What We Do Together Matters.

NHS
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Specialist Services Care Unit Operating Model: The Foundations

Contents

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Introduction

This document is intended to supplement the 'Therapeutic Acute Inpatient Care Operating Model (IOM).

Its purpose is to provide a succinct reference point for Specialist Service Care Unit staff, patients, carers and wider stakeholders, to explain how inpatient environments within our care unit have distinctly different ways of operating in the delivery of care to our patients and carers, including the differences in processes our staff are required to follow.

We consulted groups of service users, carers and staff groups from all disciplines across our specialist inpatient provision to produce this document.

We adopted an appreciative inquiry approach to ensure our ongoing operations include current activities that our stakeholders value, whilst adding value with new ways of working in areas that they have told us are important to them.

Ultimately, the IOM and this document will support delivery of high quality, safe services across all inpatient wards at Essex Partnership University NHS Foundation Trust (EPUT).

Additionally, it strives to instil hope in our patients' journey of recovery and our staff's confidence to deliver consistent, high quality care and treatment.

Our priorities and ambition

Specialist Services Care Unit Operating Model: The Foundations

Why we are here — To deliver high quality services across EPUT's specialist services inpatient wards.

What do we do to add value — We will add value through the following six key care commitments.

Deliver safe services
- Environments
- Staffing
- Resources
- Technology
- Policies
- Frameworks

Provide high quality care and treatment
- Psychiatric care
- Physical health
- Psychological
- Occupation
- Empowerment
- Patient pathways

Follow the evidence base
- Individual care
- Collaborative plans
- National guidance
- Best practice
- Outcome measures

Support and develop our people
- Training/ education
- Supervision/ appraisal
- Career progression
- Home grown staff
- Experts by Experience
- Peer support mentors

Enable quality improvement
- Quality improvement methodology
- Quality assurance
- Co-production
- East of England Collaborative
- Sustainability
- Trustwide spread

Learn lessons and share good practice
- Patient Safety Incident Response Framework
- Learning Collaborative Partnership/EPUT Culture of Learning
- Peer Review
- Royal College of Psychiatrists
- Feedback (iWantGreatCare)
- Transparency

How we add value — Through the five following service commitments.

- Trauma informed approach
- Co-production across all pathways
- Continuous review of restrictive practices
- Parity between mental and physical health
- Fostering a readiness to change culture

Purposeful admission
- Admissions must be deemed necessary
- Admissions will last for the shortest length of time, taking into account risk and safety
- Objectives of admission to be planned and agreed by all involved at point of referral
- Service information shared with patients and carers
- Keyworker/multi-disciplinary team (MDT) to be allocated at point of referral
- Pre-admission information to be available to entire MDT to facilitate planning of treatment and care.

Therapeutic inpatient care and treatment
- Care delivered in the most appropriate setting
- Patients will receive a bespoke welcoming experience
- Care goals, expert intervention and regular review will be agreed collaboratively with patients and carers
- Individualised care pathways will be evidence based and psychologically informed
- Skilled and competent MDT delivering treatment and care with a trauma informed approach

Proactive and effective discharge
- Discharge planning will begin on referral and will be the purpose of the admission
- Patients and carers will be regarded as partners throughout the discharge process
- Liaise with community services involved in onward care during admission and post-discharge
- Need for resources/funding to be agreed and planned at earliest possible opportunity

How we all benefit — We will work closely with the five following stakeholders.

Patients
- Trauma Informed Care
- Partners in Care
- Clear information
- Least restrictive
- Treated with dignity

Family and carers
- Involved in care
- Supported throughout
- Co-production
- Service development
- Carers Strategy

Staff
- Wellbeing support
- Safe conditions
- Valued and rewarded
- Career progression
- Job satisfaction

Community
- Reduced length of stay
- Reduced delayed transfer of care
- Fewer readmissions
- Peer support
- Mental health awareness

Organisation
- Meeting objectives
- Staff retention
- Fewer vacancies
- Less complaints
- Anchor Organisation

The IOM includes new ways of working that are:

- Based on national evidence-based good practice guidelines
- Developed by learning from adverse and favourable events within our services.
- Implemented based on recommendations from regulators, peer reviews and internal audits.
- Driven by significant transformation projects.
- Supporting services to provide care that uses their resources in a smarter, more efficient, way.

