** | **13** | |
| **Patient, Family & Carer**<br>**Introduce Family Group Conference Leads to support the Mental Health and Urgent Care Pathway** | **Family Group Conference Leads** | **8a** | **2** | |
| **Specialist Therapeutic Support**<br>**Increase Pharmacy provision to support Pharmacy Growth Strategy** | **Medicines Management Technician (B6)** | **6** | **2** | |
| | **Advanced Pharmacist (B8a)** | **8a** | **3** | |
| | **Pharmacy Support Worker (B3)** | **3** | **4** | |
| **Patient, Family & Carer**<br>**Introduce Peer Support Worker Team with lived experience across all wards** | **Peer Support Worker** | **3** | **14** | |
| | **Peer Support Worker Supervisor** | **6** | **2** | |
| **Leadership**<br>**Introduce Professional Nurse Educators** | **Professional Nurse Educators** | **7** | **6** | **We already have approximately 1 WTE in post so do not require equipment for all 54 WTE.** |
| **Specialist Therapeutic Support**<br>**Increase Psychology provision by filling current vacancies to ensure retention** | **Psychologist Older Adult** | **8a** | **2** | |
| **Core Ward Based Registered Practitioners**<br>**Three registered professionals per shift across all wards; four across AU and PICU** | **Registered Care Practitioner (B6)** | **6** | **151** | |
| | **Registered Mental Health Nurse (B5 and B6)** | **5** | | |
| | **Older Adults Mental Health Nurse (B5 and B6)** | **5** | | |

| | | | | |
|---|---|---|---|---|
| | **CAMHS Mental Health Nurse (B5 and B6)** | **5 & 6** | | |
| | **Forensics Mental Health Nurse (B5 and B6)** | **`** | | |
| **Specialist Therapeutic Support**<br>**Introduce Speech and Language Therapy in North East Essex to provide specialist support for swallowing and communication** | **Speech and Language Therapist (B5)** | **5** | **1.22** | |
| | **Speech and Language Therapist (B6)** | **6** | **1.22** | |
| | **Speech and Language Therapist (B6)** | **6** | **1.22** | |
| | **Speech and Language Therapist (B7)** | **7** | **1.22** | |
| **Support Services**<br>**Dedicated Admin** | **Ward Administrator** | **3** | **31.2** | |
| **Leadership**<br>**Introduce a Perinatal Nurse Specialist for the Mother and Baby Unit** | **Perinatal Clinical Lead B8a** | **8a** | **1** | **Individual recruited into role; no equipment needed** |
| **Total** | | | **336.18** | |

# CHAPTER ONE

## Purposeful Admissions - Appendices

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# Appendix One

**Indicators that are monitored at a national level to measure the effectiveness of adult acute mental health pathways:**

- **Number of inappropriate out of area placements**: Inappropriate out of area placements occur when inpatient provision is not available locally. This usually occurs when the local acute mental health pathway is under too much pressure due to a combination of high admissions, long hospital stays, and delayed discharges. Being treated out of area can negatively impact people's experience of and outcomes from care, while also being more expensive.
- **Number and percentage of admissions involving people not known to services**: If the first time people are encountering mental health services is at the point of admission, this may indicate that improvements are needed in primary care and community-based mental health services, to avoid escalation to the point that an admission is required. This is also used as an equality measure, as currently a higher percentage of people from racialised and ethnic minority communities have their first contact with mental health services at the point of admission.
- **Number of mental health related A&E attendances, and the percentage of A&E waits lasting over 12 hours**: A greater proportion of admissions coming in via A&E indicates that community-based crisis services may not be operating optimally, while long waits in A&E indicate difficulties accessing inpatient provision. Through people accessing mental health care through A&E, it may compound pressures on inpatient services, because once in A&E, consistent anecdote suggests that people are more likely to be admitted without community-based crisis alternatives being considered as fully.
- **Percentage of people on community mental health team caseloads who are admitted to hospital**: If a high percentage of people on community mental health team caseloads are admitted, this may indicate that improvements can be made within the community mental health team to identify when people's needs may be at risk of escalating, and to intervene earlier and more proactively to prevent admissions. However, it is important that when admission is needed, the person is admitted to the right inpatient service provision in a timely manner.
- **Percentage of admissions involving detention under the MHA**: Detention status can sometimes be a helpful indication of acuity. If a large proportion of people admitted to an acute ward are detained under the MHA, it may indicate high levels of need for inpatient services locally. A higher than average proportion of admission involving the MHA is not necessarily a problem however, as it may reflect higher uptake of crisis alternatives for people who would otherwise be admitted to hospital on a voluntary basis.
- **Number of adults with a learning disability and autistic people in a mental health hospital**: The NHS Long Term Plan sets out that by March 2024, there should no more than 30 adults with a learning disability and/or autism in a mental health inpatient setting, per one million adults. Therefore, it is important to monitor this metric, using data from the Assuring Transformation dataset, to determine whether alternatives to hospital are being utilised (where this is the best option for the person), in order to support this commitment.
- **Percentage of available adult and older adult acute beds that are occupied at any one time**: Very high levels of bed occupancy (above 90%) can indicate significant pressure on the acute pathway and inpatient services in particular.

