Quality Network for Prison Mental Health Services

ANNUAL REPORT

CYCLE 3 2017-18

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PRISON
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES
CCQI

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Artwork displayed on the front cover of this report:

First Light in February
HM Prison Channings Wood
Watercolour and Gouache
2017

Image courtesy of the Koestler Trust

Contents

Acknowledgements

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- Dr Huw Stone, Dr Steffan Davies and the Quality Network for Prison Mental Health Services' Advisory Group
- The staff in member services who organised and hosted a peer-review visit
- Those individuals who attended visits as part of a peer-review team
- The patients and prison staff that participated in the review process

Preface

Last week, the Ministry of Justice published their annual safety in custody figures which confirm the deteriorating state of our prison system. The number of suicides have increased from the previous year and incidents of self-harm have reached their highest levels. Concerns remain with low staffing, unacceptable living conditions and limited knowledge and awareness of mental health issues. We have seen some discussion in the past 12 months around making improvements, however progress is slow.

Further detailed in this report, the project has been busy this year developing the programme of work to better support and represent member services. Our standards have been incorporated into NHS England's specification for prison mental health services and we hope this will provide a framework to better structure services and achieve greater consistency. We have also represented our members within discussions at a political level; we gave evidence at the House of Commons Public Accounts Committee (PAC) following the National Audit Office report on mental health in prisons, and we provided information to the Cabinet Office to support an enquiry into continuity of care on release from prison.

This is the third Quality Network for Prison Mental Health Services' annual report; it provides an overview of the performance of 44 services that participated in the review period between August 2017 to July 2018. In addition to summarising the key themes and trends, member services can benchmark their practices and learn from other services through the good practice shared. New this year, we have also included a section summarising the top three discussion threads from our email discussion group.

Finally, we would like to pay recognition to the services that participated in the third cycle. Our teams work in very demanding and challenging environments, and despite these unique pressures we continue to deliver services to a high standard. Moving forward, we would like to encourage each of you to maximise the opportunities of information sharing and learning that are provided by the Network, as these will support you to further enhance your services.

Dr Steffan Davies
Consultant Forensic Psychiatrist
Co-chair Quality Network for Prison Mental Health Services

Who we are and what we do

The Quality Network for Prison Mental Health Services (QNPMHS) was established in 2015 to promote quality improvement in the field of prison mental health. It is one of over 25 quality network, accreditation and audit programmes organised by the Royal College of Psychiatrists' Centre for Quality Improvement.

Member services are reviewed against published specialist standards for prison mental health services and 24-hour mental healthcare in prisons[1].

Our purpose is to support and engage individuals and services in a process of quality improvement 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 promote the sharing and learning of best practice and support services in planning improvements for the future.

Participation in the Network is voluntary and services pay a fee to become a member.

The Network is governed by a group of professionals who represent key interests and areas of expertise in the field of mental health, and individuals who have experience of using these services. The group is co-chaired by Dr Huw Stone and Dr Steffan Davies.

The review process

Using nationally agreed standards, each service engages in an annual review cycle. Their first step is to reflect on their own practices during a period of self-review, providing

[1] www.qnpmhs.co.uk

evidence against each of the standards. As part of this stage, each service is expected to distribute surveys to their staff, prison staff and their patients in order to gain feedback about the quality of their service. This is followed by a peer-review visit whereby colleagues from other similar services review their practices using the evidence provided.

The information collected during the self-review and peer-review stages are collated into a detailed review summary. This reports on the service's compliance with each standard and identifies the key areas of achievement and challenge, whilst also making recommendations for the future. Services are required to produce an action plan to outline what steps they are taking to plan improvements for the next cycle.

The preliminary data from the year's reviews was presented at the Network's annual forum (July 2018) and published in this report.

Benefits of membership

Member services receive a package of support and opportunities for learning from the Quality Network, including:

- Involvement in the development of nationally agreed standards;
- The opportunity to visit other services to learn and share good practice;
- A detailed service report and a national aggregated annual report;
- The ability to benchmark practices with other similar services;
- Free attendance at Network events, workshops and training to enable learning and information sharing;
- Access to a dedicated annual forum;
- Opportunities to present at events and workshops;
- Access to a dedicated email discussion group for those working in prison mental health;
- A regular newsletter and the opportunity to contribute articles;
- Valuable networking opportunities.

Introduction

Membership

44 mental health services across 47 establishments in the UK and Ireland participated in the third year of the Network (appendix 1). They included male, female, and young offender populations, those of varying security category, and prisons in both the public and private sector. One immigration removal centre also participated.

Participation

As part of the self-review process, services were asked to distribute surveys in order to gain feedback about the quality of the service provided. In total, the survey was completed by 241 mental health team staff, 688 prison staff and 582 patients.

On the review visits, 155 staff working in prison mental health services participated as peer-reviewers. The majority of these individuals received training from the Network about how to participate in a peer-review visit. A representative from the Network attended all visits for guidance and consistency in the review process.

Network initiatives

We organised a number of initiatives for our member services during the year:

- Mental health in prisons: Screening, assessment and identification, 13 November 2017 (appendix 4)

- Improving the care and treatment of people with an intellectual and/or developmental disability in prison, 15 March 2018 (appendix 5)
- QNPMHS 3rd Annual Forum, 3 July 2087 (appendix 6)
- Bi-annual newsletter, available online at: www.qnpmhs.co.uk
- Email discussion group: prisonnetwork@rcpsych.ac.uk

Network developments

Since the publication of the previous annual report, we have made several developments within the project:

Standards for 24-hour mental healthcare in prisons

These standards were published in 2017 and formed part of the review process in cycle 3. They focused primarily on mental healthcare within 24-hour mental healthcare facilities or inpatient units. The use of these standards was reviewed at the end of the cycle and some revisions have been made for the next cycle of reviews and also how they are presented throughout the review process. The aggregated data for these standards is included in this report.

Standards for prison mental health services

Since publishing the first edition of standards in 2015, we have endeavoured to revise the standards on an annual basis to ensure they were appropriate for the setting and useful in monitoring quality. The fourth edition of standards was published in September 2018 and can be found online www.qnpmhs.co.uk. Within this latest publication, small changes have been made to the wording and a couple of new standards have been introduced. An effort has also been made to remove the unnecessary use of the terms 'prison' and 'prisoner'.

Outcome measurement

Over the past year, the QNPMHS advisory group has been working on introducing a simple outcome measures tool to be included within the self-review phase and includes only three items. The idea is for services to describe their case load in the context of the numbers passing through the prison. We will use this information as part of the annual aggregated reporting and to further research.

Strategic communications

To raise the profile of mental health in prisons, we have engaged in several activities over the past 12 months:

- NHS England Health and Justice Commissioning developed a service specification for integrated mental health services in prisons, these were published in March 2018. The service specification includes our standards. NHS England expect providers to be a member of the Quality Network for Prison Mental Health Services and participate in peer review of delivery against standards or, if not members, they are expected to work to the standards.
- We were proud to be able to represent our member services at the House of Commons Public Accounts Committee (PAC) in October. The session was called in response to the findings of the National Audit Office (NAO) report on mental health in prisons and QNPMHS Advisory Group Co-Chair, Dr Huw Stone, gave evidence to advocate for change.
- We supported the Cabinet Office by providing information on continuity of care on release from prison, to help guide ministers on this issue.

- We hosted the Royal College of Psychiatrists' Chief Executive, Paul Rees, at a peer-review of the Barnet, Enfield and Haringey mental health team at HMP Pentonville.

This report

This is the third annual report published by the Quality Network for Prison Mental Health Services. This document summarises the findings from the 44 review visits that were conducted over the past year. It will outline the current climate within prison mental health nationally, identifying best practice as well as the key areas of challenge experienced by participating services.

All member services are reviewed against published standards for prison mental health services. This report is structured around the following nine domains:

- Admission and Assessment
- Case Management and Treatment
- Referral, Discharge and Transfer
- Patient Experience
- Patient Safety
- Environment
- Workforce Capacity and Capability
- Workforce Training, CPD and Support
- Governance

Each section will report on the key findings by theme and examples of best practice are provided as suggestions of how to improve in a particular area.

For anonymity purposes, each member service has been assigned a unique data label. Using the graphs throughout the report, services can use their code to identify how they compare to the other services that participated. Graphs are ordered by compliance with a standard area, highest to lowest, and the average score has also been highlighted.

Executive summary

This section provides an overview of the findings from the third-year review period. It will explore the key findings identified in terms of how services are performing, reporting on the main areas of challenge and achievement across the Network.

Overview

On average, member services fully complied with 71% of standards.

Figure 1 offers a breakdown of how each member service performed against the standards, in order of strongest compliance. It illustrates the percentage of met, partly met and unmet criteria per service. The range of met criteria achieved spans from 92% to 33%. The average compliance across the 44 services is 71%, as indicated by the final bar marked 'TNS' (total number of services) on the graph.

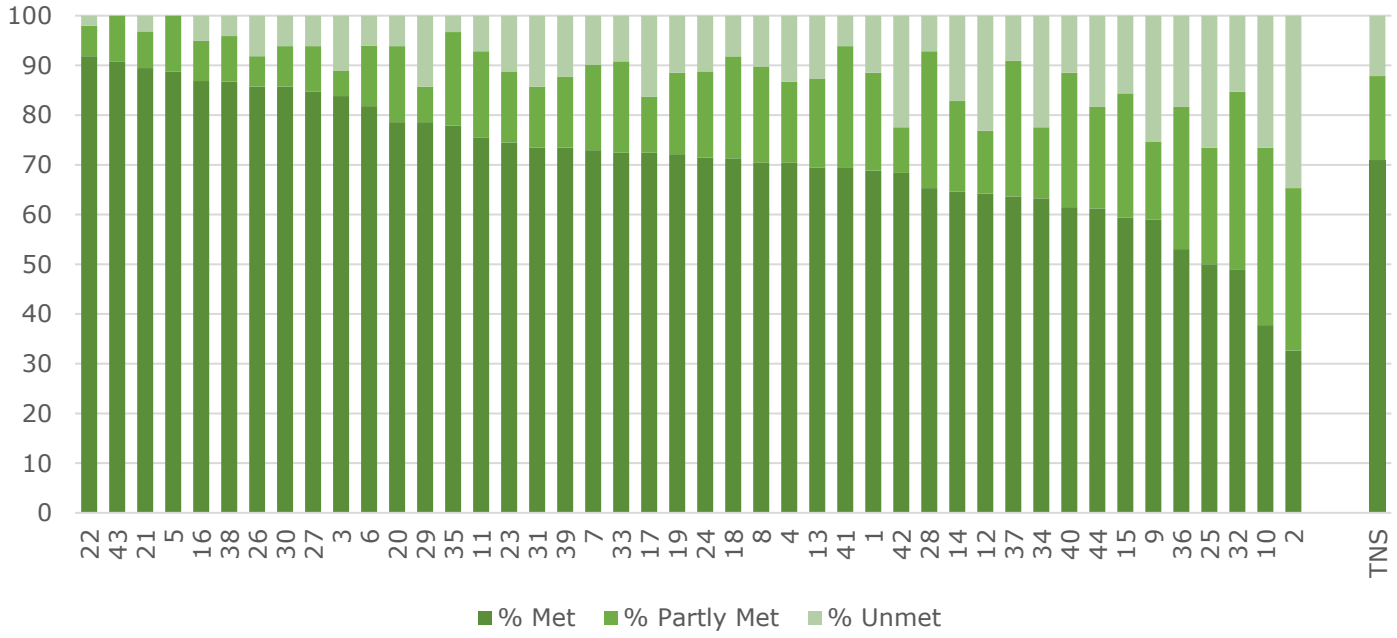


Figure 1: Percentage of met criteria by service

Figure 2 displays the average percentage of met criteria per section. Member services scored most highly in the areas of Patient Experience and Referral, Discharge and Transfer. The areas in most need of improvement are Case Management and Treatment and Workforce Training, CPD and Support.

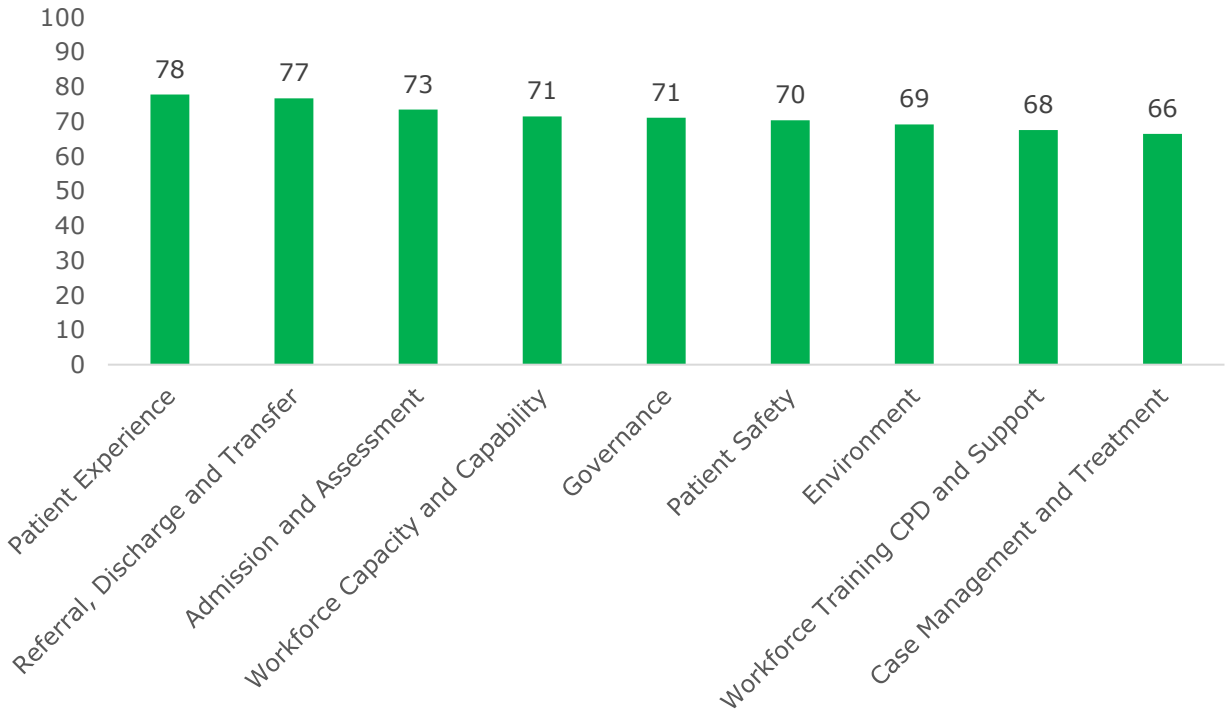


Figure 2: Average percentage of met criteria per section

Admission and assessment

On average, services fully met 73% of standards in this area.

- For the majority of services, the team's role in the screening process is clearly defined and a clinical member of staff is available to discuss emergency referrals during working hours.
- Response times for urgent and routine assessments are variable across the prison estate; this is influenced by staffing levels and high numbers of referrals.
- Access to information for patients remains a challenge for services, with many patients still not receiving written information in an accessible format.

Case management and treatment

On average, services fully met 66% of standards in this area.