The IOM will be aligned to recommendations and guidance from a number of national publications (listed on pages 8-10 of IOM) that outlines how safe, quality care will be provided within mental health inpatient services.

There are **additional national publications** that our **specialist inpatient care environments** have considered whilst preparing this document. We encourage our staff to familiarise themselves with the publications below.

CAMHS

- Royal College of Psychiatrists (RCPsych) Quality Network for Inpatient CAMHS Standards for Services
- Children and Young People's Mental Health Services – Get It Right First Time Programme National Specialty Report (April 2022)
- Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing
- Local Transformation Plans for Children and Young People's Mental Health and Wellbeing Guidance and support for local areas

Secure Services

- Standards for forensic mental health services low and medium secure care (RCPsych)
- Anti-social personality disorder: Prevention and management - CG77 National Institute for Health and Care Excellence(NICE)
- Mental health of adults in contact with the criminal justice system – NG66 (NICE)
- See, Think, Act Third Edition (Royal College of Psychiatrists, 2023)

Learning Disabilities

- Mental health problems in people with learning disabilities – NG64 (NICE)
- Standards for Inpatient Learning Disability Services (RCPsych)
- Transforming Care for People with Learning Disabilities – Next Steps (NHS England)
- Building the Right Support (NHSE 2015)

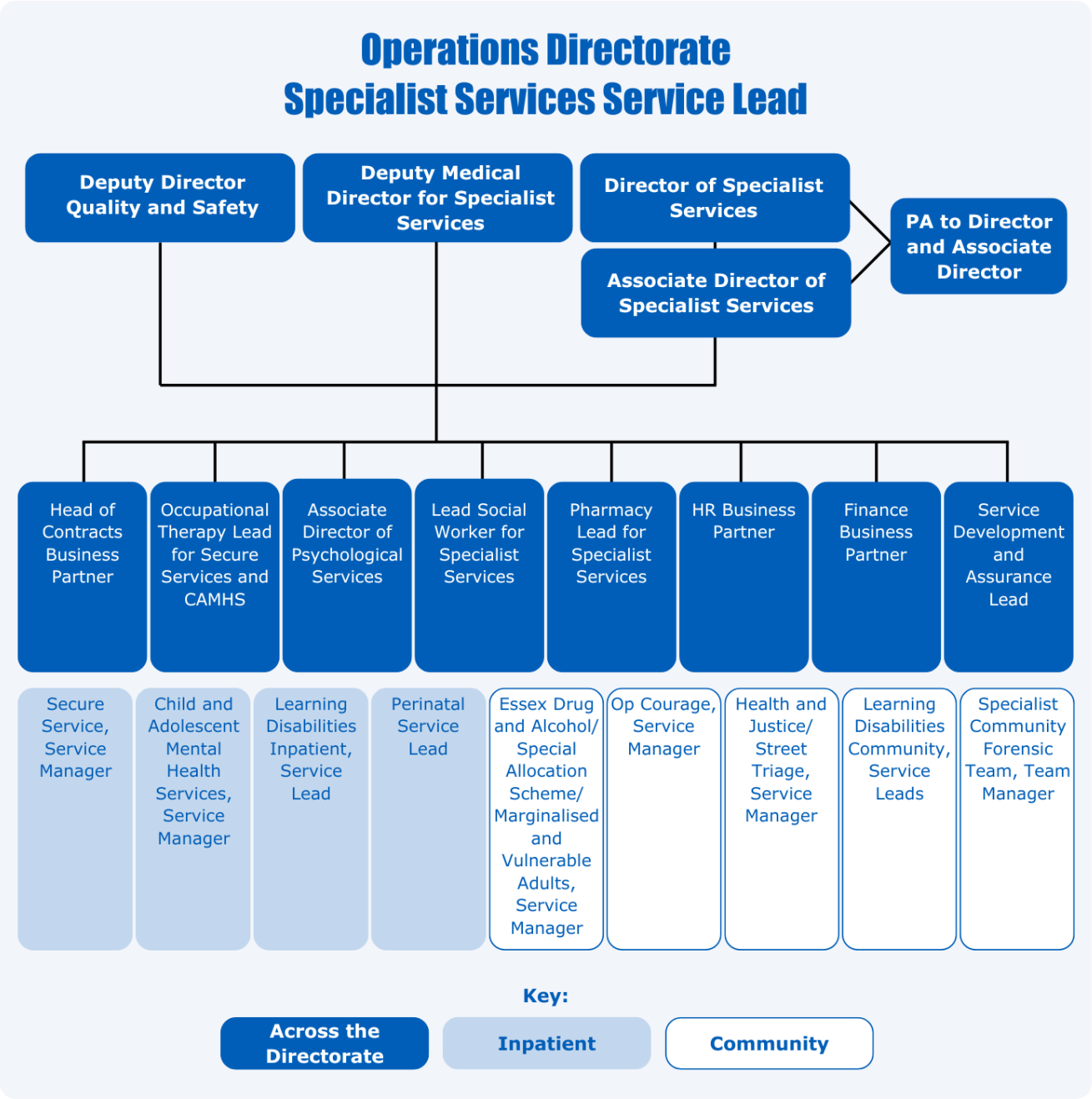
Perinatal Services

- Antenatal and postnatal mental health: Clinical management and service guidance – CG192 (NICE)
- The Perinatal Mental Health Care Pathways (NICE 2018)
- The Perinatal Mental Health Toolkit

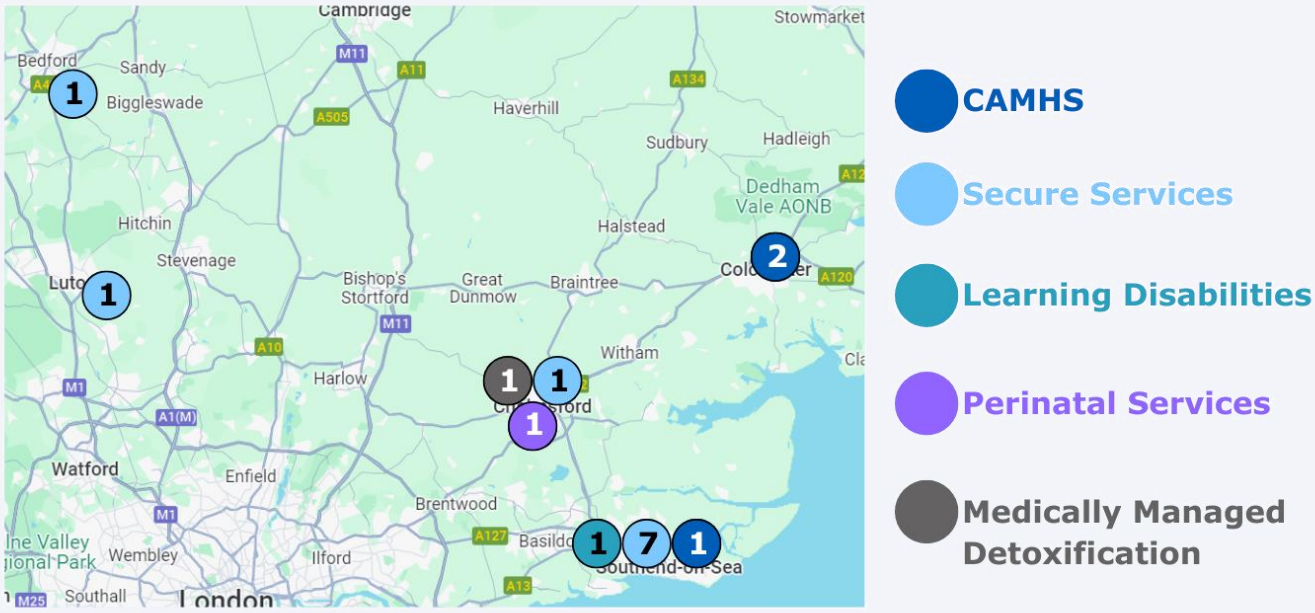
Medically Managed Detoxification

- Drug misuse: Opiate detoxification for drug misuse (NICE 2007)