- **Occupied adult and older adult acute bed days per 100,000 weighted mental health population**: How reliant the local area is on inpatient care compared to other areas. Occupied bed days is used as this takes into account number of admissions as well as length of hospital stay.
- **Average acute mental health length of hospital stay, and the rate of admissions per 100,000 weighted mental health population lasting over 60 days for working age adults and 90 days for older adults**: People's experience of care, their outcomes and service pressures all benefit if people do not spend a day longer than is necessary in restrictive hospital environments. A focus on reducing length of hospital stay (where appropriate) is also key to unlocking inpatient capacity and eliminating out of area placements. To understand true length of stay, it is important to look at the full length of stay in hospital (which may include a number of consecutive ward stays), rather than the length of individual stays on a ward. Monitoring the number of very long lengths of stay (as well as the average), helps to highlight where people are getting stuck in hospital for a very long time, which can be indicative of an admission that is not therapeutic or purposeful, or where there are barriers to discharge that need addressing.
- **Number of people who are CRFD who are occupying inpatient beds**: People are considered CRFD when no further assessments, interventions and/or treatments are needed that can only be provided in the current inpatient setting. Monitoring the number of people in an inpatient mental health service who are CRFD, and the reasons for this, sheds light on the barriers that need to be addressed to facilitate timely discharge.
- **Percentage of 72-hour follow-ups completed for people leaving acute inpatient care**: NCISH has found that there is an increased risk of dying by suicide on days 2-3 following discharge from hospital. As such, timely follow- up is key, and NHS England introduced a national standard from April 2020 that requires everyone who is discharged from an adult mental health inpatient service to be followed-up within 72 hours of discharge (excluding specialised services commissioned by NHS England).
- **Number of FTE staff members belonging to different professional groups per inpatient bed**: Higher numbers of FTE staff per inpatient bed is associated with a shorter length of hospital stay. This is particularly where there is a good therapeutic skill mix, e.g. higher numbers of psychologists and occupational therapists.

