Policy Group: Clinical
Version no.: 3.2
Date of issue: November 2024
Approved by: Charity Executive Committee

Long Term Segregation Policy

1. Policy Summary / Statement

St Andrew's intention is to follow the Mental Health Act Code of Practice 2015 in relation to the use of Long Term Segregation (LTS), and related derived standards such as the CQC Guidance on Use of Long Term Segregation (2020). In line with page 12 of the Code, where any deviations from the Code are allowable, there will be cogent reasons for them and these will be recorded clearly.

Long Term Segregation is defined in paragraph 26.150 as '*a situation in which, in order to reduce a sustained risk of harm to others (and that risk is a constant feature of their presentation), it is determined that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement, is that, if the patient were allowed to mix freely in the general ward environment, other patients and staff would be exposed to a high likelihood of serious injury or harm over a prolonged period of time*'.

This should be distinguished from seclusion which is the ' *the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of severe behavioural disturbance which is likely to cause harm to others'*

The key difference between LTS and seclusion is that in LTS, the patient is allowed to mix freely with the observing nursing staff whereas, in seclusion, the patient is confined and prevented from direct contact with nursing staff (other than via observation). Seclusion should occur only in a room designated as being for the purpose of seclusion. Long Term Segregation can occur in a variety of areas, such as an Extra Care area, or other part of the ward dependent on the environment. Seclusion is an acute intervention for management of immediate risk, whereas LTS is a planned and considered intervention.

This policy also recognizes as valid the following reasons for use of long-term segregation:

When the risk of self-harm is so persistent and severe, that it is judged that management of the risk in a general ward environment is not possible. This is usually because the patient cannot be prevented from accessing items from the ward environment with which they self harm, or to do so, would lead to excessive restriction of other patients. As per the seclusion policy and Code of Practice 26.108 this is **not** a justification for use of seclusion.

When there is an active and persistent safeguarding risk to a patient, such that the risk of severe harm to them from others is such that mixing freely cannot adequately manage the risk, despite any additional measures e.g. enhanced support.

A patient in long-term segregation will have access to, as a minimum (CoP 26.151): a bathroom, lounge area, bedroom, and a secure outdoor area. The CQC guidance also suggests that the presence of a visible clock for patients is beneficial. Although LTS may be undertaken within an extra-care facility which has these features, an extra care facility can be used in a variety of ways that does not involve segregation. Staff should avoid using terminology such as 'receiving extra-care' or 'being in extra-care' and precisely understand and be able to articulate whether a patient is under long term segregation, seclusion or on enhanced support.

All patients should continue to receive therapeutic interventions, with the aim to end the long-term segregation as soon as possible (CoP 26.152). Care should aim to be as least restrictive as possible and personalisation of the environment should be encouraged.

The Long Term Segregation Procedure will outline the standards to be followed for the initiation, review and termination of Long Term Segregation. This is to ensure that the use of LTS does not amount to 'torture' which is explained within the CQC guide:

It is inarguable that the application of LTS has the potential, in any particular case, to amount to inhuman and degrading treatment. It could do so if:
• it is applied when it is not necessary (whether from commencement or in its continuation beyond the point where it is justified); or
• if it is applied in such a way as to be inhuman or degrading (e.g. extended isolation from any human contact; lack of appropriate activity or diversion; being spoken to or fed only through a door hatch that is also used for slopping out; lack of access to fresh air, etc). There is a particular risk that the effects of such privations on a patient in LTS create an iatrogenic, circular effect of sustaining the behaviours that are deemed to justify continued LTS

2. Links to Procedures

- Please refer to Long Term Segregation Procedure Documents

Policies and procedures available via the Policy A-Z:
Policies - Policies - A-Z (sharepoint.com)

Interface with other Policies

This policy will interface most commonly with the Seclusion Policy and Seclusion Procedure and the Enhanced Support Policy (CRM23)

When a patient is started on Long Term Segregation, the LTS review procedure will apply and the patient will no longer need a concurrent enhanced support care plan or enhanced support reviews.