- Most patients who are prescribed medication have specific treatment targets set and this is reviewed regularly, however patients in around 40% of services that were prescribed mood stabilisers, antipsychotics or stimulants were not aware of any physical health monitoring taking place.
- For patients receiving 24-hour mental healthcare or an inpatient service, only one-third of services provide activities seven days a week. Similarly, a pre-arranged one-hour session was not taking place with a key worker on a weekly basis in the same proportion of services.
- The management of Care Programme Approach (CPA) continues to be variable across services and patient understanding is limited. Patients in over half of services reported that their care plan is not developed in collaboration with them and only half of patients were aware of having a care plan.

- On the whole, the relationship between the mental health service and the wider prison appear to be improving, with various accounts evidencing strong working relationships.
- Teams work collaboratively with other healthcare providers and the prison to manage self-harm and suicidal ideation, however their engagement in the ACCT process is variable.

Referral, discharge and transfer

On average, services fully met 77% of standards in this area.

- The process of managing referrals to outside hospitals needs improvement, with almost half of services not having an agreed policy in place.
- Most services report providing a handover to the receiving prison when a patient is transferred, however there are often occasions when an individual has been transferred without the mental health team being notified.
- Attempts are made to communicate and liaise with receiving services when an individual is being discharged or released, although receiving services do not always engage in the process.
- A theme continuing from previous cycles, teams are not conducting a follow-up interview with the patient and/or care coordinator within 14 days of release or transfer from prison. Services have communicated that it is difficult to achieve with limited resource and there have been concerns of where the responsibility lies should an issue be identified for an individual.

Patient experience

On average, services fully met 78% of standards in this area.

- Reports from patients highlight that they feel treated with compassion, dignity and respect by mental health practitioners and that they feel listened to.
- Around one-third of patients do not feel involved in decisions regarding their care and treatment.
- Further work is required to ensure patients' feedback is obtained and used to improve the service provided.

Patient safety

On average, services fully met 70% of standards in this area.

- A consistent theme year-on-year, mental health teams are still not being utilised to support the delivery or development of mental health awareness training for the prison.
- Mental health staff understand and engage in prison service policies relating to security and safeguarding, however further training and support is required on food refusal and mental capacity.
- Patients receiving 24-hour mental healthcare or inpatient services are not accessing safe outdoor space every day, with 43% of patients experiencing this.

Environment

On average, services fully met 69% of standards in this area.

- The service environment continues to pose significant challenges to mental health teams.
- Over half of services are working in environments that do not meet the expected safety requirements and over 40% do not have access to clinical rooms that are private and confidential.
- Roughly one-third of teams do not have sufficient IT resources to effectively execute their roles.

Workforce capacity and capability

On average, services fully met 71% of standards in this area.

- Communication within teams remains strong with the majority of services conducting team meetings on a monthly, if not more frequent, basis.
- Services tend to have access to specialists relevant to the needs of the patient group within their wider trust or organisation, however it is not clear how often this resource is utilised within the prison.
- Services are not conducting an annual review of the staff and skill mix of the team in 75% of cases, preventing the identification of any gaps or areas in need of development within the workforce.

Workforce training, CPD and support

On average, services fully met 68% of standards in this area.

- On the whole, staff are receiving their mandatory training and annual appraisals, however not all staff confirmed receiving an appropriate induction programme specific to the service. Around half of staff members had not received a prison induction within the expected time frame or before being issued with keys.
- Around half of staff members are not receiving managerial and clinical supervision, and only 34% are accessing reflective practice groups.

Governance

On average, services fully met 71% of standards in this area.

- Despite hearing a few excellent examples of patient involvement, most services are not involving their patients in the governance and development of the team.
- Due to pressures in delivering services, many teams are not able to engage in relevant research or academic activity.
- Governance systems appear to be embedded as part of the prison clinical and quality processes, and lessons learned from incidents are largely shared with the team and wider organisation.

Key recommendations

The following recommendations have been devised based on the findings from the third cycle of reviews.

Recommendation 1: Service provision and resource

- At a national level, review the contracting of services to enhance provision, introduce stability and promote consistency.

- Adopt a more consistent approach to service provision, which includes minimum requirements and expectations, and ensure these are embedded and appropriately regulated.
- At a service level, conduct a thorough assessment of the current staff and skill mix to identify areas of deficit and, where deficits exist, establish a proposed level of resource to meet the needs of the population.

Recommendation 2: Identification and awareness of mental ill-health

- Ensure a mental health assessment is conducted by a mental health professional and that it is received by all prisoners on reception to the establishment.
- Enhance the presence and visibility of the mental health team within the establishment to enable optimal joint working and information sharing.
- Communicate the referral process to all staff working within the establishment.
- Recruit mental health patient champions to enhance the awareness of mental health and wellbeing, to signpost peers to the mental health service, and support the team's governance and development processes.
- Increase the distribution of written information about the service, including in accessible formats, that are available to all within the prison.
- At a national level, introduce a mental health awareness training package that is mandatory for all staff to attend and is repeated on an annual basis. Locally, involve the mental health team in the development and the delivery of the training.

Recommendation 3: Assessment, Care in Custody, and Teamwork (ACCT) process

- Reduce variation in the implementation of the ACCT process by introducing a nationally agreed template which clearly outlines the expectations of the prison, the mental health team and other healthcare agencies.

Recommendation 4: Patient experience

- Ensure all patients are aware of their care plan, they are fully involved in the production of it, and they are involved in making decisions about their care.
- Review the practice of Care Programme Approach (CPA) in prisons to enhance understanding, reduce variation and improve care coordination.
- Provide patients with feedback mechanisms to enable them to share their experiences of using the service and to promote service development.

Recommendation 5: Service environment

- Complete a service environment audit to identify any risks or concerns to safety and privacy. Formulate a joint action plan between the mental health team and the establishment to agree methods of improvement.
- Assess the level and quality of the IT resources available to the team. Where gaps and issues are identified, develop an action plan for service improvement.

Recommendation 6: Continuity of care

- At a national level, integrate services across the pathway to introduce consistency and improved communication.
- Formalise and embed local processes for referral, discharge and transfer.
- Improve communication systems locally to promote information sharing between the prison and healthcare teams.

- Identify an individual to coordinate the care of those being referred, discharged or transferred and act as a single point of contact for each team, and to follow-up with patients following release or transfer.

Recommendation 7: Staff support and wellbeing

- Conduct an annual staff survey to monitor the extent to which staff feel satisfied with and supported in their roles.
- Deliver individual managerial and clinical supervision monthly for all staff.
- Provide staff with access to a reflective practice group.
- Ensure all staff receive a full local prison induction before being issued with keys and within at least 28 days of commencing employment.

Recommendation 8: 24-hour mental healthcare

- Define the operation of the 24-hour mental healthcare service and agree a joint-working protocol between the prison and the healthcare providers.
- Provide inpatients with a structured programme of activities, seven days a week.
- Ensure all inpatients access safe outdoor space daily.
- Engage inpatients in active conversation at least twice a day and schedule in pre-arranged sessions with their key worker.

Quality Network for Prison Mental Health Services

Key findings

Cycle 3 2017-18

Admission and assessment

On average, services fully met 73% of standards in this area, ranging from 43% to 100% compliance.

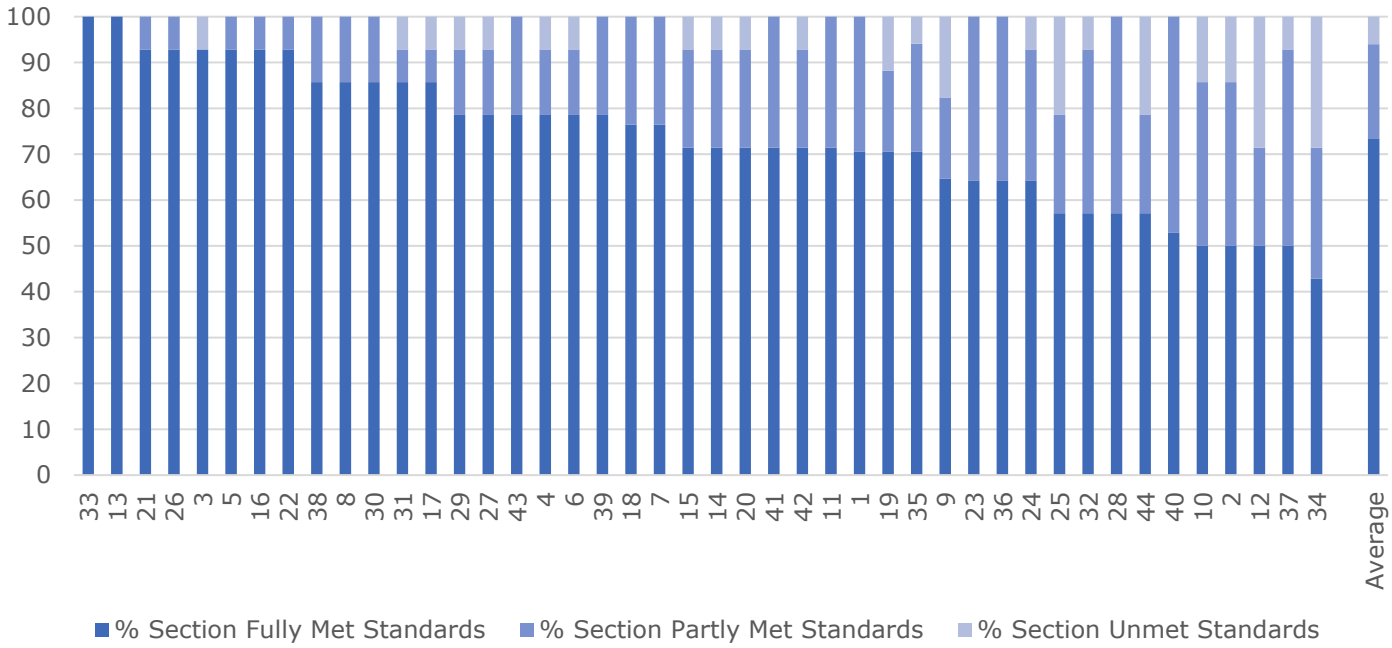


Figure 3: Service compliance for admission and assessment

Screening and admission processes

The role of the team in the screening process is clearly defined and in agreement with the prison establishment, in the majority of services.

A clinical member of staff is available to discuss emergency referrals during working hours within all services.

In 86% of services with a 24-hour mental healthcare facility, the purpose of the admission is explained to the patient and an assessment of their capacity to consent to admission, care and treatment is completed within 24 hours of admission.

Prison staff within 30% of services reported that the process to refer prisoners directly to the mental health team was not clear or consistent.

Only 68% of teams meet the recommended response times of 48 hours for urgent assessments and five working days for routine assessments.

Patients in around half of services are not involved in discussions around their assessment of risk and a management plan is not formulated jointly with the patient.

Good practice examples

The mental health team are present on reception during the screening process. This allows staff to effectively capture incoming prisoners who may require help from the team.
Leeds

Due to the size of the prison and relatively small number of new committals, the team check all new admission notes, and any prior interaction with mental health within prison establishments, to assess whether an individual may require support by the team.
Dochas Centre

Access to information

Only 16% of patients confirmed receiving verbal and/or written information on: their rights regarding consent to care and treatment; how to access advocacy services; how to access a second opinion; how to access interpreting services; how to raise concerns, complaints and compliments; how to access their own health records.

Patients in a third of services have clear, written information available on information about the mental health service, referral criteria and other relevant service information.

Good practice examples

The patients spoken with were highly knowledgeable with regards to how to access advocacy services, a second opinion, interpreting services, how to make a complaint and access their own health records. The group was also very knowledgeable about their risk assessments and care plans. The mental health team spend a lot of time ensuring information is fully understood by patients.
Bullingdon

The service has a lot of information readily available for patients. It is to hand throughout the healthcare unit and wings, including the induction wing. There is a clear description of the service, treatment and interventions available. The team names and structures are on display in the healthcare block, and the team were well-known on the wings.
Lincoln

Case management and treatment

On average, services fully met 66% of standards in this area, ranging from 22% to 100% compliance.

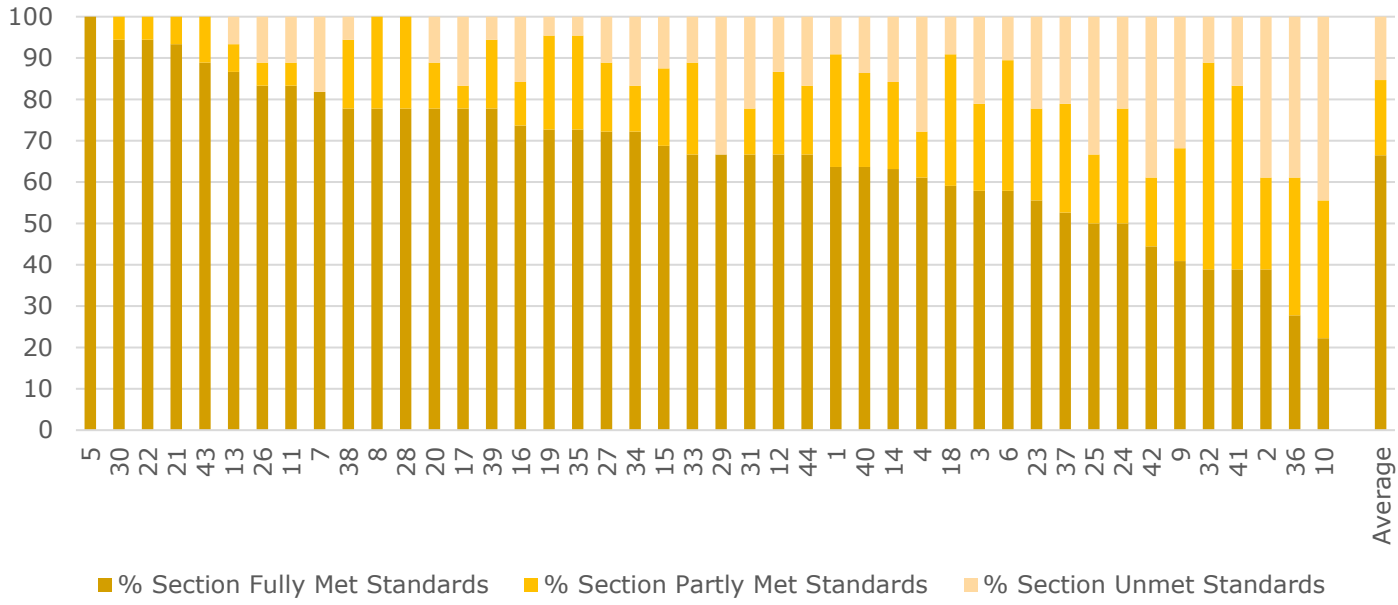


Figure 4: Service compliance for case management and treatment

Treatment and interventions

The majority of services manage their patients under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).

In 82% of services, patients who are prescribed medication have specific treatment targets, the risks and benefits are reviewed and a timescale for response is set.

Patients prescribed mood stabilisers, antipsychotics or stimulants for ADHD were aware of their physical health being reviewed and monitored in only 61% of services.