# Appendix Two

**Examples of good and poor quality purpose of admission statements**

| **Examples of good (✓) and poor quality (×) purpose of admission statements** |
| --- |
| ✓ Ayele, who is being supported by the Early Intervention in Psychosis service, is having a relapse in the community following a breakup with her partner, and has stopped taking her clozapine medication. It is known that re-starting Ayele on medication at home will not be successful and therefore hospital admission will be used to identify why she stopped taking the clozapine medication, including whether any aspects of her care plan need changing to address the reasons identified. One thing that Ayele mentioned at admission was feeling lonely so her ongoing care plan will need to include support in helping her to address this. EDD: 14 days. |
| ✓ Krish has been receiving treatment for a diagnosis of bipolar disorder from a community mental health team, alongside support from his local drug treatment service. He was doing well with managing his bipolar and drug use, until the death of his uncle. On Friday, he attended the local A&E, having made a serious attempt to take his own life. He had not taken his daily medication for more than four days. An admission is required to re-establish his medication and to understand what would help him to manage his bereavement. This support will then be put in place as part of his ongoing care plan. EDD: 21 days. |
| ✓ Reggie has recently become homeless and has been brought to a health- based place of safety by the police, because he was displaying a high level of mental distress in public. He is not known to mental health services. Reggie has been assessed as requiring admission under Section 2 of the MHA. Admission will be used to assess his mental state and identify his strengths, needs and aspirations, including how he usually manages in his day-to-day life, why he became homeless and what factors contributed to his mental health crisis. This will inform his ongoing care plan, including setting out which pharmacological, psychological, social and practical interventions are required to support Reggie's recovery in the community. EDD: 21 days. |
| × Mike required admission under Section 3 of the MHA. EDD: unknown. |
| × Aarvi has been admitted to maintain their safety. EDD: Will be discharged once risk assessment shows it is safe to discharge Aarvi. |

# CHAPTER TWO

## Therapeutic Benefit - Appendices

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# Appendix one

## Activities for adults

**1-1 Interventions**

- **Delivered by:** Medical & nursing staff, Psychological Services, AHPs, pharmacists and pharmacy technicians, care coordinators, Crisis & Home Treatment teams, discharge coordinators, social care, advocacy, peer support workers and external providers
- **Examples:** Acute Mental health interventions, including assessment, formulation, ward & medication reviews, nursing needs assessments, physical health support, short-term psychological interventions, managing emotions, sensory modulation, discharge planning and targeted work on transition of care, including reducing barriers to discharge
- **Aim:** As part of person-centred care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s and meet the person's holistic needs.

**Targeted therapeutic groups**

- **Delivered by:** Psychological Services, AHPs, pharmacists and pharmacy technicians, and nursing staff
- **Examples:** Managing emotions & coping skills (including reducing self-harm and suicidal ideation), arts psychotherapy, occupational skills development, DBT informed groups, physical health interventions, CBT, anxiety management and open talking groups.
- **Aim:** To promote self-management and coping strategies

**Psychoeducation & information giving**

- **Delivered by:** Psychological Services, AHPs, medical & nursing staff, pharmacists and pharmacy technicians, and external providers
- **Examples:** Carers' support, community meetings, drop in clinics, medication information, managing symptoms, physical health support, leaving hospital groups, advocacy, housing, benefits & employment support
- **Aim:** To provide ongoing information regarding treatment and reduce barriers to discharge.

**Wellbeing groups**

- **Delivered by:** CAPs, OTAs, HCAs, fitness instructors & volunteers
- **Examples:** Relaxation, sensory interventions, mindfulness, yoga, chaplaincy group
- **Aim:** To provide complementary coping strategies and therapies, for example, reflexology, essential oils, and others.

**Activity programme**

- **Delivered by:** Activity coordinators, OTAs, HCAs, external providers (7 day programme)
- **Examples:** Creative crafts, board games, gardening, table tennis, gentle exercise, community meetings, religious/spiritual groups, pet therapy, etc.
- **Aim:** To supplement the above interventions, this programme of activities and groups help to improve people's physical and mental wellbeing. The activity programme should run daily on each ward, including at weekends and in the evenings in order to support maintenance of routine, rebuilding confidence, concentration and social skills.

# Appendix two

## Activities for older adults

**1-1 Interventions**

- **Delivered by:** Medical & Nursing staff, Psychological Services, AHPs, pharmacists and pharmacy technicians, care coordinators, Crisis & Home Treatment teams, discharge coordinators, social care, advocacy, peer support workers and external providers.
- **Examples:** Acute Mental Health interventions, including assessment, formulation, ward & medication reviews, nursing needs assessments, physical health care, Falls prevention Tools and management, short-term psychological interventions, managing emotions, sensory modulation, discharge planning and targeted work on transition of care, including reducing barriers to discharge
- **Aim:** As part of person-centred care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s and meet the person's holistic needs.