Specialist Services organisational structure



Location and number of wards



The Trust's Specialist Services Care Unit provides inpatient mental health services for five different areas of need:

Secure Services

- We provide ten wards across four sites located in Wickford, Chelmsford, Luton and Bedford. We have approximately 150 beds and cater for adults requiring low or medium secure settings. The site in Bedford offers specialist care for individuals with a learning disability.
- Secure Services provide care and treatment for individuals with a level of risk to others that cannot be managed safely within general mental health settings.
- We provide assessment and treatment pathways. Our pathways provide care for those diverted from custody as well as other sources of referral.
- EPUT is the lead provider of low and medium secure services, each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the patient and others. We also work closely with the Ministry of Justice.

Child and Adolescent Mental Health Services (CAMHS)

- We have two General Admission Units (GAU) and one Psychiatric Intensive Care Unit (PICU). We provide care and treatment for young people between the ages of 13 – 18. All wards provide assessment and treatment pathways for a range of needs appropriate to young people.
- Our services are located in Colchester and Rochford.
- If young people require higher levels of support which cannot be provided locally, there are options to refer to other specialist provision within the East of England region and nationally.

Learning Disabilities

- We provide six beds located in Billericay. This contributes to the partnership with Hertfordshire Partnership NHS Foundation Trust, which provides a total of eleven beds across Essex. The ward provides assessment and treatment pathways. We provide care and treatment for adults with a learning disability who are experiencing deterioration in their mental health and for whom support in the community cannot meet their needs.
- Depending on the level of need some patients may be more suited to having care provided in acute working age adult inpatient mental health services. This will be decided during the pre-admission process.

Perinatal Services

- We provide six beds located in Chelmsford. The ward provides assessment and treatment pathways. We provide care and treatment for women who are within the third trimester of pregnancy up until the first birthday of their child.
- Depending on their circumstances, some mothers may be more suited to having care provided in acute working age adult inpatient mental health services, or CAMHS inpatient services even if they have a child under the age of one year. This will be decided during the pre-admission process.

Medically Managed Detoxification

- We provide four beds within an acute adult mental health ward located in Chelmsford. We provide medically managed detoxification for individuals whose addiction is putting their physical health at risk. Our pathways support detoxification from alcohol and substances.

The IOM contains four chapters. The first three describe the three phases of our patients' journey through our inpatient pathway. These are:

- **Chapter 1: Purposeful Admission**
- **Chapter 2: Therapeutic Benefits**
- **Chapter 3: Proactive, Safe, and Effective Discharge/Transfer Planning**

The fourth chapter outlines the principles of **Trauma Informed Care** and why EPUT is aspiring to be a trauma-informed organisation.

This document will define where the operations across these phases of the patient pathway differ within our five service areas.

What we do to add value

The following six objectives are integral to how we add value to the experience of everyone receiving or providing care and treatment within our inpatient services:

- Deliver safe services.
- Provide high quality care and treatment.
- Follow the evidence base.
- Support and develop our people.
- Enable quality improvement.
- Learn lessons and share good practice.

1. Deliver Safe Services

Our services will be delivered in environments where procedures are embedded to ensure we:

- Detect and control potential risks in the care environment
- Provide clean and well-maintained environments
- Comply with infection prevention control protocols and partners
- Provide an environment that is therapeutic and welcoming.

The oversight of these procedures will be an integral part of the day to day ward routine.

Our services will be delivered by skilled and experienced staff, who receive effective support, supervision and development. Staff teams will be supported to work together effectively to provide safe care and treatment, in a compassionate manner, which meets people's individual needs.

Our staffing model will enable a purposeful, therapeutic, and trauma informed staffing provision which releases quantifiable time to care for patients.

There are robust processes in place to ensure the correct amount of staff are available based on clinical need for our wards on a daily basis. These processes include regular review and escalation procedures.

The IOM, contains an overview of the new staffing model on page 79. Within our Care Unit, additional staffing roles will also be introduced in line with service need.