Half of the patients spoken with confirmed that they are offered written and verbal information about their mental illness.

Good practice examples

The service has developed a speech and language pathway, with the assistance of a specialist. The pathway has been developed so that appropriate care is given to patients with difficulties in this area, and who may not be able to communicate as clearly as others. The pathway has proven successful so far, with many high-risk patients responding well. The specialist has also delivered training to the wider establishment to increase awareness.
Holme House

The wider healthcare team offer a variety of services to support patients and the wider prison population. The team works closely with colleagues from IAPT, NACRO, probation, housing, ADHD specialists and the forensic psychology team. The team works especially closely with the complex case team who alleviate pressures on the inreach team through having their own caseload. The ADHD team are undergoing a three-year fully funded randomised control trial which is a fantastic initiative and opportunity for the prison.
Isis

The lead occupational therapist runs an impressive day-care centre that is due for refurbishment, following a successful 'dragons' den' style pitch to the Trust. The current facilities enable the team to facilitate a range of interventions and activities, including cooking, pottery and music. Following the refurbishment, there are plans to include a resource room with a smart board, improve the technology available, and enhance the existing facilities.
Pentonville

Patients have access to a wide range of group and one-to-one therapeutic sessions, such as DBT, substance misuse and art therapy. The team do not restrict access to these therapies and, if a patient has missed several sessions, they are given the opportunity to sign up for the whole course again. Patients praised the team for this as they reported they do not feel pressured to attend sessions if they are not feeling well enough. The team also discuss progression into other appropriate groups with patients, which make patients feel they are working collaboratively and involved in their care and treatment.
Downview

24 hour mental healthcare

Activities are not available for patients within 24-hour mental healthcare units seven days a week, in over two thirds of services.

Only 29% of inpatients receive a pre-arranged one-hour session at least once a week with their key worker to discuss progress, care plans and concerns.

Good practice examples

The newly opened Integrated Support Unit (ISU) enables patients to gain an enhanced level of care needed. It is an 11-bedded wing, which acts as a half-way house between a hospital and the main wings. It offers patients daily one-to-one contact with the ISU team, with dedicated core prison officers. The environment is therapeutic and social, enabling patients to build confidence during association, and has a significant impact on their recovery.
Durham

Care Programme Approach and Patient Involvement

For patients subject to the Care Programme Approach (CPA), around half of them are encouraged to be involved in their CPA meeting, and only one third are shown a copy of their draft report following the meeting with the opportunity to provide comment.

Patients in under half of services confirmed that their care plan is developed collaboratively with them and only 50% of patients were aware of having a written care plan in place that reflects their individual needs.

Good practice examples

There is a high level of patient involvement in decisions about patients' care and treatment. Patients are very clear and happy to be able to have input into the selection of their medication. Other patients also reported being involved in decisions about what group therapies to attend. It is evident the team involve patients in these decisions and their suggestions are acted upon as much as possible.
Channings Wood

Patients are very knowledgeable about the Care Programme Approach (CPA). Patients were encouraged to be involved in their care planning and CPA meetings, and are enabled to negotiate who can attend their meetings. Examples of their personal officers and probation officers being invited to meetings were given. In addition, patients are given a copy of their CPA report and able to give their own views. Overall, patients feel involved in decisions made about their care and treatment.
Grendon

Appointments

Most teams have a system in place to follow up patients who have not attended an appointment/assessment or who are difficult to engage, and they are proactive in doing so.

Good practice examples

The prison regime supports free movement and patients attend healthcare for their appointments, with plentiful access to interview and clinic rooms.
Coldingley

For patients that do not attend appointments, the reasons for this are investigated and a welfare review is opened to check in with the patient. Nursing staff review all patients who have not picked up their medication at the end of every dispensary and follow ups are conducted. Data on these aspects is taken to local quality assurance meetings for review and action planning.
Huntercombe

Joint Working and Communication

In the majoirty of prisons, the team works collaboratively with other health care providers and the prison to manage self-harm and suicidal ideation.

Almost all teams have a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.

Written policies for liaison and joint working with substance misuse services and primary care in cases of co-morbidity are only present in half of services. This is also the case for joint working with primary care to ensure high standards of physical healthcare and mental healthcare for patients with co-morbid physical and mental health problems.

Good practice examples

The team liaise well with the wider prison establishment. There are well-being wheel meetings which include discussions of physical and mental health. The team also attend complex case meetings, weekly safer custody meetings and weekly substance misuse meetings. The involvement of the mental health team within the establishment is also reported by partner agencies, who find their help and support valuable in managing self-harm and suicidal ideation. The team's involvement is also reflected in positive comments from partner agencies in survey responses.
Channings Wood

The mental health team has a commendable working relationship with partner agencies, with the prison staff praising their communication and support around the establishment. The team's relationships with Mind and Rethink, who provide the primary mental health care, were observed as being positive, with all teams working well together in order to deliver a high-quality service.
Low Newton

The team offer distraction techniques, including the BOB box (Big Orange Box) for in-cell activities, and art therapy.
Frankland

Referral, discharge and transfer

On average, services fully met 77% of standards in this area, ranging from 25% to 100% compliance.

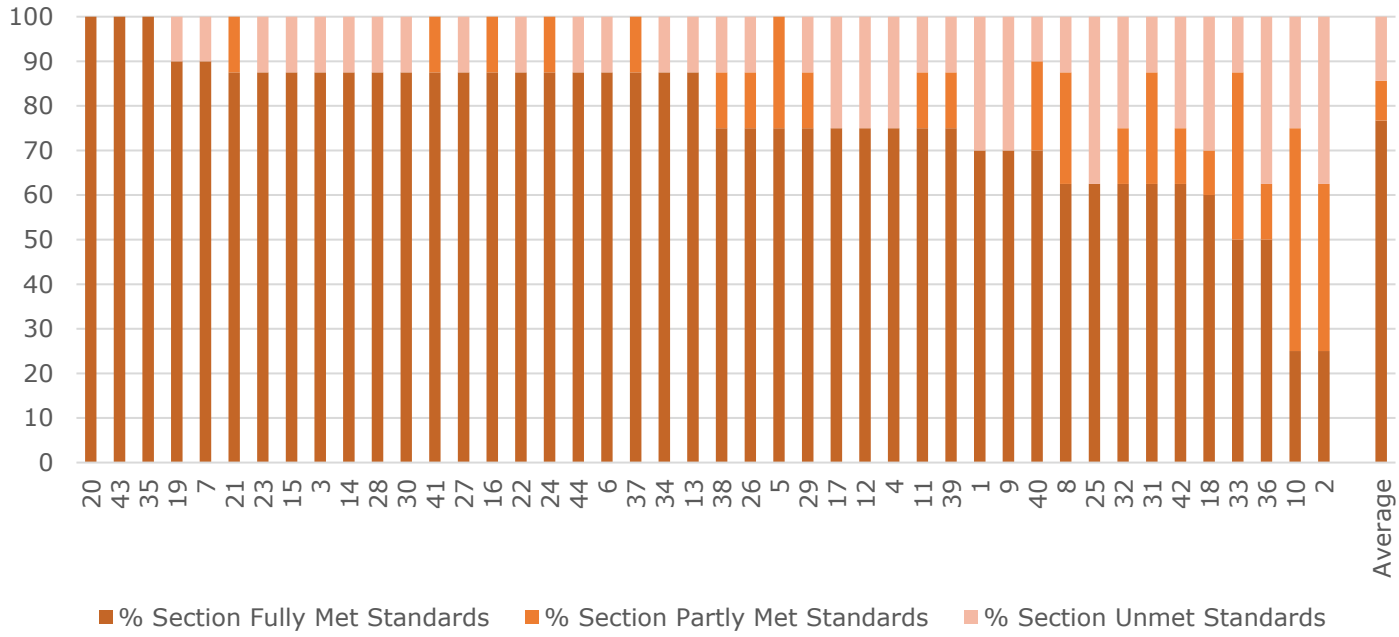


Figure 5: Service compliance for referral, discharge and transfer

Referral, transfer and information sharing

Just over half of services have an agreed policy that identifies the role of the team in initiating, facilitating and managing referrals to outside hospitals.

When a patient is transferred to another prison, the mental health team in most services provides a comprehensive handover to the receiving prison's mental team before the transfer takes place.

Discharge planning

In 80% of services, an identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning CPA meetings.

The care co-ordinator or equivalent is involved in discharge/transfer planning by the majority of services.

Good practice examples

On discharge, the service provides the patient with a discharge letter, which contains information around crises and their closest GP practices. They do so by contacting the Home Office and finding out the closest GP practices to the individual. Additionally, they conduct a welfare check the day after release.
Morton Hall IRC

A transfer and discharge coordinator supports the team in managing complex cases. They plan the discharge and the safe transfer of patients to hospital; the team members commented on how useful the support is.
Send

The team send discharge letters to all patients; these are created collaboratively from a multi-disciplinary perspective. The letters detail what engagement the patient has had with the doctor, occupational therapy, psychology and what medication they are taking. They also detail referrals being made to appropriate receiving services.
Brixton

Through the gate, handovers and follow up

Only 14% of teams conduct a follow-up interview with the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from prison.

On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service in most cases.

Good practice examples

A prisoner continuity aftercare management (PCAM) meeting helps individuals after they have left the prison. The team has good links with the two homeless organisations in Dublin, who will house patients who have nowhere to live upon release. There is a social worker in place to engage with families and try and reduce the revolving door situation.
Dochas Centre

When patients are discharged from the inpatient ward the team will support their transition carefully. The team work on transition support with follow-up on the third- and seventh-day following discharge from 24-hour healthcare. The team described good links with the community mental health services. This includes the medium and high secure services, who assist with assessments and advice when needed. HMP Birmingham provide gate keeping services across the West Midlands region to provide support and recommendations.
Birmingham

The team has a through-the-gate worker who supports patients in their transitions to the community. This allows for further support for those being released or transferred from the prison and allows for the staff member to conduct a follow up interview with the patient/new care coordinator 14 days after release/transfer from the establishment.
Wandsworth

Due to the complex nature of patients and their circumstances, the team now refer patients without an address or identified GP to the community crisis teams. For those with an identified GP, a handover is given to the receiving primary health service when a patient is transferred or released, however the team also give a detailed letter to the patient to hand to their GP of their history from prison and their current medication.

The Mount

The team has good working relationships with the community and external services, and their attendance at a patient's first Care and Treatment Plan (CTP) meeting ensures consistency in relation to the continuity of care.

Parc

There are effective systems in place to ensure a quick and efficient transfer of patients, as the consultant forensic CAMHS psychiatrist at the service maintains liaison with inpatient units to ensure a seamless transition and a good access to beds for an inpatient assessment if required.

Werrington

Patient experience

On average, services fully met 78% of standards in this area, ranging from 33% to 100% compliance.

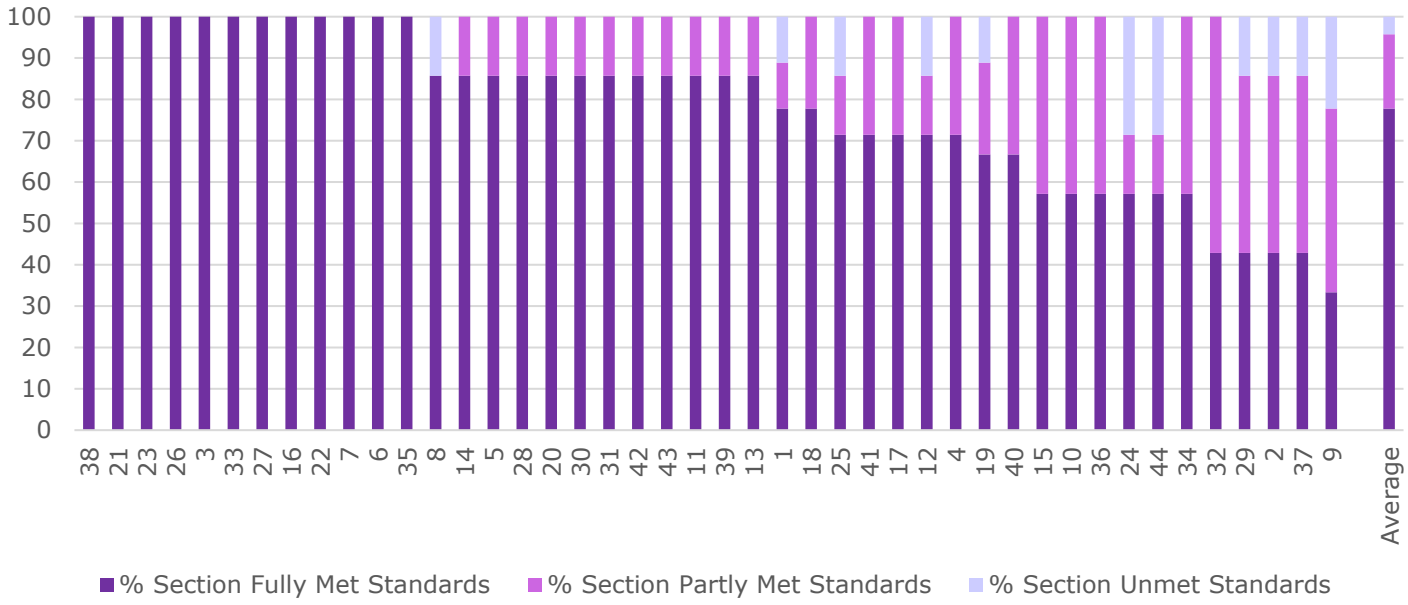


Figure 6: Service compliance for patient experience

Patient care

Patients in 95% of services communicated that they are treated with compassion, dignity and respect, and 89% felt listened to and understood in consultations with staff members.

Within 24-hour mental healthcare settings, 71% are engaged in active conversation at least twice a day by a staff member.

Two-thirds of patients reported feeling involved in decisions about their care, treatment and discharge/release planning.

Information

In most services, a patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded.

66% of services provide patients with the opportunity to feed back about their experiences of using the service.

Patients in just over half of services have received explanation both verbally and in writing on confidentiality and its limits.

Good practice examples

Inside Recovery workers gain feedback from patients about healthcare, and co-produce initiatives and recovery-focused solutions within the service. They are trained in mental health as instructors, and assist individuals in becoming healthcare, and mental healthcare representatives. They have recently co-designed and been granted money from commissioners for a mental health phone line service. This has been driven by service users and will complement the Samaritans phone line.
Birmingham

A weekly drop-in Recovery Café has begun on a Friday afternoon, hosted by the team. It provides residents an informal environment to talk about well-being. Drink orders are taken by residents working in the canteen and table service is provided.
Low Newton

The Mental Awareness Peer Support (MAPS) intervention is an effective way of providing a support service for people in prison. This involves employing and providing training to people in prison to support men experiencing difficulties with their mental health. This intervention provides individuals with meaningful activity and contributes towards enabling individuals to take care of their own mental health issues.
Ranby

Respect

Patients in almost all services reported feeling that they are treated with compassion, dignity and respect. A number of direct quotes from patients are displayed below:

Patient safety

On average, services fully met 70% of standards in this area, ranging from 25% to 100% compliance.

