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PRISON
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

Quality Network for Prison Mental Health Services Aggregated Report

Editors

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This publication is available on the QNPMHS website.

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Artwork displayed on the front cover of this report: *Lioness with Cubs by a patient from HMP Haverigg*

FOREWORD

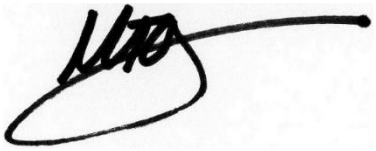
I'd like to welcome you all to this Aggregated Report that covers Cycles 7 and 8 of the Quality Network for Prison Mental Health Services and the years 2021-2023. These were the years following COVID-19 lockdowns and so represent a period when the country was making an attempt to return to business as usual, but of course the world had changed somewhat. Staff had different expectations from their working lives and organisations had to adapt in order to retain and recruit staff in what can be a challenging area. Organisations had to think of ways to deliver healthcare in this changing landscape and the QNPMHS has equally had to adapt to move back towards ensuring services receive the types of reviews that benefit them most. There remains work to be done here but we are pleased to be able to offer a variety of options to Network members.

It is worth acknowledging that the past couple of years have been especially tough for those imprisoned and those working within prisons. We are seeing prisons touch capacity, leading to early release schemes that put pressure on services; we see waits for transfer to hospital much longer than they should be and we note firsthand the healthcare climate that leads to difficulty staffing the mental healthcare in prisons. With all that said, it might be understandable for one to be quite pessimistic looking to the future. However, what we see within this Network's members is a continued commitment to the delivery of high-quality mental healthcare within prisons, despite all of the challenges; and this is to be lauded.

This report highlights several areas of good practice including formalised referral processes and follow-up for patients who struggle to engage. Importantly, the overwhelming majority of patients feel that they are treated with compassion. There are, of course, also areas of improvement highlighted. Some of these include care planning and supporting partner agencies with their mental health awareness. It is evident that there remain significant barriers for prison mental health services to deliver on all of these standards; with issues such as poor prison staffing leading to difficulties for patients to have access to all of the services we would like them to when they need them, but also for the prison to release staff to attend training that ultimately supports the whole prison.

The Network will continue to work with services to look at ways of meeting the standards, and most importantly we will continue to listen to your services and the innovative solutions you continue to find to these challenges. We hope that with your support, the QNPMHS can continue to grow so that we can drive the standard of prison mental healthcare forward in what continue to be tumultuous times. We are forever impressed by the dedication of the staff working within prison mental healthcare and look forward to seeing you during the next cycle.

Dr Matthew Tovey
Consultant Forensic Psychiatrist
Co-Chair of the Quality Network for Prison Mental Health Services Advisory Group



WHO WE ARE AND WHAT WE DO

WHO WE ARE

The Quality Network for Prison Mental Health Services (QNPMHS) was established in 2015 to promote quality improvement within and between prison mental health services. It is one of over 30 quality network, accreditation and audit programmes within the Royal College of Psychiatrists' Centre for Quality Improvement.

Member services are reviewed against the Network's published specialist standards for prison mental health services and 24-hour mental healthcare in prisons.

WHAT WE DO

We adopt a multi-disciplinary approach to quality improvement in prison mental health services as part of an annual review cycle. We report on the quality of mental health care provided in prison settings and allow services to benchmark their practices against other similar services. We serve to identify areas for improvement through a culture of openness and enquiry. The model is one of engagement rather than inspection. We aim to facilitate quality improvement through a supportive network and peer-review process. We review prison mental health services in the UK and Ireland and involve the mental health team, patients and partner agencies in this process.

Participation in the Quality Network is voluntary, and members pay a fee to be a part of the process.

OUR ADVISORY GROUP

The Quality Network is governed by a group of professionals who represent key interests and areas of expertise in the field of prison mental health, as well as patients who have experience of using these services. The group is co-chaired by Professor Andrew Forrester (Professor of Forensic Psychiatry) and Dr Matthew Tovey (Consultant Forensic Psychiatrist). The group meets quarterly and includes representatives from NHS England, The Royal College of General Practitioners, Ministry of Justice and other organisations.

Dog in Prison created by a patient at HMP Isle of Wight.

JARGON BUSTER

QUALITY IMPROVEMENT: Within this report 'quality improvement' will refer to the process of working with and supporting prison mental health services to be effective, safe and patient-centred. We use our quality standards to assess performance and make realistic and achievable recommendations for service improvement.

MULTI-DISCIPLINARY: A multi-disciplinary team involves many different disciplines or professional backgrounds that work together to deliver care to a population of patients.

PARTNER AGENCIES: This refers to teams that work in prisons but are not part of the mental health team being peer-reviewed. This can include, but is not limited to, prison officers, governors, primary care staff, substance misuse teams, chaplaincy and safer custody.

QNPMHS MEMBERSHIP

Development support

The key strength of QNPMHS is to share good practice, challenges and learning. Services will be supported to identify and address areas for improvement.

Stakeholder feedback

Our processes collate detailed feedback from staff of all professional backgrounds and patients.

Flexible face-to-face reviews

Host and attend peer-review visits to other prison services to share good practice, challenges and develop shared problem-solving.

Improved report templates

New PowerPoint slides to be shared with senior management and commissioners.

Patient competitions

Patient artwork, creative writing and festive card competitions.

Personal development

Free online peer-reviewer training for staff. Enabling staff members to improve their professional practice.

International Membership

Opportunities to connect with international services to share good practice and broaden ways of working.

Benchmarking and trend analysis

Annual aggregated or thematic report to share good practice and benchmark against other services nationally. View our previous reports here.

Events and online sessions

Free attendance to our online events. Discounted rates for in person events and annual forums.

Overarching QNPMHS Trust reports

New overarching reports exploring key themes for Trusts where all prisons are signed up.

Ongoing networking support

Access to Knowledge Hub, our online discussion platform for networking and shared learning.

Regular communication

Receive regular correspondence from the Network highlighting learning opportunities, events and updates.

Carer involvement

Continued support for services to engage with family and friends, including upcoming Network guidance developed in partnership with services.

THE REVIEW PROCESS

The review cycle runs yearly, and all services are reviewed against the QNPMHS standards.

Full Reviews

As part of a full review, services complete a self-review workbook which includes a self-rated score and comment against each standard and any accompanying evidence. Questionnaires are distributed to staff, patients and partner agencies.

A visiting peer-review team meets with managers, frontline staff, patients and partner agencies to validate the information provided. A tour of the environment is completed. The service being reviewed receives preliminary findings at the end of the review, drawing on achievements and areas for improvement.

The data that is collected is then recorded in a service report, which summarises the areas of good practice and areas in need of improvement.

Developmental Reviews

Developmental reviews were offered as an alternative review type during Cycle 7 to support services who were continuing to deal with the effects of COVID-19. The self-review process does not require services to review themselves against the QNPMHS standards. Instead, this focuses on services' own priorities, achievements and challenges. This required less resources of services whilst COVID-19 difficulties persisted.

During the review day, the review team holds open discussion meetings with managers, frontline staff, patients and partner agencies. This provides services with the opportunity to discuss their challenges in a supportive and open environment as well as sharing learning with other services.

A developmental review summary is produced following the review day, highlighting the actions taken since the previous review and the key areas of good practice and areas for improvement. Services then engage in further action planning to reflect on the feedback received. Developmental reviews have not been offered as an option since Cycle 7, this was an alternative review type to support member services during the height of COVID-19.

Open Discussions

Open discussion sessions are an opportunity for services to meet with a review team for two-hours online to discuss service priorities, achievements and challenges. These sessions are an option for services who do not have the capacity to complete a full or developmental review, and QNPMHS continues to offer these sessions in these circumstances.

During the open discussion sessions, the host team and review team share good practice examples and offer support to one another around any challenges they may have. A report is not produced following the discussion, although some services opt for a self-review report.

THIS REPORT

OVERVIEW

This is the sixth national report published by the Quality Network for Prison Mental Health Services, and uses the data collected from member services who completed their peer-review against the Standards for Prison Mental Health Services Fifth Edition (2021). It is aimed at frontline staff, senior management, patients and prison staff as well as anyone who has an interest in prison mental health services.

PURPOSE

This report presents an analysis of how well member services are performing against standards. This was done by assessing whether they were marked as 'Met', 'Partly Met' or 'Not Met' against QNPMHS standards. These include the standards for 24-hour mental healthcare in prisons, for services with inpatient provisions or enhanced care facilities.

This report also includes key areas of achievement and areas for improvement gathered from qualitative data within service reports. Alongside this, are recommendations aimed at prison mental health staff and senior management. The purpose of these recommendations is to support teams to review their own areas for improvement and to continuously improve the quality of care that they provide. Therefore, it is hoped that this report will help to increase the likelihood that individuals who use mental health services within prisons will have a good experience.