We aspire to be digitally and data enabled. We will use technology when there is an evidence base that it contributes to quality and safe treatment and care. All technology will have clear

policies to ensure they are only used for the correct purpose and any issues, such as patient privacy and dignity or impact on global restrictions, have an effective resolution. We will support our staff to improve digital capability and literacy across our workforce. Through technology, our patients, carers and partners will have improved access to treatment, care and communication.

Our services are underpinned with policies that are guided by legislation and current evidence-based good practice and standards. If required, policies will be tailored to meet individual service need. The organisation has processes in place which ensure that policies are regularly scrutinised and reviewed. All policies are accessible on the Trust's intranet.

Our services will be supported with frameworks designed to maintain oversight of all aspects of safe care and treatment delivery. The Quality of Care Framework is detailed on page 78 of the IOM. Information on all current frameworks are available on the intranet.

2. Provide High Quality Care and Treatment

Patients will receive ongoing assessment throughout the pathway so plans for risk management and treatment can be care planned. This will be in collaboration with patients and carers. Pharmacological interventions will consider previous interventions, current medication reconciliation, and safety based on monitoring of physical health parameters.

Psychiatric review and assessment will be formally completed within an MDT environment at a minimum of fortnightly and constantly monitored by ward staff. Documentation in relation to progress should correspond to the goals of the care plans. Therefore, MDT decision-making will be based on what is right for the patient and will endeavour to reduce unnecessary days in hospital.

When our patients are experiencing temporary states of heightened emotion, we will provide advice and resources to help them regain well-being in the least restrictive way. This will be based on information we have gained from patients and their carers. We will reinforce that patients have their own resources to manage their emotions and only use pharmacological interventions as a last resort. A positive example of this is the introduction of dialectical behaviour therapy (DBT) skills prescription charts in our CAMHS services.

Patients will be provided with equitable access to physical health provision in line with the general population. This will include regular physical health assessments, access to national age-related screening programmes, and access to physical health awareness and education.

A comprehensive physical health assessment will be completed within 24 hours of admission to the ward. However, we will consider individuals' circumstances so that we provide this in a trauma informed way. Where possible, preliminary care planning in relation to physical health will commence based on assessment and history obtained during the pre-admission phase.

Our staff teams will include experts in assessing, providing and monitoring physical health. Staff at all levels will have appropriate training to contribute to the provision of physical health care.

Clear processes and evidence-based outcome scales will be used to ensure our patients are referred to secondary acute physical care services in a timely manner when required.

Patients will be provided with psychological, occupational and social needs assessments, followed by subsequent therapeutic interventions. This will differ across our five service areas and will be outlined later in this document.

Our patient pathways will define clear, evidence-based interventions. These will empower patients to engage with the MDT as they work towards achieving their purpose for admission.

Our delivery of effective care and treatment will be founded upon collaboratively agreed care plans that will support the individual and their carers throughout the entire pathway.

Within the three phases we will promote the importance of individualised, collaboratively created care plans.

These will guide all aspects of care, treatment, risk management, support and personal development.

They will also ensure we put our MDT resources in the correct areas so the patient can thrive during their inpatient stay, developing skills and resilience to take with them when they leave our care.

They will also allow our staff to provide consistent individualised care and treatment to everyone.

It is important for all staff to familiarise themselves with the goals and purpose of admission at the earliest opportunity. This will ensure that the entire MDT is working collaboratively to support the patient and facilitate their safe discharge back to the community.

3. Follow the Evidence Base

Through our governance systems, we will ensure that best practice and relevant national guidance will be embedded within our five service areas.

Our services will use evidence-based national guidance, best practice and outcome measures to ensure the MDT make evidence-based decisions when implementing patients' care and treatment plans.

We will make these decisions at the earliest possible opportunity and make changes to care and treatment where required. These will be communicated to patients and carers with the rationale and evidence-base behind this.

All our wards, with the exception of medically supervised alcohol detoxification, participate in national accreditation programmes which enables us to benchmark against national standards and invites professional scrutiny from like by like services within these networks.