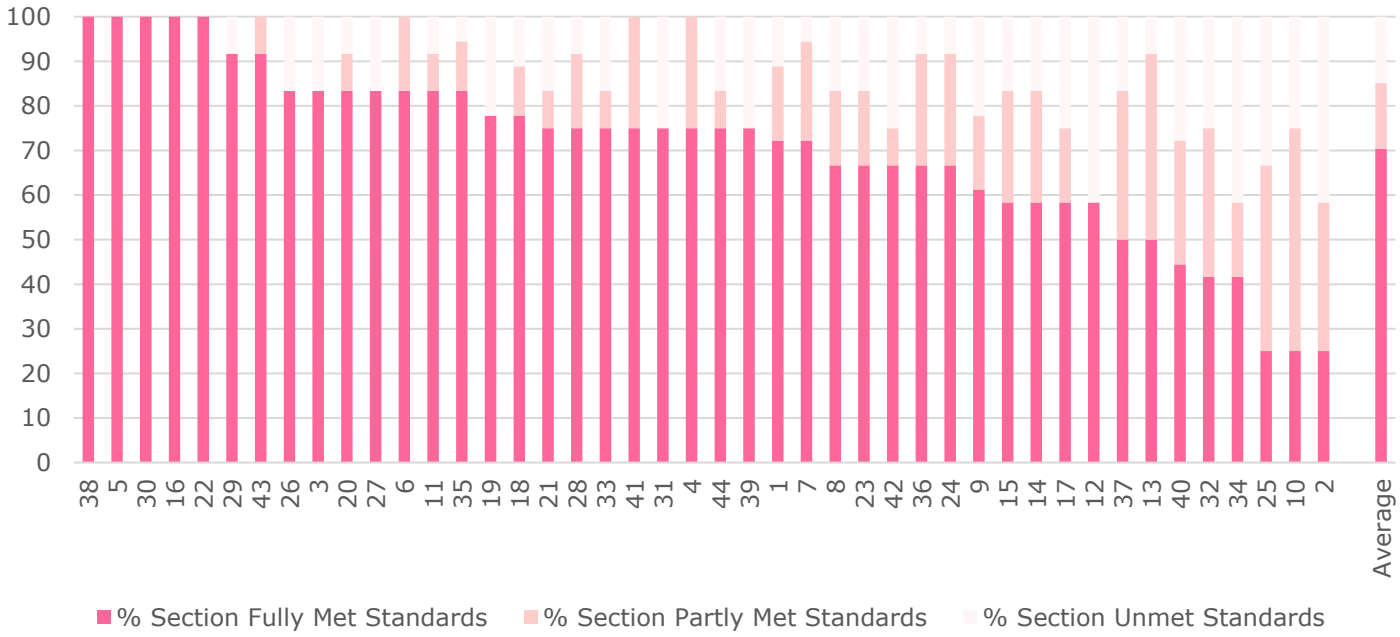


Figure 7: Service compliance for patient safety

Mental health awareness

In 61% of services, the team does not have direct involvement in delivering training sessions or has not inputted into the development of training content and learning materials for the establishment's mental health awareness training.

Good practice examples

The learning disability nurse has liaised with MENCAP and developed a five-day, five module programme which is delivered in addition to mental health awareness training to prison staff on learning disabilities, helping to increase awareness and understanding of learning disabilities and allowing for better communication.
Belmarsh

The mental health team deliver all mental health awareness training, which involves service users and is specifically tailored to the needs of the population within HMP Downview. The team is also very involved following serious incidents such as bereavements, with staff visiting the wing where the incident has occurred and speaking to every prisoner, regardless of whether they are patients within their caseload or not, to offer support.
Downview

Barnet, Enfield and Haringey Mental Health NHS Trust has designed and produced an excellent 'inside guide' for people in prison to have the opportunity to do more to help themselves while in prison. The guide focuses on ways to cope in prison, keeping busy, helping yourself and planning your future. It contains useful advice and guidance for managing prison life, setting goals for release, maintaining a healthy mind and body, and useful contact information. It also includes puzzles and ideas for activities.
Pentonville

Healthcare information packs for reception staff and new receptions have recently been introduced, containing information on the range of services available, including mental health provision. The leaflets are specifically targeted to referrers, prisoners, carers and families. The packs also include healthcare application forms to support individuals in self-referring. Another recent initiative has the mental health champions visiting women arriving at the prison to inform them of the mental health service, and issue distraction packs.
Send

As part of a mental health first aid initiative, the development of a 'stress pack' promotes self-help for patients. These packs include crisis information, distraction, relaxation and mindfulness techniques, as well as educational information for patients. Every residential unit will have a pack and access to the resources as well as simple advice regarding signposting.
Northumberland

The service writes a monthly patient newsletter in conjunction with the physical healthcare team and Addaction, the drugs and alcohol team. This newsletter covers aspects such as practical information and tips on being physically and mentally healthy, dealing with sleep problems and quitting smoking. This includes service users' poems and stories. It also raises the profile of the team within the prison establishment.
Lincoln

Interventions

All services review patients' medications at least weekly.

In 70% of cases, 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.

Only 52% of patients confirmed that they are given information on the intervention being offered and the risks and benefits are discussed with them.

Less than half of services audit the safe use of high risk medication at a service level, at least annually.

Safety processes and information sharing

Staff within most teams understand and engage in prison service policies on reporting incidents according to the Mercury Intelligence System (MIS).

Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and young people in 91% of services.

In 30% of services, team members do not fully understand and engage in policies on food refusal and mental capacity assessments.

Access to outdoor space

In only 57% of services, inpatients are able to access safe outdoor space every day.

Environment

On average, services fully met 69% of standards in this area, ranging from 29% to 100% compliance.

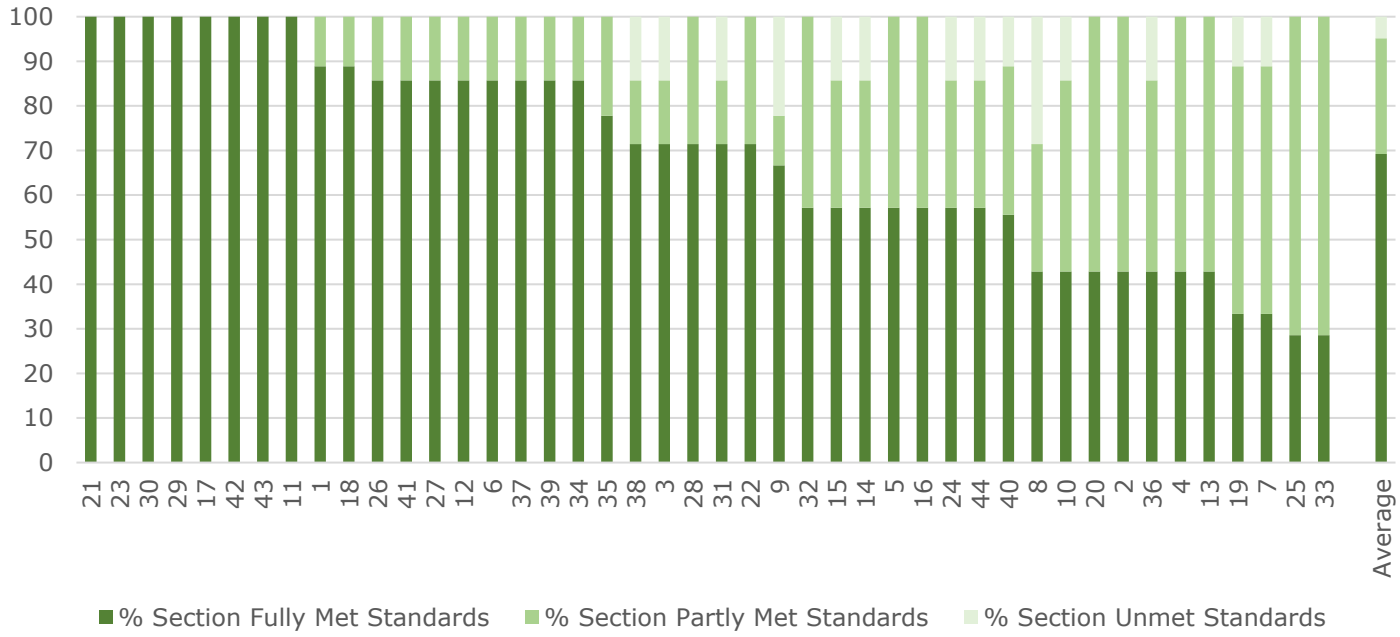


Figure 8: Service compliance for environment

Environment

Around 30% of services do not have sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements.

68% of services have designated rooms for the team to run clinics and one-to-one sessions.

Only 57% of services have access to clinical rooms that are private and where conversations cannot easliy be over-heard.

Over half of services do not have interview rooms situated close to staffed areas, have an emergency call system, an internal inspection window and the exit is unimpeded.

Good practice examples

In conjunction with the prison, the team is establishing a debrief room to provide staff with a space to discuss and reflect on serious incidents.
Elmley

The team has a number of rooms available for one-to-one clinics and larger rooms for group sessions; they are private, spacious, with adequate alarm systems and are close to well-staffed areas. The team shares a large office with healthcare and have their own desk space. There is a positive environment around the healthcare unit and induction wing. Patient art and professional graffiti is on display, and there are inspirational quotes on the walls.
Lincoln

The mental health team has recently moved to a new office in the prison, providing the team with a larger space and more computers to work on. The new office is now located on the main corridor of the prison, making the team more accessible to neighbouring wings and patients.
Low Newton

The prison environment has a calm atmosphere and sense of community. There are a number of flowerbeds and gardens that are tended to by prisoners, and the mental health team support and promote various different ways that the residents can stay active such as getting involved in working on the prison farm.
North Sea Camp

The Ashley Room at the service has a therapeutic feel. The service received funding from the Howard League to decorate the room, which now includes art murals, sofas and mood lighting. The room is used for family visits to create a homelier environment.
Deerbolt

The interview booths that the staff use on the first night centre are impressive. Each room has observation windows and alarm buttons, as well as a computer. This allows staff to complete their work efficiently and in a safe manner. The mental health team also have a large room on healthcare for their own use, which is equipped with an alarm, computer and the space for group work if needed. The IAPT worker also has her own room to carry out interviews and group therapy.
Leeds

Within an enhanced support unit, there is a sensory room that includes facilities for different lighting, vibrating padded walls and classical music. The young people have access to gardening activities, sessions to develop their kitchen skills and there is a small gym on the wing dedicated to the group. The mental health team have been heavily involved in the development and creation of this unit.
Feltham

The environment where the team operates is welcoming, spacious and free-flow, which was refreshing to observe in a category A establishment. Patients can wait for their appointments in a central communal space that includes a pool table, a seating area and access to refreshments.
Maghaberry

Appointments

The prison and healthcare regimes ensure that patients are able to attend appointments with the team at the scheduled appointment time in 70% of services.

Good practice examples

The team has a dedicated officer to collect patients and bring them to their appointments, in order to reduce the number of patients that do not attend.
Leeds

Day facilities and 24 hour mental healthcare

An audit of environmental risk, including ligature risks, is conducted annually and a risk management strategy is agreed with the prison, in just 43% of services with a 24-hour mental healthcare facility.

Good practice examples

The ongoing developments being made to improve the D2 wing was evident, with patients now contributing to adding artwork to the walls and assisting in decorating the area. The environment was observed as light and welcoming, and music is played throughout the wing for patients. The newly built interview rooms are fit for purpose and informative, with leaflets and handouts readily available for patients to take. The prison is developing plans to encourage a more therapeutic environment, and collaboration with the prison team regarding this was impressive. The population on the landing were noted to be predominantly psychotic young men and the inherent risk to the PICLS team in managing this was noted.
Cloverhill

The inpatient unit is a calming and peaceful environment, promoting patients' wellbeing. The environment was bright and clean, and comparable to that of a hospital ward. Patients' cells are also large and bright. There are dedicated healthcare officers and RMNs who work 24/7 on the ward, enabling a trusting relationship to build between staff and patients. Within the inpatient ward there are therapeutic rooms for group sessions and one-to-one clinics to happen. There is a dinner table in the centre of the unit, where patients sit together and eat at meal times to encourage social engagement and recovery.
Birmingham

Workforce capacity and capability

On average, services fully met 71% of standards in this area, ranging from 25% to 100% compliance.

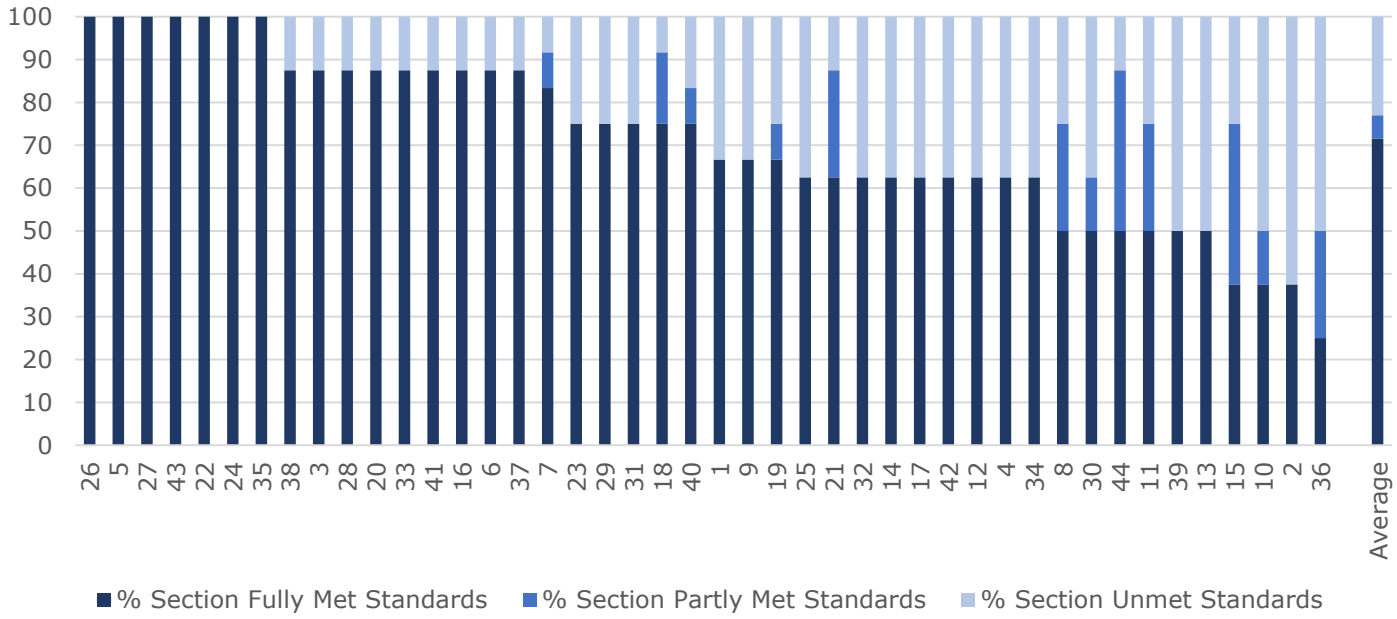


Figure 9: Service compliance for workforce capacity and capability

Written arrangements and communication

The majority of services have a minimum of monthly multi-disciplinary team clinical meetings, which are recorded with written minutes.