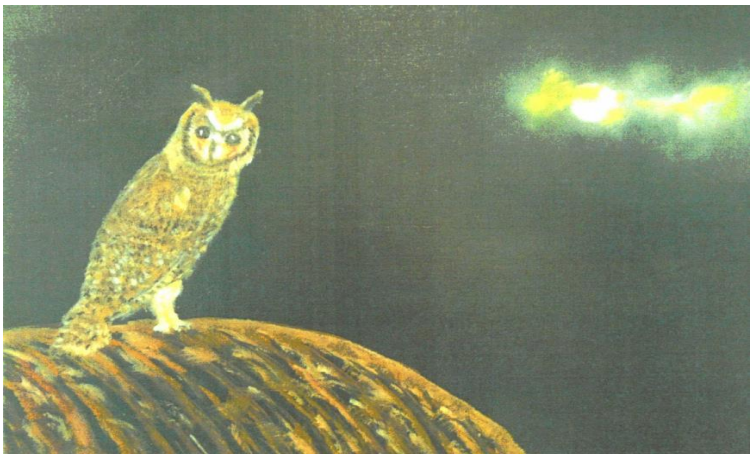
STANDARD TYPES

The standards are divided into three types:

Type 1: These are essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: These are expected standards that all services should meet.

Type 3: These are desirable standards that high performing services should meet.



Night Spy created by a patient at HMP Haverigg.

MEMBERSHIP

Between 2021 – 2022, 63 prison mental health services in the UK and Ireland took part in Cycle 7. During this time, 32 full reviews took place, 12 services opted for a developmental review, 10 services opted for an open discussion and nine reviews did not go ahead. Services requested alternative review types or cancellations during Cycle 7 largely due to COVID-19 outbreaks and low staffing levels.

Between 2022 – 2023, 43 prison mental health services in the UK and Ireland took part in Cycle 8. During this time, 21 full reviews took place, six services opted for an open discussion and 16 reviews did not go ahead. Services requested alternative review types or cancellations during Cycle 8 due to low staffing levels in the majority of cases.

You can see the geographical footprint of our member services in Figures 1 and 2.

Figure 1: Cycle 7 Prison Member Services

Figure 2: Cycle 8 Prison Member Services

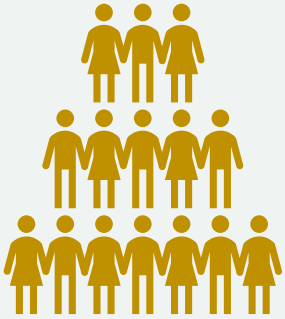
DATA COLLECTION

16

Trusts and Organisations

580

Staff completed questionnaires



820

Patients completed questionnaires

45

Teams

1187

Partner agencies completed questionnaires

HOW WAS DATA COLLECTED?

The data in this report comes from 45 members who undertook their QNPMHS self-review and peer-review between 2021 - 2023. Together, they represent 16 Trusts and organisations across the UK.

Contextual data was obtained from the information completed by services at the beginning of their self-review period. Decisions as to whether a service had met, partly met or not met standards were made by the peer-review teams based on evidence obtained from the self-review and subsequent peer-review visit.

This evidence included:

- Discussions during the peer-review
- Questionnaires
- Patient clinical notes
- Policy and documentation checks.

EXECUTIVE SUMMARY

This section provides an overview of how services from Cycles 7 and 8 are performing against the QNPMHS standards.

Figures 3 and 4 offer a breakdown of how each member service performed against the standards, in order of compliance. It illustrates the percentage of met, partly met and not met criteria per service and for each cycle.

The percentage of fully met criteria for Cycle 7 achieved spans from 27% to 92%. The average compliance across the 32 services who were reviewed against the QNPMHS standards during Cycle 7 is 63%, as indicated by the final bar marked 'TNS' (total national sample) on the graph.

The percentage of fully met criteria for Cycle 8 achieved spans from 32% to 88%. The average compliance across the 21 services who were reviewed against the QNPMHS standards during Cycle 8 is 62%, as indicated by the final bar marked 'TNS' on the graph.

Figure 5 displays the average percentage of met criteria per section for Cycles 7 and 8. Overall, member services performed strongest in the areas of 'Leadership and Governance', 'Safety', 'Reception and Assessment' and 'Patient Experience'. The areas in most need of improvement are 'Collaborative Partnerships', 'Medication Management', 'Environment' and 'Treatment and Recovery'.

Figure 3: Percentage of met criteria by service (Cycle 7)

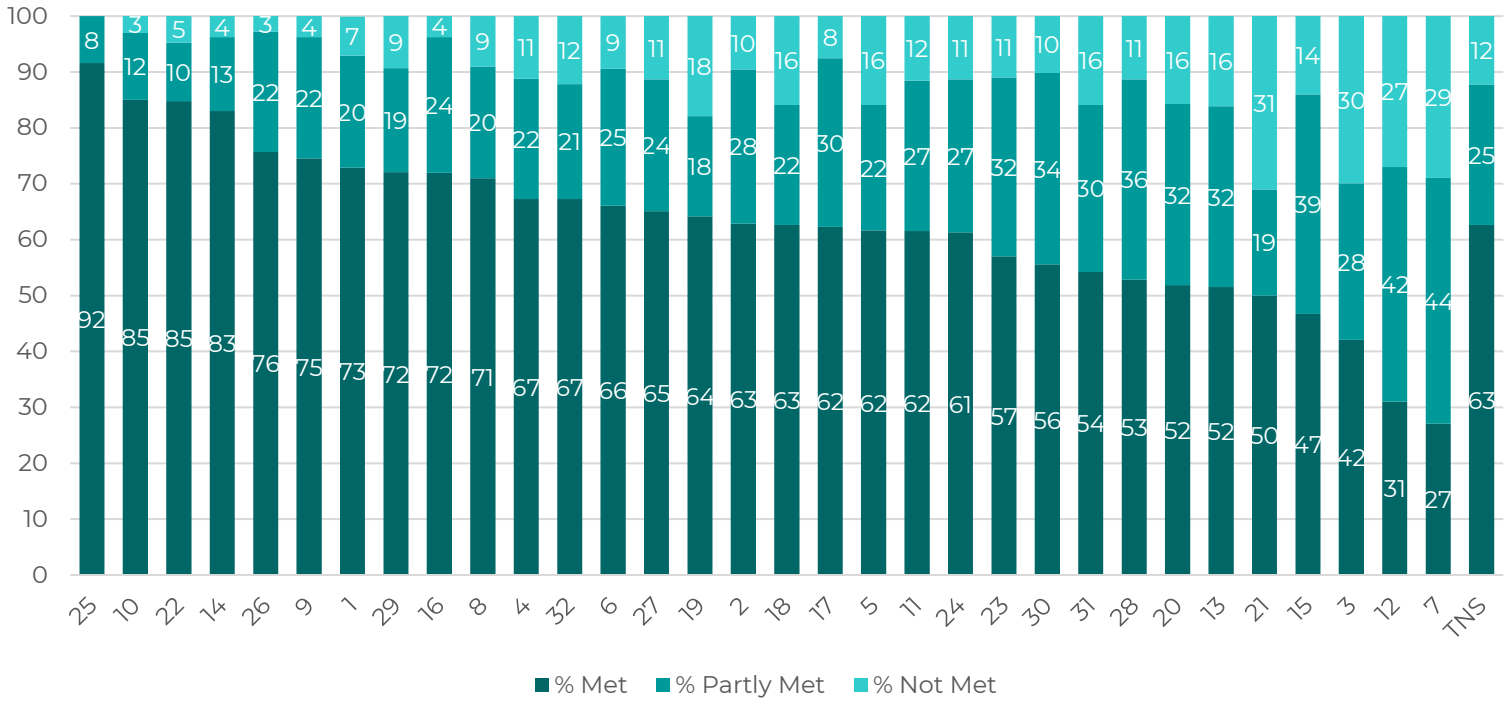


Figure 4: Percentage of met criteria by service (Cycle 8)