Our Care Unit contributes to research programmes within the Trust and nationally. Our clinical audit programme is discussed from board to ward and regularly reviewed.

We have improved our technology provision to support meaningful metrics that give assurance on key performance indicators (KPIs) and national and commissioning expectations.

We listen to patients and carers and will continue to embed the iWantGreatCare feedback platform and other forms of feedback. We will use this feedback, alongside quality improvement (QI) methodology, to provide narratives that patients and carers can relate to.

Using these above measures, we will strive to learn lessons at every opportunity to embed continuous improvement into our delivery of care and treatment.

4. Support and Develop Our People

We value our skilled and experienced staff and will continue to support them with an extensive suite of training that covers all aspects required for them to fulfil their roles.

Furthermore, we identify training needs that allow our staff to become experts in providing care and treatment to the meet the specific needs of their patient groups.

All staff are provided with regular 1:1 support that focuses on the development of their professional skills and expertise to improve patient care as well as ensuring that teams meet goals and work efficiently.

In addition, we offer space for reflective practice to ensure individuals feel supported within their professional practice. We aspire to deliver restorative supervision as part of our enhanced offer to our staff.

Within the IOM there are roles for Experts by Experience and Family Ambassadors who will directly support care. A comprehensive system of support will be built around them to enable them in their new roles.

5. Enable Quality Improvement

Dedicated staff with QI training are available to support our wards to make improvements to patient care and staff well-being through evidence-based QI methodology.

Training in QI will be available for staff who want to lead change projects within their ward environments.

All improvement work will be embraced by the staff teams, patients and wider stakeholders as required. This will ensure changes are co-produced, which is proven to support sustainability.

Staff will have access to dedicated forums where QI can be discussed and allow change ideas, that have had a positive impact, to be spread across the Care Unit and wider Trust.

The Care Unit has adopted the Trust's Quality of Care Framework, which is explained on page 78 of the IOM.

The Care Unit will also work closely with the East of England Provider Collaborative to further strengthen the spread of impactful change ideas, whilst gaining potential change ideas that have been successful across the region.

6. Learn lessons and share good practice

Our services will take every opportunity to learn lessons from adverse and favourable events. We will show transparency and candour to provide accurate accounts to all parties who have been affected by our actions.

We use the Trust's evidence-based processes to investigate patient safety incidents. These allow us to look at the systems in place that may have contributed to an incident. This aligns to the 'Just Culture' agenda that aims to support staff who were involved in incidents.

Our Care Unit will contribute our local learning to Trust-wide agendas, such as Learning Collaborative Partnership (LCP) and EPUT Culture of Learning (ECOL). This will enable us to share our learning whilst gaining learning from the wider Trust.

Our services, with the exception of medically supervised alcohol detoxification, participate in national accreditation programmes. These are used to learn lessons from feedback from peers. They also give us the opportunity to share our good practice with similar services nationally.

The learning of lessons will be an integral component of team meetings and individual supervision.

Our Care Unit will obtain feedback from our patients and carers via iWantGreatCare. We will act on this feedback to further learn lessons and improve services.

Chapter one

Purposeful Admission*

*Please refer to Chapter One of the IOM for full details on this phase of the pathway.

We will work with our regional partners to ensure our services are the right services to meet the needs of individuals who are referred to us for admission and, if so, that they are provided with an environment that is as close to their support network as possible.

Our services provide care for cohorts of the population with different circumstances to the general working age and older adult population, therefore, the way we manage our bed capacity is different. An explanation of how we identify who requires a bed and how this is allocated is provided later in the document.

We will work collaboratively with individuals and their carers to establish the purpose of admission and ensure it will be therapeutically beneficial. The objectives will be clearly described at the point of admission and the interventions co-created so they are jointly understood and owned.

With these care plans in place it will be expected that our service can provide individuals and their carers with expected discharge dates (EDD) very early in the process.

Our patients and carers told us that they appreciate transparency and openness in all communications and decisions being made about their care. Therefore, it is important to co-create care pathways to generate better outcomes. This will also reduce conflicting expectations and improve patient and carer engagement.

During this phase, we recognise that people are experts in determining the support they need, even during periods of mental ill-being.