70% of services have clear written protocols outlining prescribing responsibilities between psychiatrists, GPs and nurse prescribers.

Capacity management plans are in place to ensure continuity of service in the event of leave or sickness in just under two-thirds of services.

Good practice examples

The team are held in high regard by partner agencies and were praised by members of their wider team for being approachable, responsive, collaborative, present around the prison, reliable, supportive, hardworking and communicative. The team work jointly with partner agencies and share the responsibility of finding the most appropriate ways to work with patients and proactively overcoming barriers or blockages to treatment and intervention.
Isis

There is an hour-long weekly multi-disciplinary team meeting which is well attended by other agencies, including chaplaincy, Forward Trust (the alcohol and drug agency) and healthcare. This allows for the allocation of referrals through the appropriate pathway, and for a more in-depth update on current patients.
The Mount

Staff Members, Skill Mix and Therapies

86% of services have access to specialists relevant to the needs of the patient group.

Only one quarter of services conducted a review of the staff members and skill mix of the team within the past 12 months, to identify gaps in the team and to develop a balanced workforce which meets the needs of the service.

Good practice examples

The service has access to several specialisms relevant to the patient group, including a learning disability nurse, personality disorder nurse, acupuncture practitioner, learning disability psychiatrist, addictions psychiatrist and staff trained in conducting Eye Movement Desensitization and Reprocessing (EMDR) therapy.
Deerbolt

The role of the duty worker is well established, with this individual being alleviated of their case load whilst fulfilling this role to ensure that they are wholly available to attend an emergency and urgent cases. This further ensures the safety of patients and is a clearly defined role within the team with responsibilities that are understood by wider prison staff also.
Nottingham

The team appear to work well together and consists of a range of professionals within the MDT, including a through the gate worker, social worker, transfer and discharge coordinator and lead learning disability nurse. There are also mental health nurses working in primary healthcare and on the inpatient unit. Although the staff have been under stress due to recent inspections and serious incidents, the team remain positive and dedicated to their work within the prison.
High Down

The service has a lot of occupational therapy input embedded in the team, with two full time occupational therapy professionals facilitating a range of different group activities, including stress management, relaxation, art and drama groups, reading groups and positive steps group. They are currently working towards co-facilitating these activities with the prison.
Maghaberry

Workforce training, CPD and support

On average, services fully met 68% of standards in this area, ranging from 9% to 100% compliance.

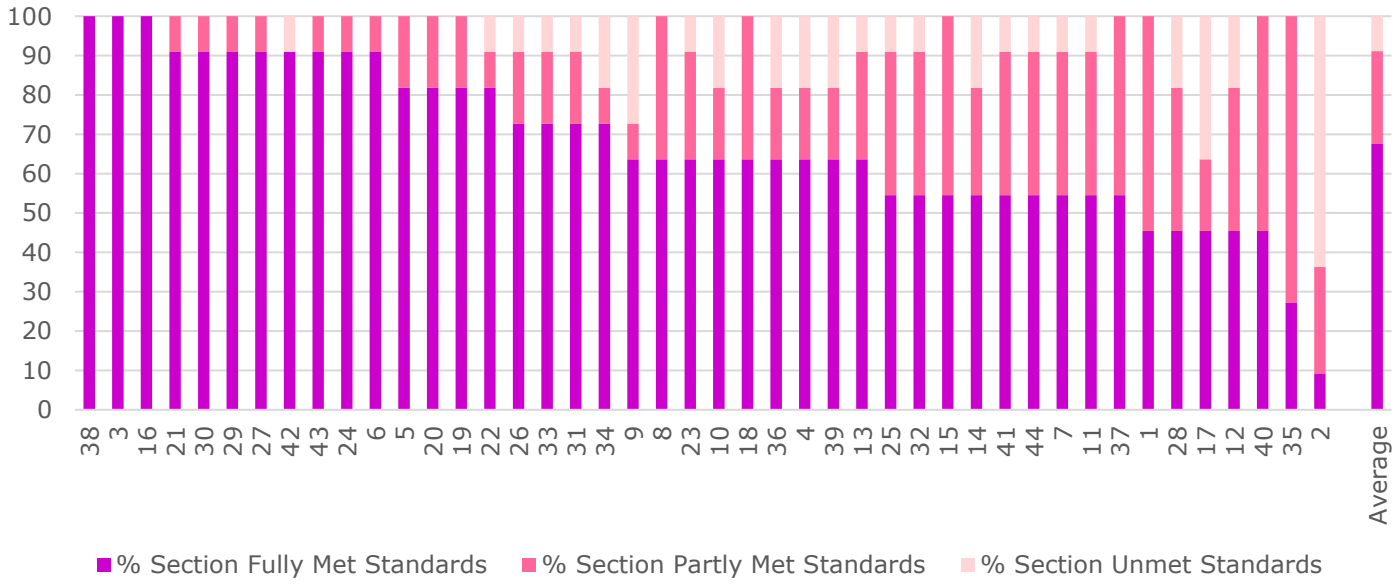


Figure 10: Service compliance for workforce training, CPD and support

Training and professional development

Staff in nearly all services receive an annual appraisal and personal development planning.

Staff in 95% of services receive training consistent with their role and in line with their professional body.

Staff in around three-quarters of services confirmed receiving an appropriate induction programme specific to the service.

Around half of staff members have not received SystmOne training and are not competent in its use.

Half of staff members have not received a full local prison induction within 28 days of commencing employment and before being issued with keys.

Good practice examples

Staff described valuing the access to training and the available opportunities to upskill, for instance some staff have attended training in DBT and MBT. Furthermore, the clinical psychologist recently provided training sessions on care planning and motivational interviewing to enhance staff knowledge and confidence, and to improve consistency in practice.
Dartmoor

The team's consultant psychiatrist provides weekly in-house training sessions as part of team meetings. Recent sessions have focused on the stepped care model and mental state exams. The team communicated that recent away days were greatly valued and they would like to see more of these.
Elmley

Staff spoken to on the review day spoke highly of the face-to-face training opportunities. This has improved since the trust took over the contact in April 2017. Training is logged on a system called DEVELOP and staff appreciate the number of opportunities available to enhance their skill set.
Exeter

There is a vast amount of training available for staff, including a comprehensive induction programme upon joining the service and mandatory training available through e-learning. Staff are also able to access additional training, with social workers currently training in EMDR.
Isle of Wight

The staff team has access to a wide range of additional training outside of their mandatory training, allowing staff to develop additional skills and further their professional development. Staff are currently undertaking training in cognitive analytic therapy (CAT), sensory training, as well as on trauma.
Lewes

Team members valued the mindfulness and yoga sessions available to them. Staff are also able to access stress management training.
Pentonville

Staff support

In 77% of services, the health and wellbeing of staff is actively supported.

Staff in 59% of services receive monthly clinical supervision and those in 50% of services receive monthly managerial supervision.

Only 34% of services provide access to reflective practice groups.

Good practice examples

Reflective practice is well embedded in the service and is held on a fortnightly basis. All staff are able to attend the sessions and prison officers are invited to attend reflective practice held for the inpatient unit, once again showing the collaboration of the team and the prison establishment.
Belmarsh

There are a number of wellbeing initiatives to ensure the team are happy and well supported in a tough environment. This includes a wellbeing champion who is trained in mindfulness, and a wellbeing wall, where staff can make suggestions and display previous team bonding activities. Staff also attend a number of offsite staff lunches, retreats and away days. Management explained that this has resulted in high staff retention rates, despite opportunities available in nearby hospitals.

Durham

The daily buzz meetings and liaison between the team creates the opportunity for staff to give feedback and to be open about any issues they are having within their role. They feel supported by senior staff and it was reported that there is a very successful handover within the team.

Long Lartin

Staff within the team reported feeling supported by their colleagues. They valued the buddy system for new starters and the access to additional training. One staff member is currently being supported to train as a nurse prescriber.

Peterborough

Governance

On average, services fully met 71% of standards in this area, ranging from 23% to 100% compliance.

Figure 11: Service compliance for governance

Patient involvement

In only 14% of services, patients are involved in the governance and development of the team. This may include representation from a patient or a patient representative in governance meetings and/or direct consultation with the patient group on areas of development.

Good practice examples

The service has assigned six patients as mental health champions to support them in service delivery and development. They are a point of contact for their peers and they can refer individuals to the team. They co-deliver mental health awareness training to prison staff and support initiatives within the prison, for instance mental health awareness week. One of the champions described being fully involved in the continual development of the role; they attend bi-weekly meetings and maintain good communication with the team.
Coldingley

The patient representative is very involved with the team and highly valued by patients. Their duties involve attending the induction of new admissions to provide information about the mental health team, attend weekly meetings to provide feedback from patients, assist in the delivering of training when required, and help promote the improvement of the service provided to patients.
Downview

There is a monthly healthcare focus group in which patient representatives attend to provide feedback about the team. This initiative allows patients to be directly involved in the governance and development of the service. Patients spoke highly of this experience.
Nottingham

There is a dedicated patient representative, who is currently employed in a paid position by the team as a full-time mental health and lead substance misuse champion. Patients receive an induction from the patient champion, along with continued support and representation.
Drake Hall

The involvement and experience group meetings have been in place at the service for 18 months and consist of representatives from all units. These meetings led to the development of a monthly newsletter. The aim is to tie in the newsletter to open days, health and well-being, patient forums and awareness days. Patients can contribute to this, for example with poetry and artwork, and this is disseminated out to all different departments, including healthcare, the library, the education centre and it is uploaded onto the prison staff intranet.
Morton Hall

Research and academic activity

Over half of services do not engage in service relevant research and academic activity.

Good practice examples

The team has a huge involvement in relevant research and academic activity, particularly in researching their own performance. This includes the published 'STRESS-testing clinical activity and outcomes for combined prison in-reach and court liaison' paper, observational cohort studies and cross-sectional research. The team's capability of comparing their past and present performance within the prison is an area of fantastic practice, especially considering the mounting pressure the service is under regarding reduced permanent staffing levels (particularly nursing staff) since previous assessments and the increasing lack of resources nationwide.
Cloverhill

The team has good engagement in research and academic activity. Most recently, the team has worked on a thematic analysis of deaths in custody and incidents of self-harm and suicide. In addition, a Ministry of Justice funded project is taking place, considering the delivery of culturally appropriate approaches to BAME offenders.
Elmley

The team is involved in a range of academic activity and they have strong links with universities. Several students work there on a regular basis and in a range of roles, promoting recruitment and employment opportunities. In addition, the team is involved in research on reducing sexual arousal using pharmacological interventions.
Isle of Wight

Governance and quality processes

Almost all services have a representative of the team as part of the prison clinical governance and quality processes.

91% of services ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.

Staff members in 84% of services feel able to raise any concerns they may have about standards of care.

Lessons learned from incidents are shared with the team and disseminated to the wider organisations in 84% of services.

Data on missed appointments are reviewed at least annually in just 55% of services. This is done at a service level to identify where engagement difficulties may exist.

Good practice examples

The trust employs a data analyst who oversees the auditing and performance processes. This individual ensures audit cycles are fully completed and that lessons learned are disseminated.
Thameside

The team has a pro-active approach to shared learning, with management encouraging this as much as possible. Staff are encouraged to visit other establishments in the trust to review their processes and to share experiences and learning.
Holme House

A robust and comprehensive action plan is in place for the service to work towards achieving. This is regularly reviewed in line with its set deadlines.
Lowdham Grange

Monthly development meetings have been introduced, which provides an opportunity to reflect on the service the team are providing, ways in which this can be improved, as well as devising ways of improving the service.
Stafford

Discussion summaries

Throughout the year, we facilitate an email discussion forum whereby individuals from member services, key stakeholder organisations and other interested parties can engage in conversation on topics of interest. This section identifies the themes of most interest with a summary of the discussions that took place.

Attendance at ACCTs

The original query centred around the author's team being requested to attend as many ACCT reviews as possible, with the prison expecting attendance at 100% of reviews. The mental health team described having an average of 35 ACCTs open at any one time, with up to ten per day. The team struggle to meet this demand and requested other services to share their experiences of how they manage reviews, expectations and any other helpful information.

Respondents shared the following information:

- Attendance at initial ACCT reviews by a representative of the mental health team significantly varies between establishments. Some teams attend all initial reviews, whereas others will attend if there are concerns raised regarding mental health.
- Some services provide a verbal or written response on occasions when they do not attend.
- One respondent commented that where the individual is already on the team's caseload, their keyworker will attend.
- In some cases, reviews are occasionally conducted without the team knowing.
- One respondent cited the prison service instruction which does not state that mental health staff are required to attend the review, but wherever possible, a member of staff who knows the prisoner (e.g. healthcare) should attend.
- Some establishments use daily briefing sheets and a diary to coordinate the reviews.
- One respondent argued that attending all reviews is a waste of resources and that only those with recognised mental health issues and has a history of contact with mental health services should be attended. It was suggested that improved relationships with safer custody and managing expectations appropriately may reduce the demand.
- Supporting the suicide and self-harm training to improve education in this area was also suggested.

Based on the responses outlined, the service that posted the initial query created a protocol for ACCT that was shared with the group. They trialled this within their own service. The discussion highlights a need for a nationally agreed protocol of the implementation of ACCT.

Prescription times

Concerns were flagged around prescription times being made earlier and patients having to take their medication at inappropriate times, specifically sedative medication.

Respondents shared the following information:

- Prescription times varied significantly between establishments and compete with the establishments' regimes. Some services reported having to administer sedatives as early as 4pm.
- One service completes a medication round with an officer and administers night sedation around 10pm for those that cannot have medication in possession. Another provides a late service in cell between 7:30pm and 8:15pm.
- Concerns around the safety of staff when issuing medication at night were raised and that this practice is avoided by GPs and psychiatrists.
- It was commented that the practice may have a detrimental impact on recovery and lead to worse outcomes for patients. It also limits normalisation and reintegration of patients back into society.

From the high number of responses received, it is evident that this practice is variable across the prison estate. The practice would benefit from review and a more robust national framework to support the administering of such medications in prisons.

Transgender patients

The discussion was started by a service wanting to provide awareness training to their mental health teams on transgender offenders and requesting suitable materials for this purpose.

Respondents shared the following information:

- One service engaged with a local transgender support group and delivered training to staff.
- Comments were made on the limited material available and the difficulty in delivering such training, as a result. A suggestion was made to work with experts by experience.
- Others alerted the group to current work taking place in this area and offered to share the materials on completion.

Ultimately, the discussion highlighted the need for greater work in this area and for the development of specific training packages to support clinicians.