**Targeted Therapeutic groups**

- **Delivered by:** Psychological Services, AHPs, pharmacists and pharmacy technicians, and nursing staff
- **Examples:** Maintaining & regaining ADLs, physical health interventions, social connectedness interventions, social and emotional modulation and regulation interventions, adherence to medication, rehabilitation and deconditioning prevention
- **Aim:** To promote self-management, coping strategies, minimizing distress and developing hope and meaning

**Psycho-education & information giving**

- **Delivered by:** AHPs, medical & nursing staff, pharmacists and pharmacy technicians, Psychological Services and external providers
- **Examples:** Community meetings, Life and coping skills, physical health support, utilization of aids and equipment, discharge planning, medication information, symptom management, sleep hygiene, carers education, social inclusion
- **Aim:** To provide ongoing information regarding treatment, reduce barriers to discharge and maximize least restrictive options

**Wellbeing groups**

- **Delivered by:** CAPs, OTAs, HCAs, & volunteers
- **Examples:** Relaxation, creative, exercises, sensory interventions, mindfulness, walking, chaplaincy group, reminiscence and topical discussions, social connectedness and inclusion groups, cognitive stimulation activities
- **Aim:** To provide complementary coping strategies, practical techniques and engagement in meaningful wellbeing approaches

**Activity programme**

- **Delivered by:** Activity coordinators, OTAs, HCAs, external providers (7 day programme)
- **Examples:** Creative crafts, cooking, board games, gardening, gentle exercise, music, brain training, community meetings, religious/spiritual groups, pet therapy, etc.
- **Aim:** To supplement the above interventions, this programme of activities and groups help to improve people's physical, mental and emotional wellbeing. The activity programme should run daily on each ward, including at weekends and in the evenings in order to support maintenance of routine, rebuilding confidence, concentration and social connectedness

# Appendix three

## Activities for patients with dementia

**1-1 Interventions**

- **Delivered by:** Medical & Nursing staff, Psychological Services, AHPs, pharmacists and pharmacy technicians, care coordinators, Crisis & Home Treatment teams, discharge coordinators, social care, advocacy, hospice, end of life and external providers
- **Examples:** Acute Mental health interventions, including assessment, formulation, ward & medication reviews, nursing needs assessments, physical health assessment and care, falls prevention tools, short-term psychological interventions, managing emotions and behaviours, sensory modulation, discharge planning and targeted work on transition of care, including reducing barriers to discharge
- **Aim:** As part of person-centred care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s and meet the person's holistic needs.

**Targeted Therapeutic groups**

- **Delivered by:** Psychological Services, AHPs, pharmacists and pharmacy technicians, and nursing staff
- **Examples:** Emotional, Behavioural or Sensory support activity, Maintaining ADLs, Regaining self-management, physical health interventions, social connectedness interventions, social and emotional modulation and sensory regulation interventions
- **Aim:** To promote self-management, coping strategies, minimizing distress and developing hope and meaning, Quality of Life

**Skills maintenance & information giving**

- **Delivered by:** AHPs, medical & nursing staff, pharmacists and pharmacy technicians, Psychological Services and external providers
- **Examples:** ADLs, Orientation meeting, Cognitive, Social, Physical and Sensory focused activities, carers information sessions, Medication and symptom management information
- **Aim:** To maintain skills and independence with least restrictive options, provide information to care givers to maximize independence and maintain dignity and respect