A patient in LTS may need management in seclusion for periods of time. Whilst in seclusion, the seclusion policy and procedure must be followed. The LTS care plan should stay open initially. If the seclusion lasts less than 2 weeks, and the patient

returns to LTS, then the existing LTS care plan episode remains and the timing of reviews will remain unchanged. If the seclusion lasts 2 weeks or longer, the LTS care plan should be closed. If the patient returns to LTS, a new care plan and episode of LTS should be started.

The guidance is to strike a balance between continually 'resetting' the review clock for LTS if the patient is briefly secluded (which may lead to a lack of independent and external reviews) and the risk of persisting indefinitely with a patient who is secluded but is triggering reviews for LTS as well.

3. **Monitoring and Oversight**

There is a line of oversight and monitoring from the Board, to the Charity Quality, Safety and Assurance Committee, to the Quality and Safety Group (QSG), and the Restrictive Practices Monitoring Group, with a line of sight to Divisional Clinical Governance meetings.

The Charity Safety Framework and Integrated Performance Report will contain data on the use of Long Term Segregation. A real-time report on current use of Long Term Segregation, lengths of segregation, and evidence of required reviews as determined by the LTS procedure, will be derived from data entered into the Electronic Patient Records (RiO) and be available as a PARIS report to relevant people within the governance framework.

The ward environment, including any extra care areas or other areas in which LTS is occurring or may occur, is checked daily as part of the expected duties of the Nurse in Charge of the ward.

This policy is also accounted for within the Charity's Risk Management Framework, incorporating appropriate controls and mitigations and as such there will be periodic reviews over the accuracy and effectiveness of any policy/procedure related controls. For further information, go to the Risk Management Hub page.

4. **Diversity and Inclusion**

St Andrew's Healthcare is committed to *Inclusive Healthcare*. This means providing patient outcomes and employment opportunities that embrace diversity and promote equality of opportunity, and not tolerating discrimination for any reason

Our goal is to ensure that *Inclusive Healthcare* is reinforced by our values, and is embedded in our day-to-day working practices. All of our policies are analysed in line with these principles to ensure fairness and consistency for all those who use them. If you have any questions on inclusion and diversity please email the inclusion team at DiversityAndInclusion@stah.org.

5. **Training**

Staff should only use methods of restrictive interventions for which they have received training. All St Andrew's staff with clinical contact will receive physical intervention training and are required to attend 12-month refresher training.

All Doctors and Registered Nurses must complete annual training in Immediate Life Support.

Training records should record precisely the techniques for which a member of staff has received training

The procedural documents are designed to be printed and visible in staff areas to aid compliance.

An e-learning module on Restrictive Practices will incorporate content from the LTS Policy and Procedure.

6. **References to Legislation and Best Practice**:
DH (2015) Mental Health Act Code of Practice

DH (2014) Positive and Proactive Care: reducing the need for restrictive interventions. www.gov.uk

Care Quality Commission (2020) *Brief Guide to Long Term Segregation*. London: The Stationary Office

7. **How to change or get an exception to this policy**
Please refer to either the Policy and Procedure Update Application Link
Or the exception process Policy and Procedure Exception Application Link

8. **Key changes** - please state key changes from the previous version of the policy

Version Number	Date	Revisions from previous issue
1.0	February2019	This policy and procedure has been entirely rewritten from the existing CRM 35 version 3.2 that was due for revision in Dec 2018
2.0	March 2019	Inclusion of 'As per the seclusion policy and code of practice 26.108 this is not a justification for use of seclusion' within the policy summary.
3.0	August 2019	Changes to the meeting groups in Monitoring and Oversight section in line with the Governance Structure/
3.1	February 2022	Further clarifications on CQC brief guide to LTS
3.2	November 2024	Added a new statement within the monitoring section to highlight this policy has an associated risk as recorded within the risk register