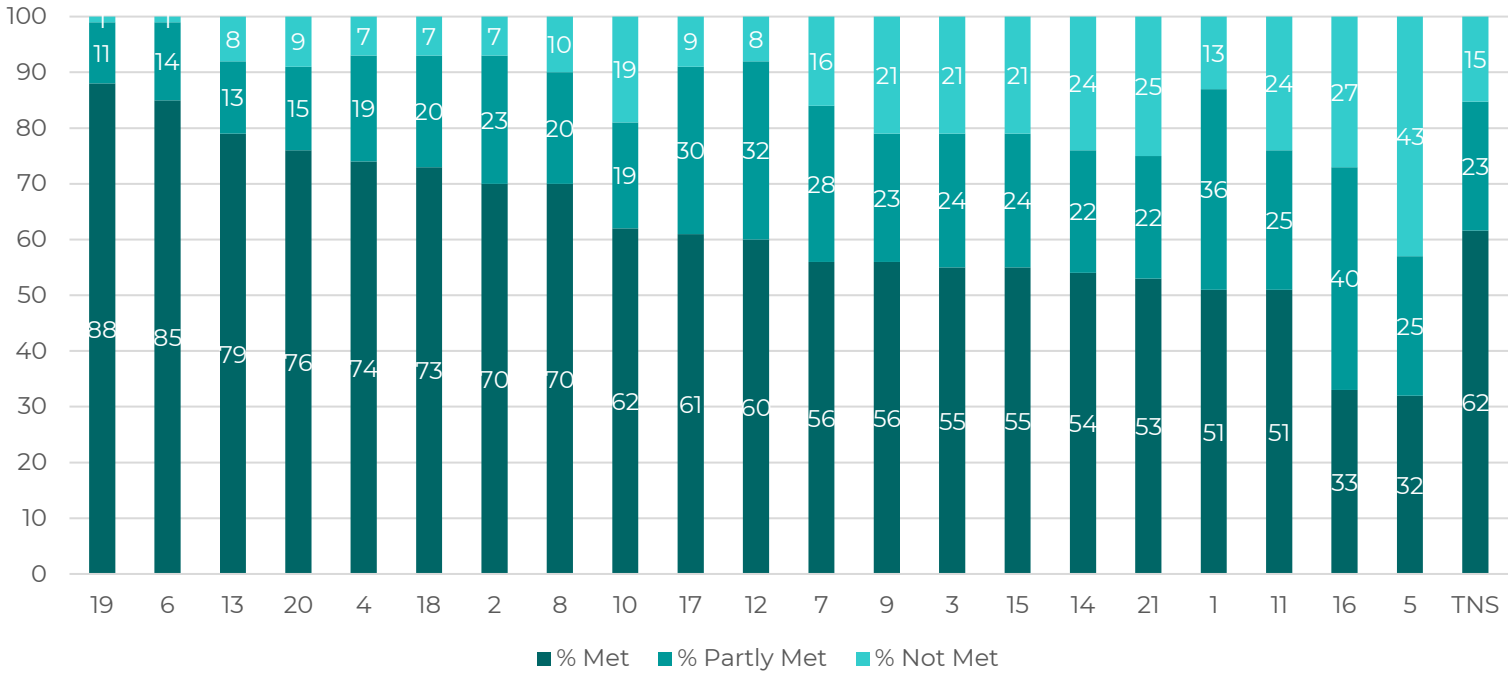
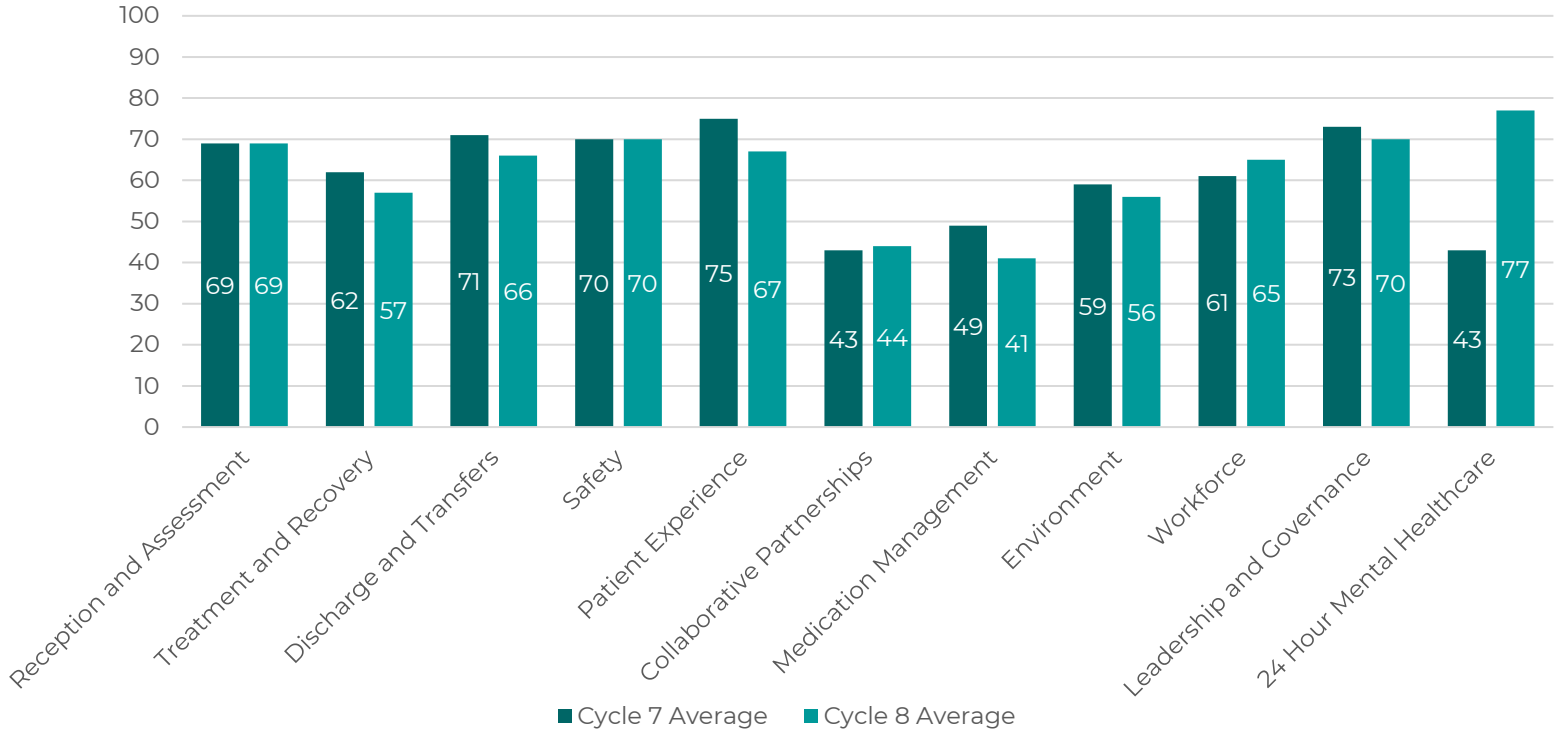


Figure 5: Average percentage of met criteria per domain for Cycles 7 and 8



CONTEXTUAL DATA

This section provides an overview of the contextual information gathered from services reviewed against the QNPMHS standards between 2021 - 2023. We collect this information to help gain an overview of the prison population size, type and category as well as staffing numbers and caseloads. The following data has been collected from those services that provided this information. Where the data has not been provided or is unclear, this has not been included in the figures.

PRISON INFORMATION

The data below shows the types and categories of prison services that were QNPMHS members. This indicates there were a larger number of male and category B prison services, with sex offenders as an additional specialism. It is worth noting some prisons were a mix of the different types.

Figure 6: Number of male, female, young adults and young people member services

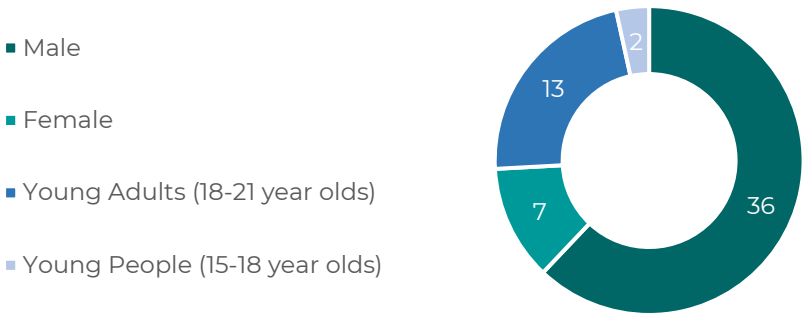
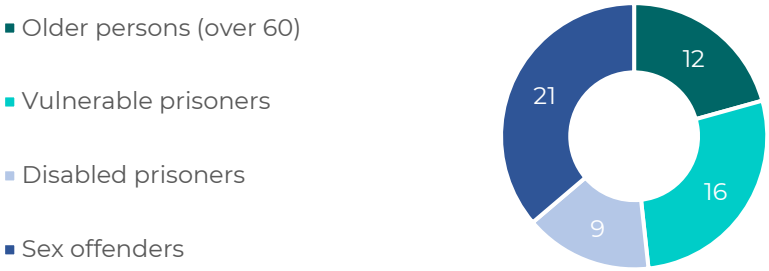


Figure 7: Category breakdown of member services

Figure 8: Specialism breakdown of member services



MENTAL HEALTH TEAM INFORMATION

This section looks at number of patients on the mental health teams' caseloads and prison population sizes. The number of patients on the teams' caseloads ranged from 19 to 571, with the average being 130 patients. The prison population size ranged from 129 to 2049, with the average being 685.