**Wellbeing groups**

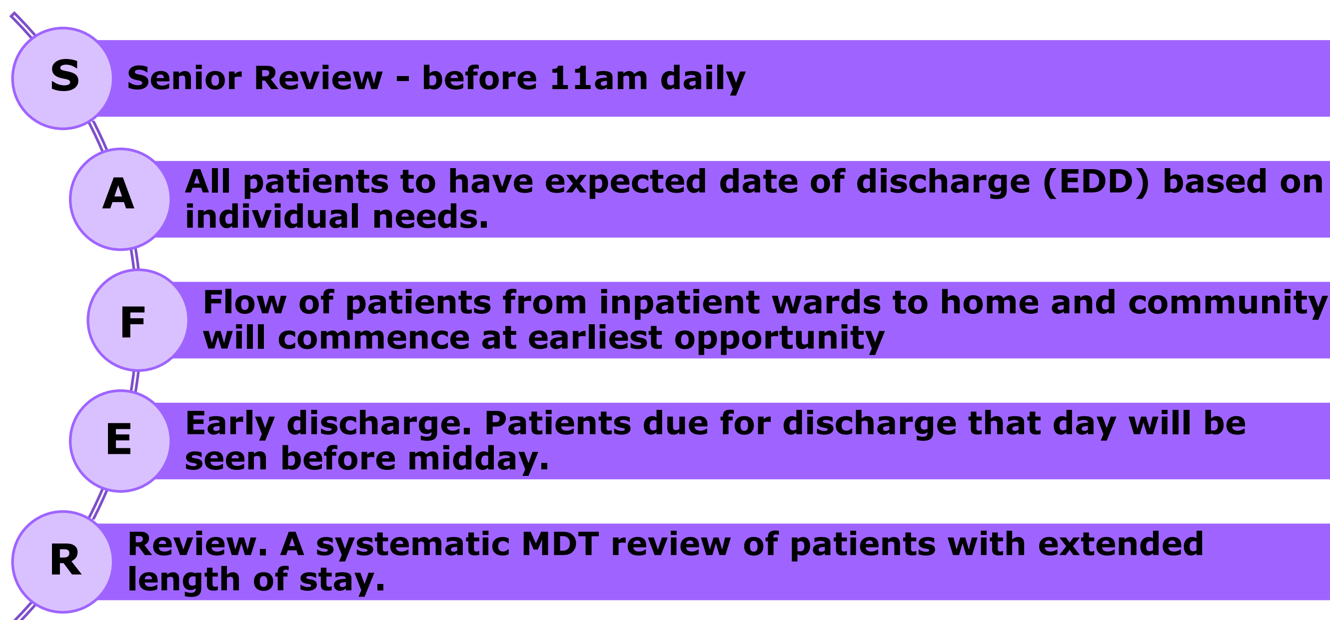
- **Delivered by:** CAPs, OTAs, HCAs, & volunteers
- **Examples:** functional familiar, physical, sensory, cognitive and social activities, reminiscence, music and movement, relaxation, mindfulness, creative, chaplaincy group, reminiscence, topical discussions and Pet Therapy
- **Aim:** To provide structure to enable individuals to cope and engage in meaningful wellbeing approaches

**Activity programme**

- **Delivered by:** Activity coordinators, OTAs, HCAs, external providers (7 day programme)
- **Examples:** meaningful familiar activities, ball games, gardening, music & movement, games, creative crafts, gentle exercise, singing, orientation meetings, religious/spiritual groups, pet therapy, etc.
- **Aim:** To supplement the above interventions, this programme of activities helps to support people's physical, mental, sensory, cognitive and emotional wellbeing. The activity programme should run daily on each ward, including at weekends and evenings in order to support the maintenance of routine and structure, regulate the socio-emotional environment, managing complex behaviours, and provide opportunity for social connectedness

# Appendix four

**Safer Care Mental Health Bundles**




### Senior Review:

- Have new patients been given expected date of discharge (EDD) within 72 hours?
- Have new patients been seen by consultant psychiatrist and Home Treatment within 72 hours to confirm EDD? (functional model)
- Are there any patients to be discharged today/tomorrow?
- Are there any delays that need to be expedited?
- The MDT care review should follow the clinical meeting each morning.
- Patients should be seen in a specific order with those planned for discharge first.
- A record of the review with clear management plans should be written and entered onto clinical record.
- Medication should be prescribed, and diagnostics ordered in real time.

### All patients with EDD

- Identify patients for early discharge tomorrow.
- Has the patient's EDD been set within 72 hours and confirmed with Home Treatment and psychiatrists?
- Is the EDD realistic?
- Has the EDD been reviewed? Does the Care Co-ordinator support?
- Is EDD reflected in My Care, My Recovery document?
- Is the patient aware of their discharge plan, date and time they are expected to go home, have they been given a letter, do their relatives know?