Appendix

Appendix 1 – Member services' contact details and information

Service	Contact Details	Information
Belmarsh *Oxleas NHS Foundation Trust*	Sunita Arjune Operational Manager s.arjune@nhs.net 0207 147 5010	**Prison Provider:** Public **Population Size:** 900 **Type:** Male **Category:** A **Dedicated Beds:** 25
Birmingham *Birmingham and Solihull Mental Health NHS Trust*	Tracey Fisher Service Manager (Mental Health) tracey.fisher@bsmhft.nhs.uk 0121 598 8009	**Prison Provider:** Private **Population Size:** 1500 (1240 at time of review due to wing closure) **Type:** Adult male **Category:** B **Dedicated Beds:** 15 **Exclusion Criteria:** Personality disorder
Brixton *Barnet, Enfield & Haringey Mental Health NHS Trust*	John Martins Team Manager john.martins01@hmps.gsi.gov.uk 020 8588 6161	**Prison Provider:** Public **Population Size:** 850 **Type:** Adult male **Category:** C **Patients on Caseload:** Approx. 100 **Exclusion Criteria:** Those requiring or undergoing detoxification regimes.
Bullingdon *Midlands Partnership Trust*	Rebecca Byrne Team Manager rebecca.byrne@sssft.nhs.uk 01869 353425	**Prison Provider:** Public **Population Size:** 1114 **Type:** Adult male and YOI **Category:** B **Patients on Caseload:** 58
Channings Wood *Devon Partnership Trust*	Julie Donaghue Business Manager j.donaghue@nhs.net 01626 884475	**Prison Provider:** Public **Population Size:** 731 **Type:** Adult male **Category:** C **Patients on Caseload:** 66
Cloverhill Remand Prison *Health Service Executive*	Conor O'Neill Consultant Forensic Psychiatrist cjoneill@irishprisons.ie 003531 2157585	**Prison Provider:** Public **Population Size:** 400 **Type:** Male, mainly remand **Category:** Closed, medium secure **Patients on Caseload:** 28 **Dedicated Beds:** 29
Coldingley *Central & North West London NHS Foundation Trust*	Ishmael Nyachengwe Team Leader ishmael.nyachengwe@nhs.net 01483 344641	**Prison Provider:** Public **Population Size:** 512 **Type:** Adult male **Category:** C **Patients on Caseload:** 31

Dartmoor *Devon Partnership Trust*	Julie Donaghue Business Manager j.donaghue@nhs.net 01626 884475	**Prison Provider:** Public **Population Size:** 640 **Type:** Male **Category:** C **Patients on Caseload:** 73
Deerbolt *Tees, Esk and Wear Valleys NHS Foundation Trust*	Tracey Keaveney Mental Health Team Manager tkeaveney@nhs.net 0191 3765221	**Prison Provider:** Public **Population Size:** 538 **Type:** Male, sentenced YOI **Category:** YOI **Patients on Caseload:** 142
Dochas Centre, Mountjoy Women's Prison *Health Service Executive*	Ronan Mullaney Consultant Forensic Psychiatrist ronan.mullaney@hse.ie +35312989266 Ext 283	**Prison Provider:** Public **Population Size:** 136 **Type:** Female sentenced and remand **Category:** Closed
Downview *Central & North West London NHS Foundation Trust*	Lee Thorogood Head of Healthcare l.thorogood@nhs.net 0208196622	**Prison Provider:** Public **Population Size:** 350 **Type:** Female **Category:** Closed **Patients on Caseload:** 110
Drake Hall *Midlands Partnership Trust*	Helen Broad Team Manager helen.broad@mpft.nhs.uk 01785 221529	**Prison Provider:** Public **Population Size:** 340 **Type:** Female **Category:** Closed
Durham *Tees, Esk and Wear Valleys NHS Foundation Trust*	Kayleigh Parris Team Manager kayleigh.parris@nhs.net 01913323400	**Prison Provider:** Public **Population Size:** 1100 **Type:** Adult male **Category:** B **Patients on Caseload:** 15-20% of population on caseload **Dedicated Beds:** 11
Elmley *Oxleas NHS Foundation Trust*	Dean Grace Mental Health Team Manager dean.grace@nhs.net 01795 802234	**Prison Provider:** Public **Population Size:** 1252 **Type:** Adult male **Category:** B **Patients on Caseload:** 87
Exeter *Devon Partnership Trust*	Julie Donaghue Business Manager j.donaghue@nhs.net 01626 884475	**Prison Provider:** Public **Population Size:** 561 **Type:** Adult male **Category:** B **Patients on Caseload:** 64

Feltham *Barnet, Enfield & Haringey Mental Health NHS Trust*	Brian Ashley Service Manager brian.ashley@nhs.net 0208 844 5440	**Prison Provider:** Public **Population Size:** 540 **Type:** A side, aged 15-18; B side, aged 18-21 **Category:** YOI; B/A **Patients on Caseload:** 10-15
Frankland *Tees, Esk and Wear Valleys NHS Foundation Trust*	Claire Hammal Team Manager chammal@nhs.net 0191 3765221	**Prison Provider:** Public **Type:** Adult male **Category:** A, B **Exclusion Criteria:** Westgate patients (severe personality disorder unit)
Grendon *Barnet, Enfield & Haringey Mental Health NHS Trust*	Lynn Glassup Bucks Cluster Prisons MHIT Manager lynn.glassup@nhs.net 01296444251	**Prison Provider:** Public **Population Size:** 238 **Type:** Adult male **Category:** B **Patients on Caseload:** 19
High Down *Central & North West London NHS Foundation Trust*	Suzanne Nunn Transfer and Discharge Officer suzanne.nunn2@nhs.net 02071476743	**Prison Provider:** Public **Population Size:** 1100 **Type:** Adult male **Category:** B **Patients on Caseload:** 161 **Dedicated Beds:** 23
Holme House/ Kirklevington Grange *Tees, Esk and Wear Valleys NHS Foundation Trust*	Richard Hand Service Manager richard.hand@nhs.net	**Prison Provider:** Public **Population Size:** 1200 **Type:** Adult male **Category:** C **Patients on Caseload:** 348
Huntercombe *Midlands Partnership Trust*	Joanne Rowsell Service Manager Joanne.Rowsell@mpft.nhs.uk 01491 643303	**Prison Provider:** Public **Population Size:** 480 **Type:** Adult male **Category:** C **Patients on Caseload:** 11
Isis *Oxleas NHS Foundation Trust*	Peter Brabander Operational Manager peterbrabander@nhs.net 0203 356 4256	**Prison Provider:** Public **Population Size:** 660 **Type:** Adult male **Category:** C **Patients on Caseload:** 34

Isle of Wight *Care UK*	**Jane Manning** **Mental Health Team Leader** **Jane.Manning@careuk.com** **01983 635360**	Prison Provider: **Public** Population Size: **1050** Type: **Adult male** Category: **B** Patients on Caseload: **140** Dedicated Beds: **Beds available, although not dedicated. Two occupied at the time of review.**
Leeds *Care UK*	Ian Cowell Mental Health Team Manager ian.cowell@careuk.com 0113 2032946	**Prison Provider:** Public **Type:** Adult male **Category:** B **Patients on Caseload:** 124
Lewes *Sussex Partnership NHS Foundation Trust*	Flis Thomas Head of Healthcare Felicity.Thomas@sussexpartnership.nhs.uk 01273 785140	**Prison Provider:** Public **Population Size:** 712 **Type:** Adult male **Category:** B **Patients on Caseload:** 76 **Dedicated Beds:** 10
Lincoln *Nottinghamshire Healthcare NHS Foundation Trust*	Suzan Lilley Clinical Matron suzan.lilley@nottshc.nhs.uk 01522 663321	**Prison Provider:** Public **Population Size:** 600 **Type:** Adult male **Category:** B
Long Lartin *Midlands Partnership Trust*	Linda Ventress Regional Lead Linda.Ventress@mpft.nhs.uk 01785 221529	**Prison Provider:** Public **Population Size:** 510 **Type:** Adult male **Category:** A **Patients on Caseload:** 158
Low Newton *Tees, Esk and Wear Valleys NHS Foundation Trust*	Teresa Purvis Clinical Lead tpurvis@nhs.net 0191 3764069	**Prison Provider:** Public **Population Size:** 352 **Type:** Female **Category:** Closed
Lowdham Grange *Nottinghamshire Healthcare NHS Foundation Trust*	Jane Barber Head of Healthcare jane.barber@nottshc.nhs.uk 01159669200	**Prison Provider:** Private **Population Size:** 950 **Type:** Adult male **Category:** B **Patients on Caseload:** 145
Maghaberry *South Eastern Health and Social Care Trust*	Ian Bownes Consultant Forensic Psychiatrist ian.bownes@setrust.hscni.net 028 92633594	**Prison Provider:** Public **Population Size:** 843 **Type:** Adult male **Category:** A

Morton Hall (IRC) *Nottinghamshire Healthcare NHS Foundation Trust*	Jaqueline Stephens, Clinical Matron Mental Health jacqueline.stephens@nottshc.nhs.uk 01522 666919	**Prison Provider:** Public **Population Size:** 392 **Type:** Adult male **Category:** IRC **Patients on Caseload:** 40
North Sea Camp *Nottinghamshire Healthcare NHS Foundation Trust*	Suzan Lilley Clinical Matron suzan.lilley@nottshc.nhs.uk 01522 663321	**Prison Provider:** Public **Population Size:** 420 **Type:** Adult male **Category:** D
Northumberland *Tees, Esk and Wear Valleys NHS Foundation Trust*	Eunice Waddell Team Manager eunice.waddell@nhs.net 01670 383100	**Prison Provider:** Private **Population Size:** 1348 **Type:** Adult male **Category:** C
Nottingham *Nottinghamshire Healthcare NHS Foundation Trust*	Adeline Hunt Clinical Matron - Mental Health adeline.hunt@nottshc.nhs.uk 0115 872 4052	**Prison Provider:** Public **Population Size:** 1060 **Type:** Adult male **Category:** B **Patients on Caseload:** 261
Parc *ABMU Health Board*	Donna Stuckey Service Manager Donna.Stuckey@wales.nhs.uk 01656 753452	**Prison Provider:** Public **Population Size:** 1800 **Type:** Adult male and YOI **Category:** B
Pentonville *Barnet, Enfield & Haringey Mental Health NHS Trust*	Junaid Dowool Team Leader jdowool@nhs.net 0207 023 7380	**Prison Provider:** Public **Population Size:** 1310 **Type:** Adult male **Category:** B **Patients on Caseload:** Around 100 **Dedicated Beds:** 22 **Exclusion Criteria:** Detox
Peterborough *Cambridgeshire and Peterborough NHS Foundation Trust*	Anne Marie Paul Service Manager Anne-Marie.Paul@cpft.nhs.uk 07980911979	**Prison Provider:** Private **Population Size:** 1312 (396 females; 916 males) **Type:** Adult and YOI male; adult and YOI female; restricted status and mother and baby unit **Category:** B and C male; closed female **Patients on Caseload:** 161

Ranby *Nottinghamshire Healthcare NHS Foundation Trust*	Lindsey Watson Clinical Matron (Mental Health) lindsey.watson@nottshc.nhs.uk 01777 8623015	**Prison Provider:** Public **Population Size:** 1050 **Type:** Adult male **Category:** C **Patients on Caseload:** 194
Send *Central & North West London NHS Foundation Trust*	Suzanne Nunn Transfer and Discharge Officer suzanne.nunn2@nhs.net 02071476743	**Prison Provider:** Public **Population Size:** 282 **Type:** Female **Category:** Closed **Patients on Caseload:** 129
Stafford *Midlands Partnership Foundation Trust*	Mark Smith Team Manager Mark.Smith@mpft.nhs.uk 01785 221529	**Prison Provider:** Public **Population Size:** 750 **Type:** Adult male **Category:** C **Patients on Caseload:** 168
Thameside *Oxleas NHS Foundation Trust*	Daniel Chikanda Service Manager daniel.chikanda@nhs.net 0208 317 977	**Prison Provider:** Private **Population Size:** 1232 **Type:** Adult male **Category:** B and C **Patients on Caseload:** 98 **Dedicated Beds:** 18
The Mount *Hertfordshire Partnership NHS Foundation Trust*	Sue Harker Interim Team Leader Susan.Harker@hpft.nhs.uk 01442836630	**Prison Provider:** Public **Population Size:** 1025 **Type:** Adult male **Category:** C **Patients on Caseload:** 56
Wandsworth *South London and Maudsley NHS Foundation Trust*	Tracey Lewis, Offender Health Service and Business Development Manager Tracey.lewis@slam.nhs.uk 07969587099	**Prison Provider:** Public **Population Size:** 1600 **Type:** Adult male **Category:** B and C **Patients on Caseload:** 140 **Dedicated Beds:** 12
Werrington *South Staffordshire and Shropshire Healthcare NHS Foundation Trust*	Mark Smith Team Manager Mark.Smith@mpft.nhs.uk 01785 221529	**Prison Provider:** Public **Population Size:** 117 **Type:** Male 15-18 years of age **Category:** YOI **Patients on Caseload:** 94

Appendix 2 – Standards for prison mental health services (3rd edition) and Standards for 24-hour mental healthcare in prisons (1st edition)

No.	Standard
1	As part of the formal prisoner induction process, all prisoners undergo health screening that incorporates a mental health assessment.
2	The secondary care mental health assessment is carried out by a mental health professional.
3	The role of the team in the screening process is clearly defined and in agreement with the prison establishment.
4	There is a clear and consistent process for prison staff to refer prisoners directly to the mental health team.
5 (C1.4)	A clinical member of staff is available to discuss emergency referrals during working hours.
6	Urgent assessments are undertaken by the team within 48 hours and routine assessments within 5 working days. *Guidance: The term 'urgent' refers to an individual in a mental health crisis, or with rapidly escalating needs or presentation, and/or at risk of immediate harm to self or others.*
7	The mental health assessment uses a standardised format, which includes a relevant previous history, an assessment of mental health, intellectual and developmental disabilities, substance misuse, psychosocial factors, risk to self and others. *Guidance: Standard mental health assessment tools are used and they are compliant with NICE guidelines.*
8 (C3.4)	The assessing professional can access notes about the patient (past and current) from primary care, secondary care and other relevant services (NICE guideline 66, 2017). *Guidance: Notes should be accessed for all patients known to mental health services and where notes are available, including how up to date the information is and how it was gathered.*
9 (C4.6)	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.
10 (C5.1)	All patients have a diagnosis and a clinical formulation. *Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation should be devised.*
11 (C17.5)	When talking to patients, health professionals communicate clearly, avoiding the use of jargon so that people understand them.

12 (C17.2)	Information is provided to patients. *Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.*
13 (C1.3)	Clear information is made available, in paper and/or electronic format, to patients and healthcare practitioners on: • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for service, including emergency and out of hours details.
14 (C3.3)	Patients are given verbal and/or written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.
15	Patients are managed under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).
16 (C8.1.6)	Patients are offered written and verbal information about their mental illness. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.*
17 (C7.3)	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting.*
18 (C7.4)	Every patient has a written care plan, reflecting their individual needs. *Guidance: This clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or stated wishes that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*
19 (C7.5)	The practitioner develops the care plan collaboratively with the patient.
20 (C7.2)	The team reviews and updates care plans according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.