Looking at what percentage of the prison population is part of the mental health team's caseload, this ranged from 3% to 86%, with the average being 21%.

STAFFING

Data was collected on the staffing whole time equivalent (WTE) of each service. The average staffing numbers, including the highest and lowest numbers, can be seen on the table below:

Staffing	Average WTE	Lowest WTE	Highest WTE
Nursing	6	1	22
Social Work	0.6	0	4
Psychiatry	0.8	0	3
Psychology	0.8	0	4
Occupational Therapy	0.6	0	4.5
Support Workers	1.6	0	11
Admin	1	0	4

Some services highlighted having other staff as part of their team. Those who completed this information highlighted having access to art therapists, counsellors, speech and language therapists, trauma therapists, psychological wellbeing practitioners, recovery practitioners, specialist doctors, neurodiversity practitioners/nurses, pharmacy technicians, non-medical prescribers, health and wellbeing coaches and care navigators. This also included assistants of various types, such as psychology assistants and occupational therapy assistants.

RECEPTION AND ASSESSMENT

Overall, 69% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 15 [1] There is a clear system for the management of referrals.

94% of services met this standard in Cycle 7.
100% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 3 [2] During the initial mental health assessment, individuals over 50 years old are offered an older adult assessment, and reasonable adjustments are made where required.

30% of services met this standard in Cycle 7.
42% of services met this standard in Cycle 8.

Reflection on Standard 3 [2]:

Many services are offering older adult assessments where this is clinically indicated; however, they are not offering these to all individuals over 50 years old. Where assessments have taken place, many services are implementing reasonable adjustments. An increase of 12% across the cycles indicates that services are recognising the need for an older adults' pathway.

60% of patients

reported they know how to access different formats of information including, easy-read and pictorial formats, or different languages.

75% of patients

reported that when they arrived at the establishment, they were asked about their mental health.

51% of patients

reported they are involved in the development of their risk assessment and management plan.

77% of partner agency staff

reported they know how to refer someone to the mental health team if they were concerned about an individual's mental health.

GOOD PRACTICE EXAMPLES

Along with the University of Birmingham the service are looking at evidence-based screening tools for informing dementia screening and older adult needs. The team are trained to use the quick assessment tool that flags deteriorating behaviour. The service has a dementia pathway and standard operating procedure (SOP).

HMP Birmingham, 2022-2023

The service has a partnership with Dementia UK, where patients can contact them for assistance. Further, the service is looking into recruiting a nurse from Dementia UK who will oversee and complete assessments for older patients, as well as assessing the environment to see whether it is appropriate and safe.

HMP Hull, 2022-2023

As part of the crisis intervention initiative, the Early Days project, all prisoners receive an initial mental health screen within 24-hours. They are then referred to the mental health team if needed, as well as signposting to other services within the prison.

HMP Hewell, 2022-2023

The team have been working to develop resources for 'Wayout TV' which is an in-cell TV channel packed with educational content such as English, maths, faith-based programming and other skills. It also allows for the team to communicate with the prisoners directly in their cells.

HMP Dovegate, 2021-2022

The team have facilitated a new arrival unit. Staff train peer mentors who live on the unit, who provide guidance and help to integrate new arrivals. The mental health team have supported officers working on the unit with training around learning disabilities and Autism Spectrum Disorder, to meet the needs of patients on the unit.

HMP Bullingdon, 2021-2022

The team and the establishment have carried out an extensive piece of work to improve the experience of older adults in prisons. An organisation conducted a survey and found a number of environmental issues, resulting in one wing being transformed into an older adult wing. This is a quieter and calmer wing with selected staff. The team are proud of the piece of work developing the older adult wing.

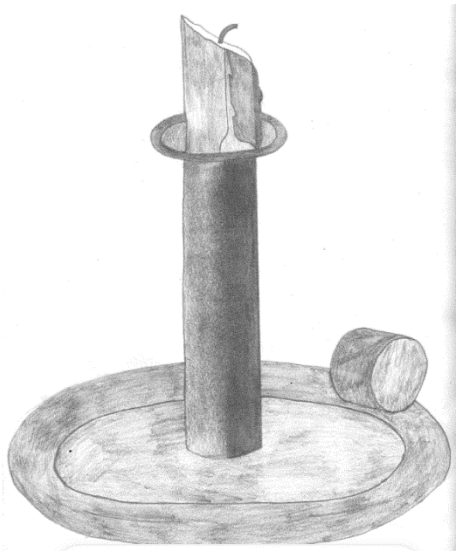
HMP Belmarsh, 2021-2022

AREAS FOR IMPROVEMENT

- Not all services have a formal process for the management of referrals. This increases waiting times.
- Patients and staff do not always receive confirmation that their referral has been accepted, or information on expected waiting times.
- Improvements could be made to the provision of over 50s pathways, including access to screening and assessments.

RECOMMENDATIONS

- Develop a process for the management of referrals, including a weekly timetabled meeting to discuss the allocation of referrals. Consider allocating a duty worker daily to oversee and triage any new referrals.
- Inform referrers of the outcome of their referral (within the limits of confidentiality). Where a referral has been accepted, inform patients of their expected wait times.
- Formalise an over 50s pathway, ensuring all new receptions over 50 are considered for an older adults' assessment. Where additional needs are identified, reasonable adjustments and any appropriate referrals should be made.



Artwork created by a patient at HMPYOI Cookham Wood.

TREATMENT AND RECOVERY

Overall, 54% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 21 [1] The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. This is clearly documented in the multi-disciplinary team meeting and patient records.

97% of services met this standard in Cycle 7.
90% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 16 [1] Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients when developing the care plan and they are offered a copy.

34% of services met this standard in Cycle 7.
10% of services met this standard in Cycle 8.

Reflection on Standard 16 [1]:

59% of services in cycle 7 and 62% of services in cycle 8 were partly meeting this standard. Services often feedback that patients are offered a copy of their care plan, but due to issues with confidential paperwork in shared cells, patients often decline. Patient feedback indicates that they are not involved in their care plan or are unsure as to what this is.

72% of patients

reported having their physical health checked upon admission.

67% of staff

reported that a representative from the mental health team and the prison are present during formalised reviews of patients' care.

36% of patients

reported always being involved in developing their care plans.

GOOD PRACTICE EXAMPLES

Self-help and self-management workbooks have been developed for patients including in easy-read and accessible formats. These cover a range of issues including sleep, anger management, depression and low mood, self-harm, post-traumatic stress disorder, medication and more.

HMP Swinfen Hall, 2021-2022

The service is engaging in the SPaR (stabilisation, progression and recovery) programme. This is a formulation-based programme for patients with complex issues and includes sensory work, psychological therapies, art therapy and activities.

HMP Woodhill, 2021-2022

Staff reported that they receive training to deliver psychological interventions to patients. For example, they receive training in safety and stabilisation, which forms part of the phased based treatment for people affected by trauma.

HMP Perth, 2021-2022

The team has recently managed to secure attendance at care programme approach (CPA) meetings from a range of external organisations including probation, forensic services, social care and community mental health teams.

HMP North Sea Camp, 2021-2022

Staff discussed their trauma-informed practice, explaining that they are assigned to patients with trauma-informed reasoning where possible and take time to understand each person individually.

HMP New Hall, 2021-2022

The service has a robust Did Not Attend (DNA) policy with a flow chart detailing each step and the rationale. Staff are clear on this procedure and are also working to reduce repeated DNAs.

HMP Gartree, 2021-2022

Pregnant and post-natal patients are identified early, assessment is offered and all patients are discussed at least once a week at MDT meetings. Patients on the pathway have prioritised access to psychiatry. On return to custody, an appointment with a psychiatrist is made within four weeks.

HMP Low Newton, 2021-2022

Patients have access to a range of interventions including mindfulness, a book group, acupuncture, sleep hygiene, mental health gym and art group. More structured therapies are also on offer. Further to this, the team are working with patient collaboration to identify what needs are not currently being met through the interventions on offer.

HMPYOI Deerbolt, 2022-2023

AREAS FOR IMPROVEMENT

- Many patients are not aware of their care plans and risk management plans, and have not been involved in developing these collaboratively.
- Patients report wanting more accessible information about their diagnosis and treatment.
- Many patients have not received information about their rights regarding consent to care and treatment, how to access advocacy services, how to access a second opinion doctor, how to access interpreting services, and how to view their records.
- Many patients are either not aware of what the Care Programme Approach (CPA) process is or are not involved.