### Flow of Patients

- Flow of patients will commence at the earliest opportunity from inpatient wards to home treatment and community services.

- Home Treatment need to participate in Senior Review/SITREP/Care Reviews, promoting early discharge and ongoing community treatment.
- Community Care Co-ordinators/Team representative needs to attend ward within first week of admission to support EDD, My Care My Recovery and identify any bio psychosocial barriers to discharge.

**Earlier Discharge:**

- A third of discharges from inpatient wards should be before midday.
- Patients are pre-prepared on admission for discharge and use of the home treatment team as an alternative.
- Medication is written up in advance or real time.
- Patients transport arrangements confirmed.
- Home Treatment facilitated discharge for patients with clear clinical criteria for discharge (My Care, My Recovery)
- Purposeful / supportive leave model.

**Review Length of Stay**

- Do all patients have clear management plans?
- Is the patient waiting for any procedures or tests, do these need chasing, can they wait in community for these procedures?
- For the majority of patients, definitive assessment of social care needs should occur outside of hospital (discharge to assess).
- What is being done to expedite appropriate discharge and what could have been done earlier in the patient's journey to prevent an extended length of stay.
- Teams to use the **red** and **green** improvement model to highlight non- value adding days. A **green** day indicates that something positive has happened to contribute towards discharge planning. A **red** day means that nothing has changed, and the patients care needs to be flagged for review.
- Areas to analyse length of stay/delayed discharges weekly.

# CHAPTER FOUR

## Trauma Informed Care - Appendices

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# Appendix one

**Specific issues with regards Older People's Inpatient Experience**
**Dr C Lawson**

1. All staff must have an understanding of personality disorder/complex emotional needs and the links with trauma on both the acute mental health and dementia admission wards.
2. All staff understand attachment styles and understand the ways that inpatients will relate to them and the ward as attachment figures.
3. All staff have an understanding of person centred dementia care – to understand what people's behaviour is communicating to help prevent care being traumatising (e.g. in the overuse of anti-psychotics, sedation and restraint in challenging behaviour). The Newcastle model is recommended as it recognises the importance of the person's life story and past trauma. A clear issue is around how people with dementia who are survivors of child sexual abuse experience personal care e.g. around incontinence.
4. To ensure that staff have a recognition of their own emotional needs in what can be a traumatising workplace.

# Appendix two

This is an adaption of a table from the Power, Threat, Meaning Framework, Johnstone and Boyle 2018. It shows examples of behaviour seen in mental health presentations (in the left hand column) alongside a column indicating the how the behaviour may be serving a purpose to help that person survive or stay safe.

| Examples behaviour which may serve | The following safety/survival purpose |
|---|---|
| dissociation, self-injury, memory fragmentation, bingeing and purging, , carrying out rituals, intellectualisation, 'high' mood, low mood, hearing voices, use of alcohol and drugs, compulsive activity of various kinds, overeating, denial, projection, splitting, derealisation, somatic sensations, bodily numbing, differential memory encoding | Regulating overwhelming feelings |
| hypervigilance, insomnia, flashbacks, nightmares, fight/flight/ freeze, suspicious thoughts, isolation, aggression. | Protection from physical danger |
| self-starvation, rituals, violence, dominance in relationships | Maintaining a sense of control |
| idealisation, appeasement, seeking care and emotional responses, use of sexuality | Seeking attachments |
| rejection of others, distrust, seeking care and emotional responses, submission, self-blame, interpersonal violence, hoarding, appeasement, self-silencing, self-punishment | Protection against attachment loss, hurt and abandonment |

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| grandiosity, unusual beliefs, feeling entitled, perfectionism, striving, dominance, hostility, aggression | Preserving identity, self-image and self-esteem |
| striving, competitiveness, appeasement, self-silencing, self-blame | Preserving a place within the social group |
| self-harm, skin-picking, bingeing, alcohol use, over-eating, compulsive sexuality, self-rocking, | Meeting emotional needs/self-soothing |
| self-injury, unusual beliefs, voice-hearing, self-starvation | Communication about distress, elicit care |
| unusual beliefs, overwork, high moods | Finding meaning and purpose |