Our services will often have admissions that are planned in advance. In these instances, we will endeavour to start planning care at the earliest opportunity. In this way our staff can familiarise themselves with the goals and purpose of admission in advance and be ready to start working with the patient to achieve these goals as soon as they enter the ward.

To support this objective, and where possible:

- Patient information will be accessible to the entire MDT as if the patient was already occupying a bed.
- Pre-admission MDT meetings will be arranged to discuss and plan care. Where possible patients and carers will be involved. Formulating and agreeing purpose of admission will be main focus of these meetings.
- Each patient will be allocated a named professional, who will be identified at the earliest possible point. The named professional will be expected to be involved in the pre-admission assessment process, take a lead on drafting the care plans, and endeavour to form relationships with the patient, their carers and wider networks.

Having full MDT input in this initial phase is essential and pre-admission meetings and communications will be encouraged to ensure the purpose of admission, including everyone's role in achieving this, is well defined.

Identifying carers as key stakeholders and recognising their expertise as a valuable resource to achieve the purpose of admission will be an area of focus. The named professional will:

- Establish preferred methods and times for communication with carers. Including consent from patient and areas of care that can be shared.

- Offer carers protected time to discuss their individual circumstances. We understand that carers have their own lives and commitments and want to ensure we allow them to continue their lives outside their role as a carer.

Chapter two

Therapeutic Benefit*

*Please refer to Chapter Two of The IOM for full details on this phase of the pathway.

We will work with our regional partners to manage our patient flow optimally so that we can provide patients with care as close as possible to their home and support networks. Repatriation to the most appropriate bed for the individual will be discussed regularly if they are placed out of the local area.

Our services will deliver care and treatment individualised to the patient's needs and circumstances. We will plan care and treatment, and define goals and expected milestones. We will encourage mutual decision-making by the patient, their carers, their MDT and any other partners involved in their network of care.

We endeavour to provide care and treatment in a setting that patients find therapeutic and promotes the optimal conditions for the achievement of their care plans. Our physical environments, our staff, and our processes all contribute to this.

Our patients and carers informed us that their experiences in the first 24 hours of admission is central to their subsequent ongoing experience and ability to focus on recovery.

We will ensure that sufficient resources are available (information, staff time, peer time) to provide a welcoming experience and ensure our patients are reassured that our wards are a place where they will be safe and can focus on their recovery.

The MDT and named professional will introduce themselves at the earliest stage and will ensure everyone is properly welcomed to the ward.

Staff, in particular the named professional, will prioritise getting to know patients, their preferences, individual needs, reasonable adjustments to consider, communication styles and how to avoid retriggering historic trauma.

We will approach and assess each individual through the lens of 'What has happened to you?' rather than 'What is wrong with you?'

This will stimulate the patient to understand the context of their current circumstances, realise their value and aspirations and rediscover their resilience and strengths.

This will be achieved by completing formal assessments and having informal conversations.

We will see our patients as individuals who need support to achieve objectives that will enable discharge, whilst acknowledging their lives, experiences and strengths.

Supporting patients to structure their day to include time to focus on their recovery and time to focus on themselves as a person will achieve better outcomes and reduce feelings of confinement and subsequent incidents of conflict.

The roles of Activity Coordinators and Peer Workers will be central to supporting the recovery journey by providing additional support that complements the interventions of registered healthcare professionals.

Furthermore, activities, particularly in the evening, should be tailored around what patients and staff collectively agree upon. These should be reviewed regularly to allow for our changing cohorts of patients and staff.

All of the above will allow us to deliver the care plan that was set out at the point of admission. As the patient progresses, we may discover new needs and priorities and we will, in partnership, ensure that adjustments are made to meet these additional needs.