RECOMMENDATIONS

- Review the care plan templates and, where this is not available, add a "patient views" section. Develop care plans in collaboration with patients, and review and update them regularly with patient insight. Additionally, include patient input within risk management plans and share these with patients where appropriate.
- Provide patients with easy-to-understand verbal and written information about their diagnosis and treatment. This could include leaflets with information on their diagnosis and treatment options, or more patient-specific information, for example, the section of their care plan which details their diagnosis and treatment.
- Develop a patient leaflet with information on rights regarding consent to care and treatment, how to access advocacy services, how to access a second opinion doctor, how to access interpreting services, and how to view their records. Share this leaflet with patients. This information should be made available in other formats.
- Review the QNPMHS CPA guidance and identify initiatives that can be introduced at the service to increase patients' awareness and involvement in CPA processes. Additionally, introduce a CPA passport for patients.

DISCHARGE AND TRANSFER

Overall, 67.5% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 30 [1] When a patient is transferred to another establishment, the mental health team provides a comprehensive handover to the receiving establishment's mental health team before the transfer takes place. *Guidance: Where a transfer is not known, the handover is provided to the receiving team as soon as they are made aware.*

94% of services met this standard in Cycle 7.
86% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 31 [1] An identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning meetings. This includes a formalised review of care for patients on secondary care caseload. *Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.*

41% of services met this standard in Cycle 7.
29% of services met this standard in Cycle 8.

Reflection on Standard 31 [1]:

Whilst key workers may be invited to key meetings, it may not be possible for them to join due to workload and scheduling. There also may not be options for staff to join via phone call or virtually.

GOOD PRACTICE EXAMPLES

The service has recently recruited a housing support worker. The new post has been a welcome addition to the team and beneficial to patients, facilitating more comprehensive post-sentence continuity of care.

Dochas Centre, Mountjoy Female Prison, 2021-2022

Patients are involved in setting their recovery goals. The inclusion team are working closely with patients that are soon to be released, they keep them updated of their transfer, support them with housing and are in contact with their next point of care.

HMP Stafford, 2021-2022

I can honestly say through the intervention of inclusion, they have put me on the path to where I am now. I am moving on and feeling better.

HMP Long Lartin, 2021-2022

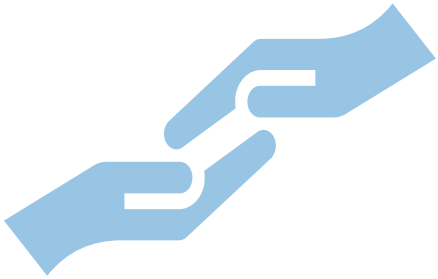
AREAS FOR IMPROVEMENT

- The discharge and transfer process is not always formalised, and often a key worker or responsible clinician is not present at key meetings.
- Not all services have template letters to provide to the receiving service to ensure continuity of care and follow ups. Communication with receiving services can be difficult due to a lack of response.
- Engaging with community teams and securing their attendance at key meetings is a challenge. Where this is not a challenge, they are not always invited to key meetings.
- Patients do not always receive a 14-day follow up and there is not a formal process in place to ensure this happens.

RECOMMENDATIONS

- Implement a written processes for transfer and discharge. This should follow national good practice guidance. Invite patients' key workers or responsible clinicians to key discharge or transfer meetings. Where they are not able to attend meeting in person, provide alternative ways to join remotely, such as via phone or virtual means.
- Develop discharge letter templates which staff can utilise to ensure all key points are covered. Put processes in place for follow up with receiving services, which includes sending a chasing email or additional phone calls to ensure a response is received and recorded following discharge or transfer.
- Liaise with key staff from the community teams to discuss ways in which joint working can be improved between teams. This could include organising a meeting with community team leaders to discuss difficulties with engagement and how both teams can work together to ensure better outcomes for patients. Invite community teams to key meetings and encourage their attendance. Offer telephone or virtual joining options, particularly when the team is based in a different area than the prison.
- Include a 14-day follow up within the written transfer/discharge process. The team should contact the patient, new care co-ordinator or service within 14 days of release or transfer. The follow up is to confirm that the patient has been able to access the service, and could be done via telephone, email, writing or in person. This can be an admin task.

SAFETY



Overall, 69.5% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 43 [1] When mistakes are made in care this is discussed with the patient themselves in line with the Duty of Candour agreement (or equivalent).

94% of services met this standard in Cycle 7.
100% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 37 [1] There is a clear process to follow when visiting patients outside of clinical rooms to ensure the staff are safe when working with patients.

50% of services met this standard in Cycle 7.
43% of services met this standard in Cycle 8.

Reflection on Standard 37 [1]:

While processes may be in place, staff are not always aware of this or supported to follow the protocol. For example, staff may be asked to take a radio to meet with patients alone, but there are not enough radios available.

69% of mental health staff

reported that they actively participate in the prison process to manage self-harm and suicide. Specifically, referring to ACCT, SPAR Evolution, Talk To Me or equivalent processes.

95% of partner agency staff

reported the mental health team share information with them that might affect a patient's safety, within the limits of confidentiality and patient consent.

GOOD PRACTICE EXAMPLES

Partner agencies were extremely positive about their relationship with the mental health team, describing instances where the team would create care plans for complex cases, so officers knew the best way to approach the individuals.

HMP Guys Marsh, 2021-2022

Partner agencies praised the visibility of the team on the wings and their presence in meetings. They explained that the mental health team is very hands on, making them approachable.

HMP Lincoln, 2022-2023

AREAS FOR IMPROVEMENT

- A formal mechanism to respond to safer staffing is not always in place, and there is a lack of contingency planning to cease non-essential processes.
- Intelligence reporting processes are not clear. Staff are not always aware of how to escalate concerns or how to raise this via the prison reporting systems such as Quantum or NOMIS. Services report that not all staff have access to intelligence reporting systems.
- Lone working procedures are not always robust. Some services report not having access to a radio when attending the wings and not all staff are aware of lone working policies.

RECOMMENDATIONS

- Liaise with the Trust/organisation to develop a mechanism for responding to low or unsafe staffing levels. This should include a method for the team to report concerns, access to additional staff and an agreed contingency plan.
- Work with the prison to provide all staff members with access to intelligent reporting systems. Develop an incident reporting protocol which is easily accessible to staff members. This should include information about how to report incidents and how to escalate concerns.
- Put measures in place to support staff to work safely with patients, this should include introducing a lone working policy, regular risk assessment and identifying measures to prevent or reduce any identified risks. Liaise with he prison staff to ensure the safety of the team when visiting patients, including identifying safe rooms to use for this purpose.

PATIENT EXPERIENCE

Overall, 70.5% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standards are some of the most commonly met in this section:

Standard 46 [1] *Patients are treated with compassion, dignity and respect. Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.*

94% of services met this standard in Cycle 7.
81% of services met this standard in Cycle 8.

Standard 47 [1] Patients feel listened to and understood by staff members. *Guidance: Efforts and adjustments are made for patients with communication difficulties.*

97% of services met this standard in Cycle 7.
81% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 44 [1] Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.

47% of services met this standard in Cycle 7.
48% of services met this standard in Cycle 8.

73% of patients

reported they know who is coordinating their mental healthcare in prison and how to contact them.

52% of patients

reported they are involved in decisions about their care, treatment and discharge planning, where applicable.

> *The team are so supportive, genuine and sincere. They all listen and care.*
>
> **HMP Long Lartin, 2021-2022**

GOOD PRACTICE EXAMPLES

Feedback mechanisms are visible and readily available, including in pictorial format. Themes identified and actions taken are clearly displayed on 'You Said, We Did' noticeboards.

HMP Humber, 2022-2023

There are recovery champions who offer peer support from a psychosocial perspective. There are also healthcare champions who support residents to attend their appointments.

HMP Oakwood, 2021-2022

Patients spoke positively of the mental health team, highlighting good levels of rapport and a range of interventions. Patients have access to a drug and alcohol service available which offers a range of interventions such as acupuncture and training on the use of naloxone. Moreover, speech and language therapy input has led to the development of 'Lego therapy' groups to improve patient engagement.

Hydebank Wood College, 2021-2022

The service routinely collects and reflects on patient feedback. There are comment boxes on the wings and monthly meetings between patients, the mental health team and the governor. Patients explain that the team "work with you to make it better".

HMP Bristol, 2021-2022

Distraction packs have been distributed to patients during lockdowns or when patients are isolating, and the team has continued to contact patients using the in-cell phone system. The team have also placed information about the mental health team on the wings.

HMP Isle of Wight, 2021-2022

The service have recently introduced patient representative roles, trained by the patient engagement worker. They are held in high regard by staff and other patients as a good source of information and support.