21	Where applicable, patients are encouraged and supported to be fully involved in their CPA meeting, or equivalent.
22	Patients discuss, negotiate and agree with their care coordinator on who should be invited to their CPA meeting, or equivalent, and a joint decision made on what happens if people are unable to attend.
23	Patients will be shown a copy of the final draft report after the CPA meeting, or equivalent, and will have the opportunity to add their views at this stage.
24	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.
25	There are written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity in accordance with NICE guidelines 57 (2016) and 66 (2017). *Guidance: This can be an individual policy or included as part of a wider operational policy.*
26	There are contracted agreements for joint working with primary care to ensure high standards of physical healthcare and mental healthcare for patients with co-morbid physical and mental health problems.
27	The team works collaboratively with other health care providers and the prison to manage self-harm and suicidal ideation in accordance with NICE guidelines 16 (2004), 133 (2011), 57 (2016), and 66 (2017).
28	The team actively participates with the Assessment, Care in Custody and Teamwork (ACCT) process in managing the risk of self-harm and suicide. *Guidance: The mental health team attends or contributes to all ACCT reviews for prisoners under their care. They are involved in decisions about location, observations and risk.*
29 (C8.1.1)	Patients are offered evidence based pharmacological and psychological interventions and any exceptions are documented in the case notes. *Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base.*
30 (C8.2.1)	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.

31 (C9.2.1)	Patients who are prescribed mood stabilisers, antipsychotics or stimulants for ADHD are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient: • A personal/family history (at baseline and annual review); • Lifestyle review (at every review); • Weight (at every review); • Waist circumference (at baseline and annual review); • Blood pressure (at every review); • Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review).
32 (C6.2)	The team pro-actively follows up patients who have not attended an appointment/assessment or who are difficult to engage.
33 (C9.1.5)	The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.
34	There is an agreed policy that identifies the role of the team in initiating, facilitating and managing referrals to outside hospitals.
35	The process for referral and transfer of patients under Part 3 of the Mental Health Act follows the Good Practice Procedure Guide (DH, April 2011).
36	When a patient is transferred to another prison, the mental health team provides a comprehensive handover to the receiving prison's mental team before the transfer takes place. *Guidance: Where a transfer is not known, the handover is provided to the receiving team within one working day of the individual's reception to the establishment.*
37	The care co-ordinator or equivalent is involved in discharge/transfer planning. *Guidance: Planning occurs ahead of the individual's discharge/transfer and the timescale for this depends on the individual patient's presentation and identified needs.*
38	An identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning CPA meetings.
39	Referrals to community mental health services are made for those patients who require continued care and follow-up support following release.
40	On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service.

41	The team carries out a follow-up interview with the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from prison. *Guidance: This includes communication in person, by telephone, email or in writing.*
42	The patient is involved in decisions about their care, treatment and discharge/release planning.
43 (C14.1)	Patients are given the opportunity to feed back about their experiences of using the service, and their feedback has been used to improve the service. G*uidance: This might include patient surveys or focus groups.*
44 (C16.1)	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.*
45 (C16.2)	Patients feel listened to and understood by staff members.
46 (C17.3)	The service has access to interpreters.
47 (C18.1)	Confidentiality and its limits are explained to the patient at the first assessment, both verbally and in writing.
48 (C18.3)	The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded.
49	The patient is given information on the intervention being offered and the risks and benefits are discussed with them. This is recorded in clinical records.
50 (C13.1)	Capacity assessments are performed in accordance with current legislation and codes of practice.
51 (C8.2.5)	The safe use of high risk medication is audited at a service level, at least annually. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines and stimulants for ADHD.*
52	The team proactively follows up with patients who fail to collect or take their medication.
53	A system is in place for recording non-compliance with medication. *Guidance: Guidance is available to the team on the management of medication and how to deal with non-compliance.*
54	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.
55 (C10.2)	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and young people. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
56	The team understands and engages in prison service policies on food refusal and mental capacity assessments.

57	The team understands and engages in prison service policies on reporting incidents according to the Mercury Intelligence System (MIS).
58	There is a joint working policy between the prison, primary care, substance misuse services and the mental health team on the control and management of substance misuse and substances.
59	The team understands and engages in prison service policies on Multi-agency Public Protection Arrangements (MAPPA).
60	The team supports the prison establishment in the provision of mental health awareness training for prison staff in accordance with NICE guidelines 66 (2017). *Guidance: This could include: The direct involvement of the team in delivering training sessions; or the team has input into the development of training content and learning materials.*
61	The prison and healthcare regimes ensure that patients are able to attend appointments with the team at the scheduled appointment time.
62	There are designated rooms for the team to run clinics and one-to-one sessions.
63	There are designated rooms for the team to run group sessions.
64	All interview rooms are situated close to staffed areas, have an emergency call system, an internal inspection window and the exit is unimpeded.
65 (C19.3)	Clinical rooms are private and conversations cannot be easily over-heard.
66	The team has dedicated spaces and meeting rooms for confidential working.
67	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements.
68	The multi-disciplinary team consists of or has access to staff from a number of different professional backgrounds that enables them to deliver a full range of treatments/therapies appropriate to the patient population.
69	The team has access to specialists relevant to the needs of the patient group. This may include: child and adolescent mental health, intellectual disabilities (ID), autistic spectrum disorder (ASD), neuropsychiatric disorders and cognitive impairment.
70	There is a clearly identified clinical lead for the team. *Guidance: The clinical lead has overall responsibility for the clinical requirements of the service.*
71 (C22.4)	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify gaps in the team and to develop a balanced workforce which meets the needs of the service.
72	There are written arrangements and processes in place which ensure that the prison healthcare team can access specialist mental health advice out of hours.

73	Capacity management plans are in place to ensure continuity of service in the event of leave or sickness. *Guidance: This is a written document that describes the measures the service will take to manage sudden increases in demand.*
74	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' (RCGP, 2011).*
75	There is a minimum of monthly multi-disciplinary team clinical meetings, which are recorded with written minutes.
76 (C25.1)	The team actively supports staff health and well-being. *Guidance: For example; providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*
77	All permanent staff within the team receive a full local prison induction within 28 days of commencing employment and before being issued with keys. *Guidance: This includes: key security, prison awareness, the Assessment, Care in Custody and Teamwork (ACCT) process and personal protection, or equivalent.*
78	All staff who use SystmOne are fully trained and are competent in its use.
79 (C23.2)	Staff members receive an induction programme specific to the service, which covers: The purpose of the service; The team's clinical approach; The roles and responsibilities of staff members; Care pathways with other services. *Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme.*
80 (C10.1)	The team receives training consistent with their roles on risk assessment and risk management. This is refreshed in accordance with local guidelines. This training includes, but is not limited to training on: • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence.
81 (C26.3)	Staff receive training consistent with their role and in line with their professional body. This is recorded in their personal development plan and is refreshed in accordance with local guidelines.
82 (C24.1)	All staff members receive an annual appraisal and personal development planning or equivalent. *Guidance: This contains clear objectives and identifies development needs.*
83	All staff within the team receive Continuing Professional Development (CPD) in line with their personal development plan and revalidation requirements.

84 (C24.2)	All clinical staff members receive individual clinical supervision at least monthly or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. The activity should offer the supervisee an opportunity to reflect upon their practice and to think about how their knowledge and skills may be developed to improve care.*
85 (C24.6)	All staff members receive monthly line management supervision. *Guidance: Supervision forms a part of individual performance management and discusses organisational, professional and personal objectives.*
86 (C25.3)	Staff members have access to reflective practice groups.
87	A representative of the team is part of the prison clinical governance and quality processes.
88	Patients are involved in the governance and development of the team. *Guidance: This includes representation from a patient or a patient representative in governance meetings and/or direct consultation with the patient group on areas of development.*
89 (C27.4)	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.
90 (C27.1)	The team attends local business meetings that are held at least monthly. *Guidance: Business meetings address strategic matters and the general management of the service, e.g. audit processes, quality and governance systems, finance, and performance.*
91 (C6.3)	Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist. *Guidance: This should include monitoring a patient's failure to attend the initial appointment after referral and early disengagement from the service.*
92 (C27.2)	In conjunction with partner agencies, the team reviews its progress against its own local plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.
93 (C29.3)	When staff undertake audits they; • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle.
94 (C30.1)	Staff members can quickly and effectively report incidents. Managers encourage staff members to do this and staff members receive guidance on how to do this.
95 (C30.3)	Team members and patients who are affected by a healthcare related serious incident are offered a debrief and post incident support.

96 (C30.4)	Lessons learned from incidents are shared with the team and disseminated to the wider organisation. *Guidance: This includes audit findings and action planning information.*
97 (C30.5)	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations, examples of innovative practice.
98 (C20.7)	Staff members feel able to raise any concerns they may have about standards of care. *Guidance: Staff members should follow their Trust or local policy.*
99	The team engages in service relevant research and academic activity.
i1	There is an agreed operational policy which includes the following areas: • admission and discharge criteria; • admission decision making, including out of hours; • leadership of the unit, including clinical and discipline; • the clinical model of the service, including therapeutic activities and prescription/administration of medicines; • the process by which other prisons may refer to the unit when it operates as a regional resource; • the process for liaising with families; • follow-up arrangements.
i2	Patients have a comprehensive assessment which is started within 4 hours and completed within 48 working hours. This involves the multi-disciplinary team and includes the patient. An immediate care plan is completed which includes: • mental health and medication; • physical health needs; • risk assessment, including risk of suicide.
i3	The purpose of the admission is explained to the patient and an assessment of their capacity to consent to admission, care and treatment is completed within 24 hours of admission.
i4	Managers and practitioners have agreed weekly clinical review meetings that comply with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.
i5	Activities are provided seven days a week. *Guidance: This can include occupational therapy, art/creative therapies, non-therapeutic activities and in cell activities.*
i6	Each patient receives a pre-arranged one-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.
i7	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.
i8	Discharge planning begins at the first review and outcomes for discharge are agreed.

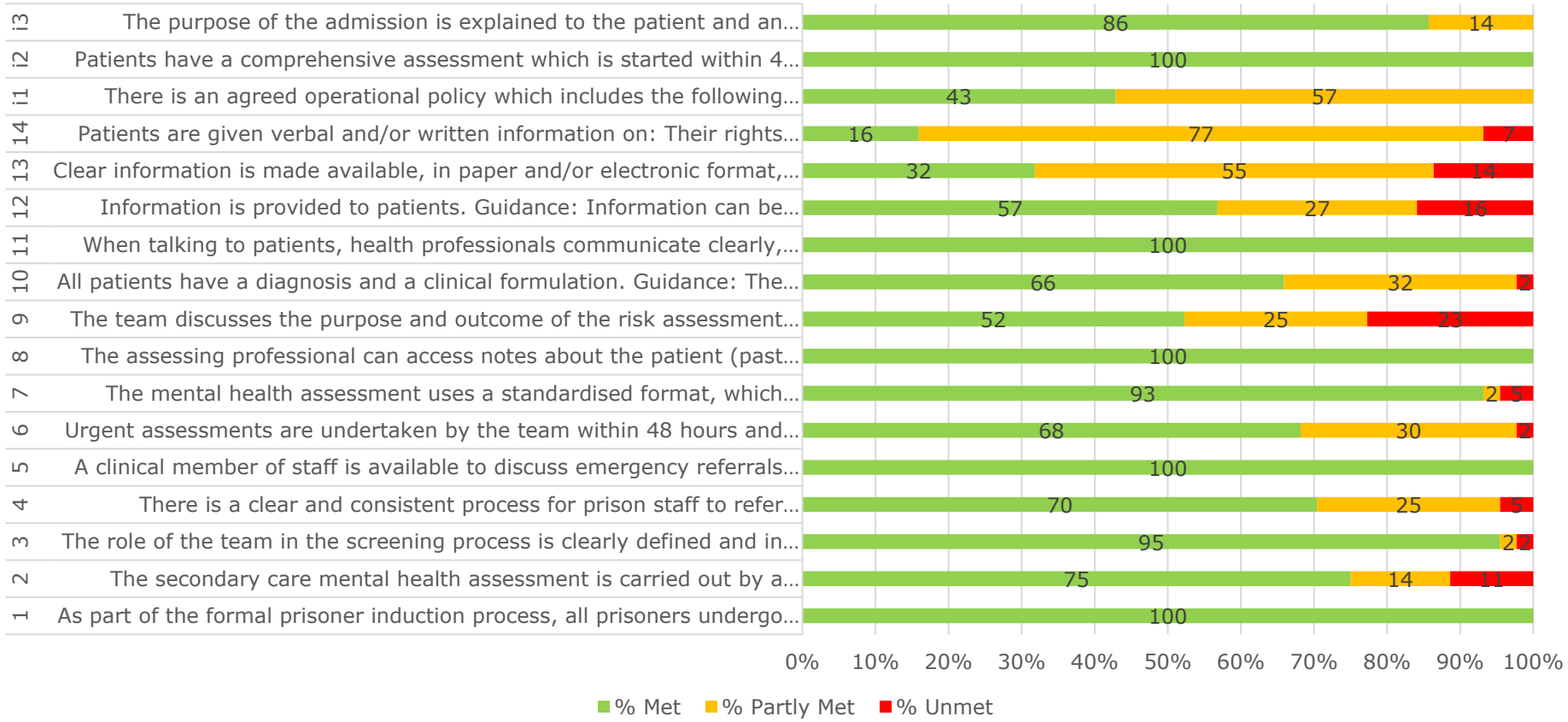
i9	There are protocols agreed with the prison to enable patients to access accident and emergency services.
i10	Every patient is engaged in active conversation at least twice a day by a staff member. *Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.*
i11	There is a weekly minuted community meeting that is attended by patients and staff members. *Guidance: This is an opportunity for patients to share experiences, to highlight issues on the unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.*
i12	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.
i13	Patients are able to access safe outdoor space every day and should be encouraged and supported to do so.
i14	Patients have their medications reviewed at least weekly. Medication reviews include: • assessment of therapeutic response; • safety; • side effects, with a clear care plan to manage them when they occur; • adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*
i15	The team keeps medications in a secure place, in line with the organisation's medicine management policy.
i16	There is a clear policy agreed with the prison concerning the management of violence and aggression within the unit. This includes: • the roles of discipline staff and healthcare staff; • the use of restraint; reviews following episodes of restraint in the unit; • audits of restraint.
i17	There is a clear policy regarding the use of rapid tranquilisation within the unit, which includes the issue of consent.
i18	An audit of environmental risk, including ligature risks, is conducted annually and a risk management strategy is agreed with the prison. *Guidance: Any problems are recorded and reported to prison senior management personnel.*
i19	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes and is maintained and checked weekly and after each use.
i20	The team has access to a specialist pharmacist and/or pharmacy technician to support their prescription of medication.

i21	There are agreed minimum staffing levels that include at least one qualified nurse present on all shifts.
i22	The unit is staffed by permanent staff members, and bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need. *Guidance: The use of agency staff is monitored on a monthly basis. An overdependence on bank and agency staff members results in action being taken.*
i23	Arrangements are in place to ensure that a doctor is available at all times to attend the unit, including out of hours.
i24	The operation of the unit is explicitly included in the commissioning specification from NHS England.