Here are some steps that can be taken to support every person in inpatient settings to receive personalised care, which empowers them to make choices about their care and aids their recovery:

- Ongoing assessment and care planning process will be holistic.
- Establish advanced decisions and ensure they are documented, known to the MDT, and follow the patient through subsequent care episodes.
- As far as possible, follow any advance directives. Advanced decisions and directives will be reviewed regularly, particularly during transition, to ensure they are still the choices of the patient and their carers.
- Make sure people have access to and are supported to meet with independent advocates and peer support workers to gain more information about their rights, how the mental health system works.
- Individual patients will be assessed regarding 'global restrictions' to ensure their path to recovery is not unnecessarily impacted.
- Patients will be introduced to the ward's mutual expectations (including tolerable behaviours) at the earliest appropriate point. This will allow the service to constantly review global restrictions with a review to reducing them.
- Where national restrictions apply, patients will be made aware of the rationale for these. This should not eliminate creative thinking to ensure these restrictions do not become a barrier to recovery.

Chapter three

Proactive Discharge*

*Please refer to Chapter Three of the IOM for full details on this phase of the pathway.

Our patients regularly have no or unstable community provision to discharge to. This compounds the importance of planning the social aspect of their discharge at the earliest point. Reduction of delayed transitions, when patients have achieved their purpose of admission, is an important aim within our operations.

Furthermore, our patient groups are more likely to be subject to restrictions whilst they are an inpatient. Longer than required admissions can have a detrimental effect on their ongoing mental health.

As well as supporting the individual to recover from mental health deterioration, the purpose of admission will often involve resolving practical issues in the community, such as securing accommodation.

There should be a clear process in place in relation to any funding decisions around post-discharge care and support, including section 117 aftercare arrangements where applicable. We will ensure these processes are identified early and allocated to the correct MDT members to resolve.

Our services will be required to link in with multiple agencies to facilitate safe transfer from hospital to the community, such as children's social care and the Ministry of Justice, to ensure arrangements in the community are safe and established to manage and reduce the risk of re-admission. Mandatory requirements, such as access to education, will also need to be in place.

Our patient groups may be required to transition between wards during their pathway. In these circumstances we will provide seamless experiences with minimal interruption to their therapeutic benefits.

All of the above objectives should be underpinned in care plans, which may involve multi-agency input to ensure our patients spend the least amount of time in hospital as possible.

To encourage multi-agency engagement, we will provide and promote technological options to facilitate attendance for all stakeholders involved in discharge. This will ensure individuals take responsibility in delivering on agreed care plans around discharge.

Glossary

Term	Definition
CETR	Care (Education) and Treatment Review
CIN	Child in Need
CP	Child Protection
CAMHS	Child and Adolescent Mental Health Services
DBT	Dialectical Behaviour Therapy, a type of talking therapy for people who feel emotions very intensely.
DTOC	Delayed transfer of care
DTR	Duty to refer
ECG	Electrocardiogram
EDD	Expected discharge date
EofE PC	NHS East of England Provider Collaborative
EPUT	Essex Partnership University NHS Foundation Trust
ICS	Integrated Care System
IOM	Inpatient operating model
Life minus violence	A cognitive behavioural therapeutic package designed to reduce risk of aggression amongst forensic populations.

LSU	Low Secure Unit
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-disciplinary team – a team made up of people trained in different disciplines/professions working together.
Mental Health Casework Section	The Mental Health Casework Section makes decisions about the appropriateness of discharging restricted patients.
MHA	Mental Health Act 1983
MOCA	Model of Creative Ability. An occupational therapy tool which highlights positive attributes, increased self-esteem, confidence, and sense of self.
MoJ	Ministry of Justice
MSU	Medium Secure Unit
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OT	Occupational Therapy
OTA	Occupational Therapy Assistant
PA	Personal Assistant
PICU	Psychiatric Intensive Care Unit
PRN	'Pro re nata' means 'when required'. Patients might be given extra doses of medication when required.
SCFT	Specialist Community Forensic Team

Section 117	Section 117 aftercare is a legal duty that is placed on health and social services to provide aftercare services for people who have been detained under specific sections of the Mental Health Act 1983.
SITREP	Situation report
SMART	Surge Management and Resilience Tool Set
STAR charts	A STAR chart is a helpful way of assessing what happens before, during and after an episode of unacceptable behaviour.
STaRS	Specialist Treatment and Recovery Service
STOMP	Stopping over medication of people with a learning disability, autism, or both with psychotropic medicines.
VS	Victim Support