HMP Dartmoor, 2021-2022

> *The mental health team are amazingly caring, supportive and compassionate. Thank you to all the mental health team.*
>
> **HMP Drake Hall, 2021-2022**

AREAS FOR IMPROVEMENT

- Patients are not always asked for their feedback on service provision, and where they are, this is not always embedded into service improvement.
- Patients do not feel involved in decision-making about their treatment, their care plans or discharge planning.
- Confidentiality is not always explained. Patients report not receiving digestible information on confidentiality and some report that information surrounding their care is shared with prison officers without their consent.
- Patients are not always aware of referral processes, how to access the mental health team or who their key worker is.

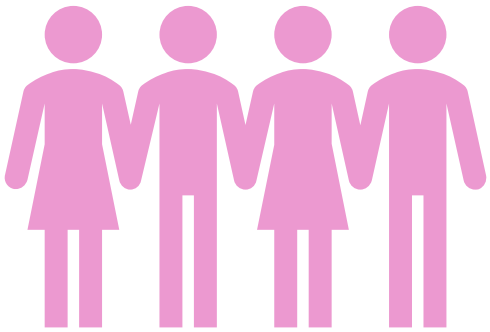
RECOMMENDATIONS

- Gather feedback from patients around their experiences of using the service. For example, through surveys, during discussions in one-to-one sessions, through patient representatives or during a focus group. Follow-up with patients to show how this feedback has been used to improve the service, for example, through a 'You Said, We Did' board.
- Develop a system to consistently involve patients in key discussions and meetings regarding their treatment and discharge planning. Allocate time prior to key meetings for patients to discuss their feedback one-to-one and support them in sharing their views during the meeting.
- Explain confidentiality and its limits to patients both verbally and in writing. This information should be made available regularly. Record, respect and regularly review patients' preferences for sharing information with third parties.
- Develop a leaflet on how patients can self-refer to the mental health team. This information could be shared with patients in a format they understand and displayed in key areas such as notice boards on the wings or in healthcare. When a patient is on the caseload, share the name and contact details of the staff member who will be their key worker.

> *When I see anyone from inreach to give me my medication, they always ask how my mental health is and how the side effects are. They take me seriously and if there was some kind of award I could give them, I would do that!*
>
> **HMP Swaleside, 2021-2022**

COLLABORATIVE PARTNERSHIPS

Overall, 46.5% of standards in this section were met across Cycles 7 and 8.



Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 56 [2] The team understands and engages in policies on reporting intelligence according to the establishment's security reporting system.

88% of services met this standard in Cycle 7.
81% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 52 [2] The team has a policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within limits of patient consent, confidentiality and risk management.
Guidance: Where integrated healthcare models are in place, the policy will detail effective multi-professional working and collaboration.

22% of services met this standard in Cycle 7.
24% of services met this standard in Cycle 8.

Reflection on Standard 52 [2]:

Many services work collaboratively with other teams and organisations, however, not all communication is formalised in a policy.

GOOD PRACTICE EXAMPLES

As the team have faced difficulties with prison staff being released to attend mental health awareness training, written packs have been developed and distributed amongst prison staff.

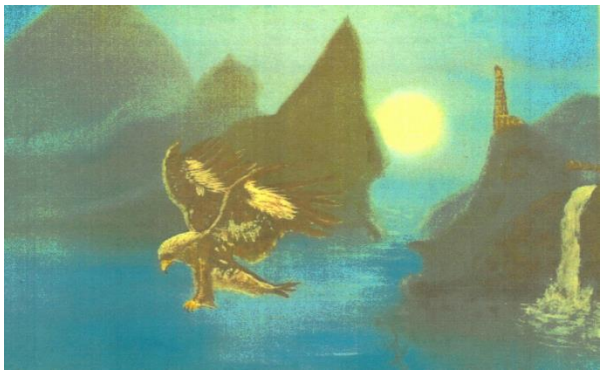
HMP Channings Wood, 2021-2022

There are frequent complex care meetings and monthly multi-pathway meetings to share information and management plans with primary care and substance misuse.

HMP Rochester, 2022-2023

Partner agencies shared that the mental health team is very accessible, and they have excellent communication with them. They also shared that the mental health team is very visible within the prison and are always out on the wings interacting with other staff and patients.

HMP Preston, 2022-2023



Sea Hunter created by a patient at HMP Haverigg.

Partner agencies described their working relationship with the mental health team as "excellent", the referral process as clear, and that they work together effectively to support patients.

HMP Nottingham, 2021-2022

AREAS FOR IMPROVEMENT

- There is a need for increased information provision and mental health training for partner agencies, including information about mental health interventions on offer, mental health presentations and how to manage self-harm and suicide.
- Communication between mental health teams and criminal justice, social care, physical healthcare and the third sector could be improved. Relevant information or risk details, where consent allows, is not routinely shared, and partner agencies are not often invited to key meetings.
- Partner agency staff are unaware of how to contact the mental health team, referral processes and expected waiting times for assessment and treatment.

RECOMMENDATIONS

- Facilitate mental health awareness training for partner agencies in collaboration with the prison. This could involve directly providing the training to partner agencies or inputting into the development of training content and materials. Alternatively, liaise with the prison to allocate the mental health team a slot within the new prison staff induction to provide this training.
- Establish local policies for liaison and joint working between teams within the prison and within the community. These policies should consider patient consent, confidentiality and risk management.
- Provide partner agencies with information on how to make a referral to the mental health team and guidance around what an appropriate referral looks like. If not already available develop a referral template and share this with all agencies. Share information on current waiting times widely, for example, on notice boards on the wings or in healthcare, and directly with referrers.

MEDICATION MANAGEMENT

Overall, 45% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 65 [1] Compliance with medication is recorded as part of the patient's care plan and this is reviewed on a monthly basis, or more frequently where required. *Guidance: The team proactively follows up with patients who fail to collect or take their medication and this is included in their care plan.*

59% of services met this standard in Cycle 7.
62% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 66 [2] There are clear written protocols outlining prescribing responsibilities between psychiatrists, GPs and nurse prescribers. *Guidance: Clinicians refer to 'Safer Prescribing in Prisons: Guidance for Clinicians, Second Edition' (RCGP, 2019).*

34% of services met this standard in Cycle 7.
19% of services met this standard in Cycle 8.

Reflection on Standard 66 [2]:

There are not always clear written protocols outlining responsibilities for prescribers, and often documents are in draft format.

62% of patients

reported being provided with information on the benefits, risks and side effects of their treatment.

GOOD PRACTICE EXAMPLES

The safe use of high-risk medication is audited at a service level, at least annually. The medicine management meeting is chaired by the pharmacist which includes a review of high-risk medication, and trends are analysed.

HMPYOI Feltham, 2021-2022

Compliance with medication is recorded as part of the patient's care plan and this is reviewed on a minimum of a monthly basis. Compliance and missed medication are discussed in meetings and handovers.

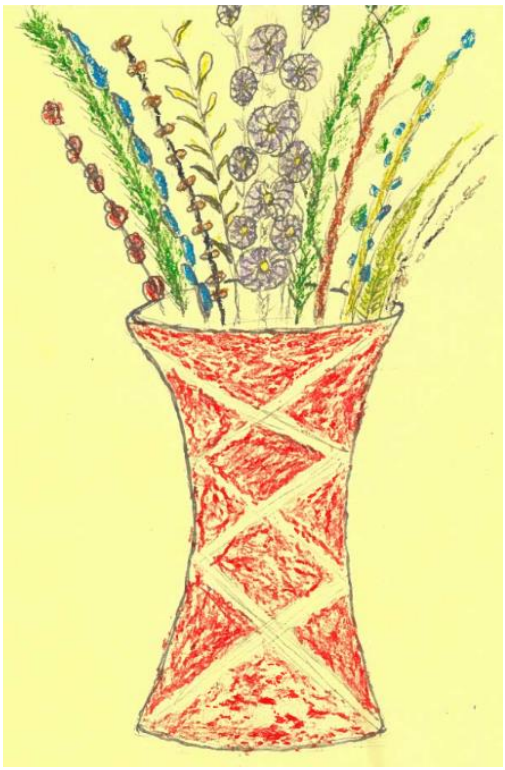
HMP Lowdham Grange, 2021-2022

AREAS FOR IMPROVEMENT

- Not all services formally audit the use of psychotropic or high-risk medications.
- Accessible information, both written and verbal, on medication, benefits and side effects is limited.
- There are not always clear written protocols outlining responsibilities for prescribers.

RECOMMENDATIONS

- Audit the safe use of high-risk medication at least annually. This should be completed at service level and include medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines, gabapentinoids and stimulants for ADHD.
- Share information with patients, both verbally and in writing, about their medication options, benefits and potential side effects. This should be recorded in patient notes.
- Utilise the *'Safer Prescribing in Prisons: Guidance for Clinicians, Second Edition' (RCGP, 2019)* to develop clear written protocols outlining prescribing responsibilities between psychiatrists, GPs and nurse prescribers.



Vase of Wildflowers created by a patient at HMP Birmingham.

ENVIRONMENT

Overall, 57.5% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 72 [1] The team has dedicated spaces and meeting rooms for confidential working.

72% of services met this standard in Cycle 7.
62% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 70 [2] All interview rooms are safe. This includes the rooms being situated close to staffed areas, having an emergency call system, an internal inspection window and the exit is unimpeded. Objects cannot easily be used as weapons.

44% of services met this standard in Cycle 7.
33% of services met this standard in Cycle 8.

Reflection on Standard 70 [2]:

There are not always designated spaces for the mental health team to meet with patients. This can lead to the team using other available spaces or rooms that are not safe.

84% of patients

reported being able to attend schedules appointments with the mental health team.

GOOD PRACTICE EXAMPLES

The Loft is a new therapeutic wing. The team have worked to introduce new engagements to the space such as weekly bingo, pet therapy and circle time conversations. Patients have input on the environment and have jobs on the wing.

HMPYOI Doncaster, 2022-2023

The team, including the neurodiversity practitioner, have adapted the environment to create therapeutic cells and a sensory room. There are training programmes around neurodiversity and workshops for patients to support with employment opportunities.

HMP Ranby, 2022-2023

The team has an excellent 'mental health hub' space within the prison which is calm and comfortable. The team has made the space feel safe and therapeutic by playing the radio on a low volume to prevent conversations from being overheard, and diffusing essential oils. The space is decorated with artwork and includes a therapeutic garden which the team uses for small groups or one-to-ones.

HMP Magilligan, 2022-2023

The health centre has dedicated spaces and meeting rooms for confidential working which are bright and spacious. There is an activities centre for patients to engage in a range of actives and courses, including artwork, bike repair, gardening and a media centre.

HMPYOI Polmont, 2022-2023

AREAS FOR IMPROVEMENT

- Computer access, internet speeds and working spaces for staff are not always adequate. This impacts incident and intelligence reporting.
- There is a lack of designated one-to-one and group-based rooms for mental health staff to conduct patient care. This leads to appointments being cancelled or held on the wing. This impacts the privacy, quality and frequency of appointments.
- Clinic rooms are not always suitable for purpose or safe. Not all spaces have easily accessible alarm buttons, or they do not have them at all, often objects in the room could be used as weapons or exits are impeded.

RECOMMENDATIONS

- Liaise with the Trust/organisation to ensure there are sufficient IT resources for the mental health team to be able to access key information. This could include putting in a business case to the prison/organisation for more space and additional computer terminals or laptops.
- Work with the prison to identify designated rooms for the mental health team to carry out one-to-one and group sessions. These rooms should be private where conversations cannot be easily overheard. Where needed, a room booking system should be introduced.
- Liaise with the prison to highlight concerns regarding the safety of the rooms used, identifying where emergency call systems and internal inspection windows are missing. Clinic rooms should be situated close to staffed areas and should only contain objects which cannot be easily used as weapons. The prison establishment should work together with the mental health team to ensure this is in place and rooms are safe.

WORKFORCE

Overall, 62.5% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 76 [1] When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.

94% of services met this standard in Cycle 7.
95% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 93 [2] All staff members receive monthly line management supervision.
Guidance: Supervision forms a part of individual performance management and discusses organisational, professional and personal objectives.

38% of services met this standard in Cycle 7.
24% of services met this standard in Cycle 8.

80% of mental health staff

reported that the team actively supports staff health and well-being.

83% of mental health staff

receive training consistent with their role and in line with their professional body.

GOOD PRACTICE EXAMPLES

The service uses the Enhanced Support Service (ESS) to allocate a team, including a prison officer, a mental health nurse and a psychologist, to work with an individual. They take a "preventative approach" to try to reduce the risk of assaults and self-harm. Staff members highlighted the system is a 'helpful and fair' way to delegate caseloads to different members of staff.

HMP Wandsworth, 2022-2023

Staff spoke positively of the reflective practice and debrief procedures in place. There are monthly journaling clubs and monthly CPD sessions during which staff can present a CPD opportunity they are interested in. Additionally, managers have open door policies for ad hoc discussions surrounding staff mental wellbeing.

HMP Brixton, 2021-2022

Staff have regular reflective practice sessions, can take their breaks and can use Time off in Lieu (TOIL) if needed. There are training opportunities, including opportunities to gain postgraduate qualifications.

Cloverhill, 2021-2022

The team work cohesively and every decision is made as a team. Wellbeing initiatives include meditation, Christmas lunch, team away days, access to freedom to speak up guardians and wellbeing champions. Staff take regular breaks.

HMP Haverigg, 2021-2022

The service has access to a neurodiversity service and neurodevelopmental disorder training, enabling the team to support patients.

HMP Eastwood Park, 2021-2022

The service has been proactive in their approach to address low staffing levels, including trainee placements for student nurses and reaching out to local University students.

HMP Norwich, 2021-2022

Clinical supervision, managerial supervision and reflective practice are available monthly which is valued by the team. Staff shared that they can seek support from the team and other prisons within their cluster.

HMP Exeter, 2021-2022

AREAS FOR IMPROVEMENT

- Not all staff receive a formal induction where they can shadow colleagues.
- Clinical and line management supervision are not consistently provided monthly, and reflective practice is not offered every six-weeks.
- Formal debriefs following incidents are not always in place.
- Staff are not always able to take their breaks.
- There is a general call for an increased provision of training in trauma informed care.

RECOMMENDATIONS

- Provide all new starters with an induction based on an agreed list of core competencies. This should include shadowing colleagues, joint working with more experience colleagues, being observed and enhanced supervision.
- Arrange clinical and line management supervision monthly for all staff, and keep a record of when this does and does not take place. These records should be regularly audited and action plans should be put in place where supervision sessions are repeatedly missed. Additionally, offer reflective practice sessions at least every six weeks where the team can meet to consider team dynamics and develop their clinical practice. Allocate protected time for staff to attend supervision and reflective practice sessions.
- Offer staff members who are affected by a healthcare related serious incident post incident support which includes attention to physical and emotional wellbeing, reflection and learning. Consider introducing TRiM practitioners.
- Support and encourage staff to take their breaks, including providing adequate cover where needed.
- Liaise with the Trust/Organisation to provide staff with training in the principles of trauma informed care. Teams should reflect on how their practice can be influenced by what has been learned from the training.

LEADERSHIP AND GOVERNANCE

Overall, 71.5% of standards in this section were met across Cycles 7 and 8.

Standard Highlights

The below standard is one of the most commonly met in this section:

Standard 103 [1] Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.

86% of services met this standard in Cycle 7.
95% of services met this standard in Cycle 8.

The below standard is one of the least commonly met in this section:

Standard 105 [2] Complaints are reviewed on a quarterly basis to identify themes, trends and learning.

69% of services met this standard in Cycle 7.
43% of services met this standard in Cycle 8.

83% of mental health staff

reported feeling able to raise concerns about the standards of care being delivered by the mental health team.

76% of mental health staff

reported the mental health service's policies, procedures and guidelines are easily accessible and presented in an understandable format.

GOOD PRACTICE EXAMPLES

The team have looked at enhancing service user engagement and exploring the listeners scheme to identify and overcome barriers to participation among the foreign national population through research. Outcomes include integrating basic mental health awareness and knowledge into the listeners scheme and working with religious leaders to make accessing services more inclusive.

HMP Huntercombe, 2021-2022

The service is working with Northumbria University to analyse the impact of the integrated support unit (ISU). The team provides data on the benefits of the service, including hospital referrals. Further, a recent masters project from a team member included looking at staff experience working on the ISU.

HMP Durham, 2022-2023

A QI project has been completed on reducing the time between referral and accessing the Stepped Care programme. Steps taken include changing the location of appointments and strengthening referral criteria to reduce waiting times.

HMPYOI Isis, 2021-2022

The team have produced their own patient feedback forms. This data is shared with key stakeholders, the organisation's board and staff.

HMP Cardiff, 2021-2022

The team has been involved in an ongoing segregation pilot, which includes a review of the existing safety unit against a set of standards.

HMP Lancaster Farms, 2021-2022

AREAS FOR IMPROVEMENT

- Service engagement with research and academic activity is limited. This includes staff and patient input.
- There is a lack of patient steering groups or mental health representatives within the prison estate to allow patient involvement within service development.
- Staff do not always feel able to raise concerns to management. When they do raise concerns, they do not always feel listened to or receive feedback.
- When complaints are made, these are not reviewed on a quarterly basis to identify themes, trends and learning.

RECOMMENDATIONS

- Identify research and quality improvement (QI) activity that can be undertaken at the service and encourage staff and patients to be involved in this. Where needed, liaise with the Trust/Organisation research/QI teams to support with this.
- Establish patient representative roles in collaboration with the prison. They should be invited to governance meetings and involved in discussions regarding service development. Where attendance is not possible, gather feedback from patients to include their experience in service development discussions.
- Encourage staff members to challenge decisions and raise any concerns they may have during team meetings, supervision sessions or reflective practice. Offer staff options to share feedback anonymously, for example, through surveys or a comments box. Display whistleblowing information in staff areas. Where feedback is received, ensure this is followed up on and staff are provided with feedback around any actions taken.
- Add complaints as a standing agenda item during governance and team meetings. This is to identify themes and trends in the complaints received. Share the findings with the team, including any learning and actions taken to address the complaints.

24 HOUR MENTAL HEALTHCARE

Overall, four services with 24-hour mental healthcare took part in Cycle 7, compared to two services in Cycle 8.

43% of standards in this section were met in Cycle 7. This increased to 77% in Cycle 8.

GOOD PRACTICE EXAMPLE

The wellbeing centre includes a kitchen, music studio and an art room, offering patients the opportunity to participate in occupational therapy courses in cooking, creative expression, pottery and art classes. Patients are able to access a safe outdoor space every day, including an outdoor gym, and are encouraged and supported to do so.

HMP Pentonville, 2021-2022

AREAS FOR IMPROVEMENT

- Activities do not always span over seven days, including evenings and bank holidays. Contributing factors include the prison regime and staffing.

RECOMMENDATIONS

- Develop personalised activity timetables which include evenings and weekends. These should include a range of therapeutic and recreational activities tailored to each patient, which the team encourages engagement with. Where difficulties are encountered due to prison regime, liaise with the prison to identify what actions can be put in place to support with the activity provision.

Mental Health and Communication
created by a patient at HMP Durham.

RESOURCES AND EVENTS

COMING SOON: QNPMHS Carer Engagement and Involvement Guidance

Carer involvement is important to ensure patients are provided with holistic care and support. This can be done at many levels from providing background information about a patient, to having input and involvement in care plans. Carers should also be offered support from prison mental health services, both to engage and offer support to their loved one, and with their own needs. Prison mental health services face a number of barriers to engaging carers due to the nature of services. The subject of carer engagement has been a point of discussion within QNPMHS over the last few years, and this has now become a focus for the Network.

In 2023, QNPMHS revised the Standards for Prison Mental Health Services and introduced two carers' standards. Furthermore, to support services to improve and develop their carer engagement and involvement, the QNPMHS Carers Working Group was introduced. The group explored the current picture of carer engagement within prison mental health services, barriers faced when trying to engage carers and identified good practice examples. The group also explored how carers can begin to be involved in QNPMHS processes.

This guidance document is due to be published in summer 2024 and aims to provide prison mental health services with good practice examples to help improve their engagement with carers.

Events

Peer-Reviewer Training

Peer-reviewer training is a free event for staff from a service that is a member of the Quality Network. The training is a great learning experience for those who are interested in participating in peer-reviews of prison mental health services. The training takes place online via MS Teams. Over Cycles 7 and 8, nine training sessions were run with a total of 107 delegates. Training sessions included some Trust specific training, where interest arose.

Moral Injury Webinar 2022

In June 2022, the team hosted a Moral Injury webinar for member services. The day included presentations on moral injury and mental health in healthcare staff, exclusion culture and moral injury, and moral injury: for life, not just for Covid. The day concluded with a fruitful open discussion session.

Annual Forum 2022

The QNPMHS Annual Forum ran on 16 December 2022. Despite the decision to move it to a virtual event due to national strike action, it was a success. The day was filled with fantastic speakers with great interaction from those watching. The morning covered a range of topics including RECONNECT and Enhanced RECONNECT, prison healthcare through the lens of occupational therapy and mental health in immigration detention and in quasi-detention accommodation. The afternoon was filled with workshops focusing on 'Allied Health Professionals in Prison Settings' and 'Quality Improvement and research projects' which included a workshop from one of our patient representatives, Sarah Markham. Overall, the day was informative and forward thinking.

Standards Consultation Event 2023

The QNPMHS Standards Consultation Event was held in April 2023 which provided member services, the advisory group and patient representatives the opportunity to review the existing standards. The aim was to collect feedback on the standards and whether these were still fit for purpose, reflecting current best practice and measure the quality of care received by patients. The sixth edition of the standards was published in September 2023 and will inform Cycles 9 and 10.

Annual Forum 2023

The Network hosted an Annual Forum on 26 October 2023. This was the first in person event since 2019. Speakers covered topics such as ADHD pathways, involvement of families, interagency working, therapeutic communities and enabling environments. The event was live tweeted from the CCQI twitter account, and was enthusiastically received, gathering over 1.8K views.

Previous Newsletters

The Network publishes two newsletters a year which focus on specific topics. The most recent editions have focused on 'Staff Wellbeing and Retention' and 'Neurodiversity Pathways in Prison Settings'. Previous editions can be found on our website or KnowledgeHub.


PRISON eNewsletter

Issue 16, December 2023

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WELCOME

Welcome to the 16th and final newsletter of 2023! This edition of the newsletter is on *Staff Wellbeing and Retention*.

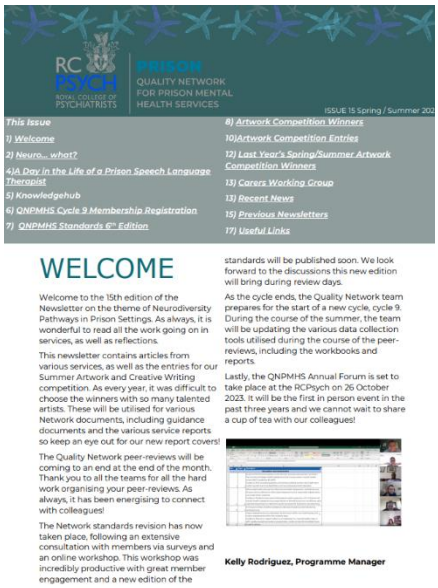
As always, it is incredible to read through so many articles and good practice examples from our member services. Included in this newsletter is also the fantastic Festive Card Competition entries and the winner. We would like to thank all participants for their submissions and all our members for their support with this competition. It has truly been amazing to see so many submissions!

As many of you will know, the Network hosted an Annual Forum on 26 October this year. This was the first in person event since 2019! Speakers covered topics such as ADHD pathways, involvement of families, interagency working, therapeutic communities and enabling environments.

As the new year starts, so do the peer-reviews. The team and I very much look forward to working with teams again to share good practice and provide networking opportunities.

I hope everyone has a wonderful Christmas, and we look forward to speaking to you in the New Year. 2024 here we come!

Kelly Rodriguez, Programme Manager


PRISON QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

ISSUE 15 Spring / Summer 202

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WELCOME

Welcome to the 15th edition of the Newsletter on the theme of Neurodiversity Pathways in Prison Settings. As always, it is wonderful to read all the work going on in services, as well as reflections.

This newsletter contains articles from various services, as well as the entries for our Summer Artwork and Creative Writing competition. As every year, it was difficult to choose the winners with so many talented artists. These will be utilised for various Network documents, including guidance documents and the various service reports so keep an eye out for our new report covers!

The Quality Network peer-reviews will be coming to an end at the end of the month. Thank you to all the teams for all the hard work organising your peer-reviews. As always, it has been energising to connect with colleagues!

The Network standards revision has now taken place, following an extensive consultation with members via surveys and an online workshop. This workshop was incredibly productive with great member engagement and a new edition of the standards will be published soon. We look forward to the discussions this new edition will bring during review days.

As the cycle ends, the Quality Network team prepares for the start of a new cycle, cycle 9. During the course of the summer, the team will be updating the various data collection tools utilised during the course of the peer-reviews, including the workbooks and reports.

Lastly, the QNPMHS Annual Forum is set to take place at the RCPsych on 26 October 2023. It will be the first in person event in the past three years and we cannot wait to share a cup of tea with our colleagues!

Kelly Rodriguez, Programme Manager

Artwork and creative writing

The Network hosts an annual artwork and creative writing competition for patients. All artwork and creative writing is showcased in our newsletters and the winners of the artwork competition are used on publications such as reports. Winners of the artwork competition have been used on the cover of this report and throughout. Additionally, the Network runs a festive card competition on a yearly basis, which also includes entries from patients.

In partnership with our sister network QNFMHS, a creative writing booklet was compiled to showcase the fantastic entries for the 2021 competition.

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