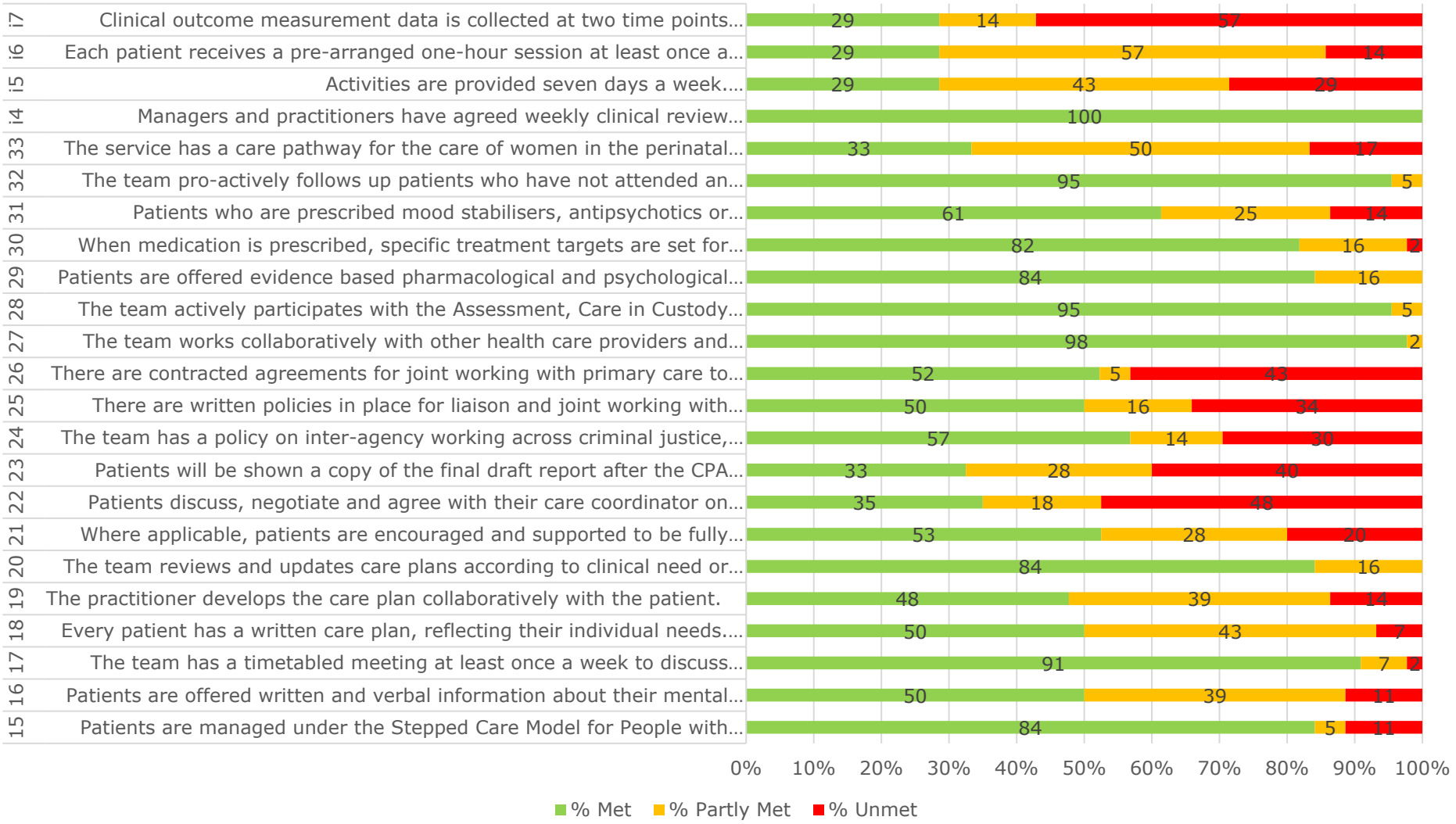
Appendix 3 – Aggregated data by standard

The following tables illustrate overall service compliance for each standard. The wording of the standards in this section has been condensed for the purposes of presentation. A full list of standards used in cycle 3 can be found in appendix 2.

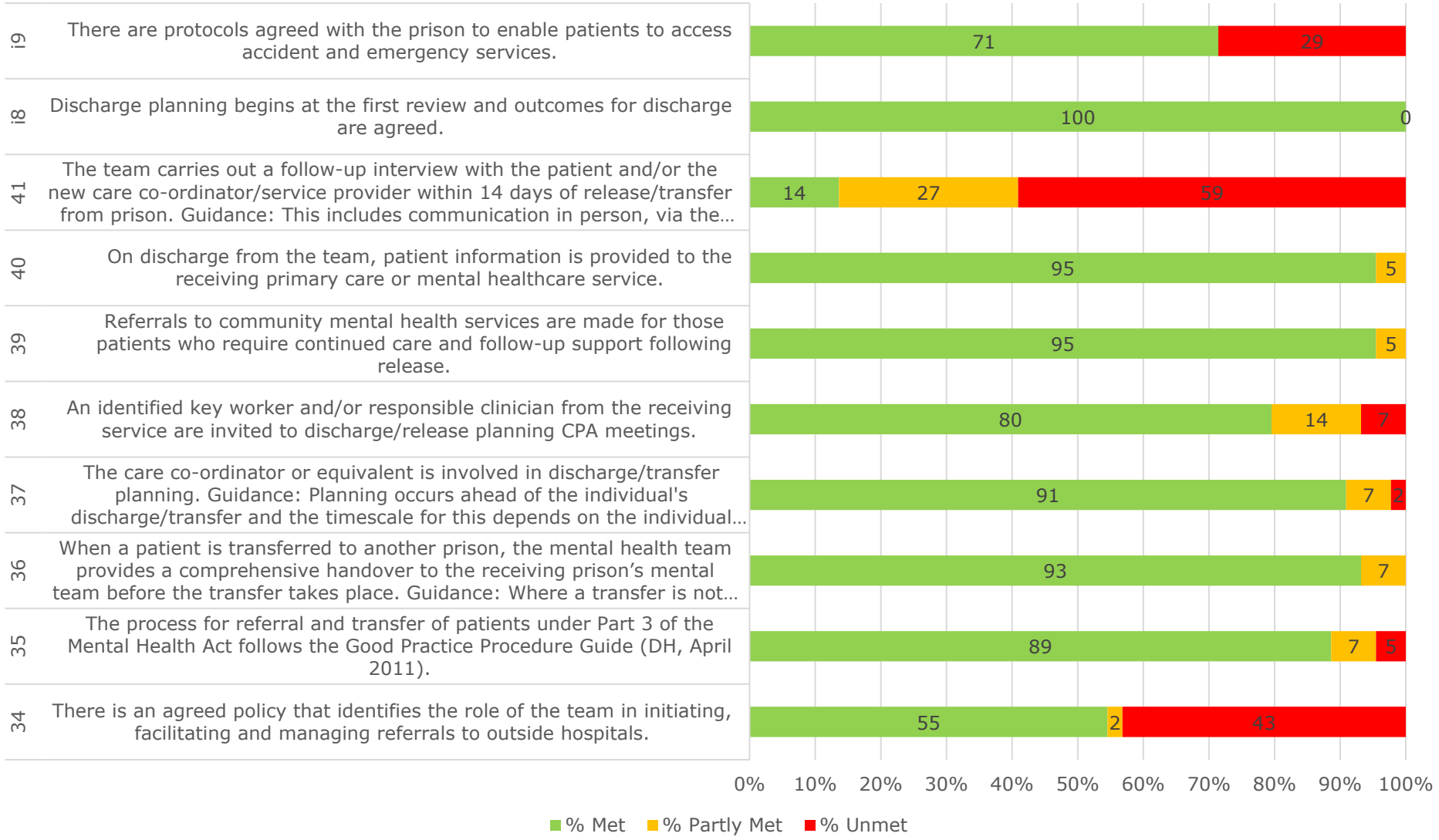
Admission and assessment



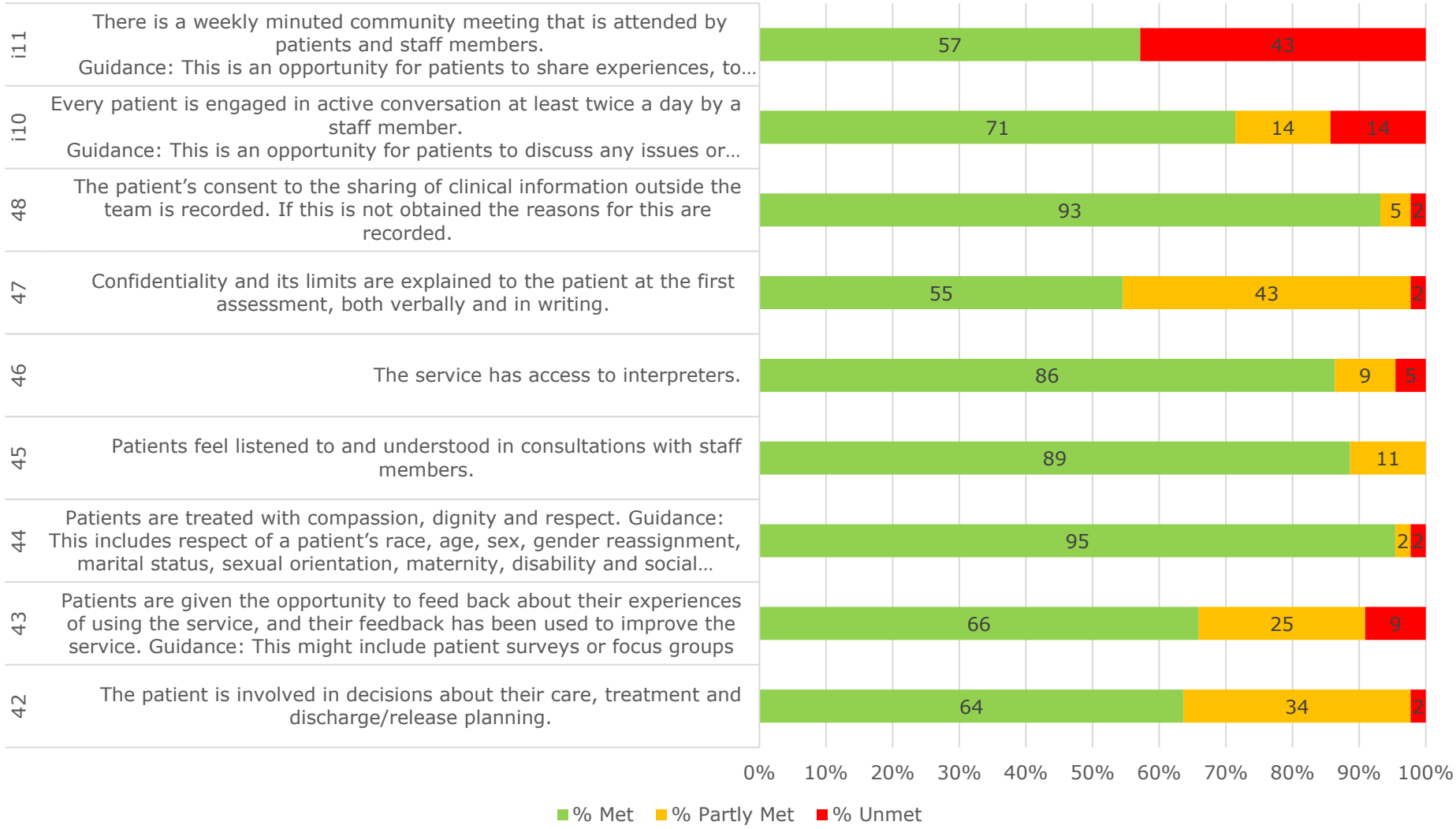
Case management and treatment



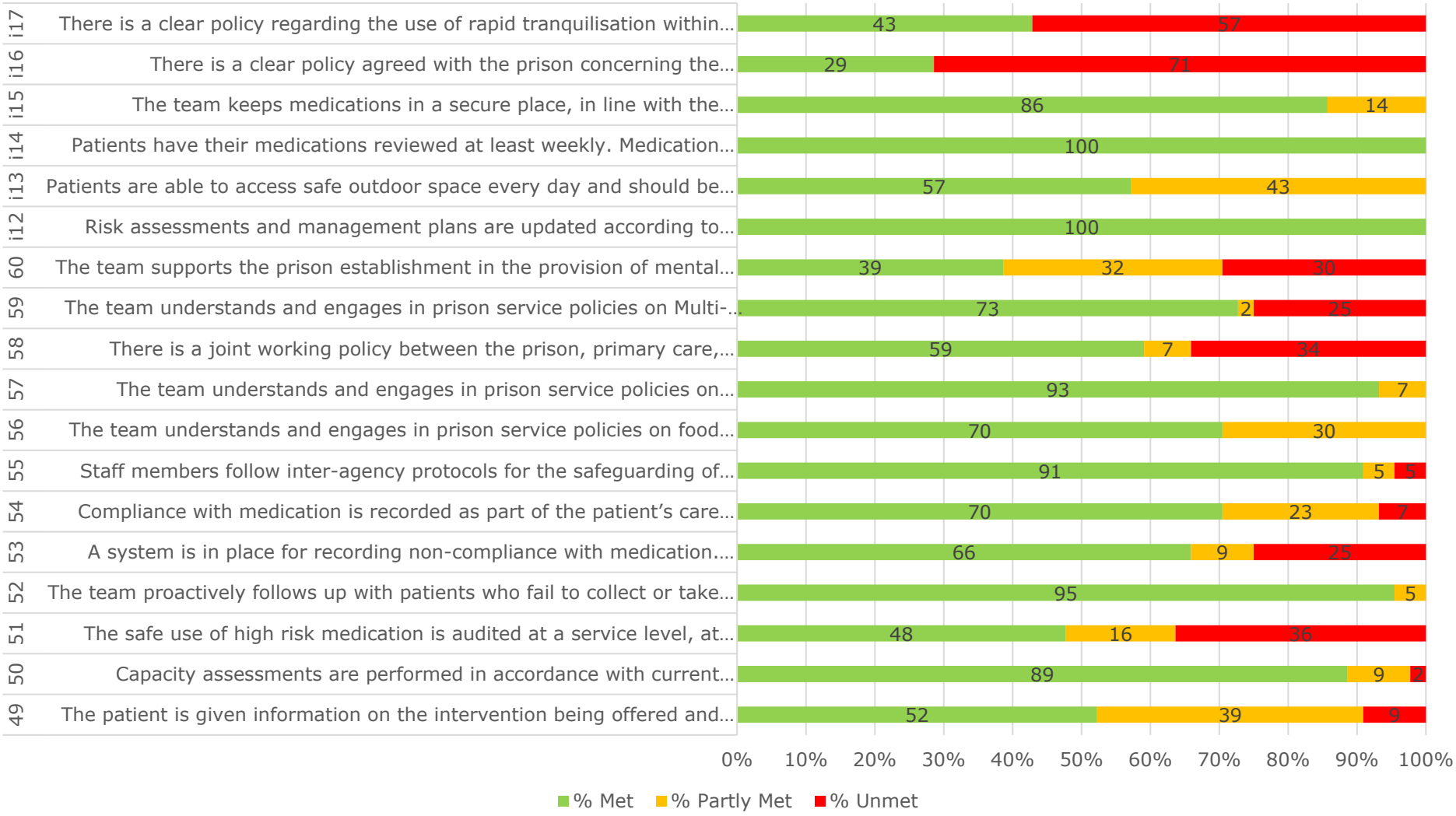
Referral, discharge and transfer



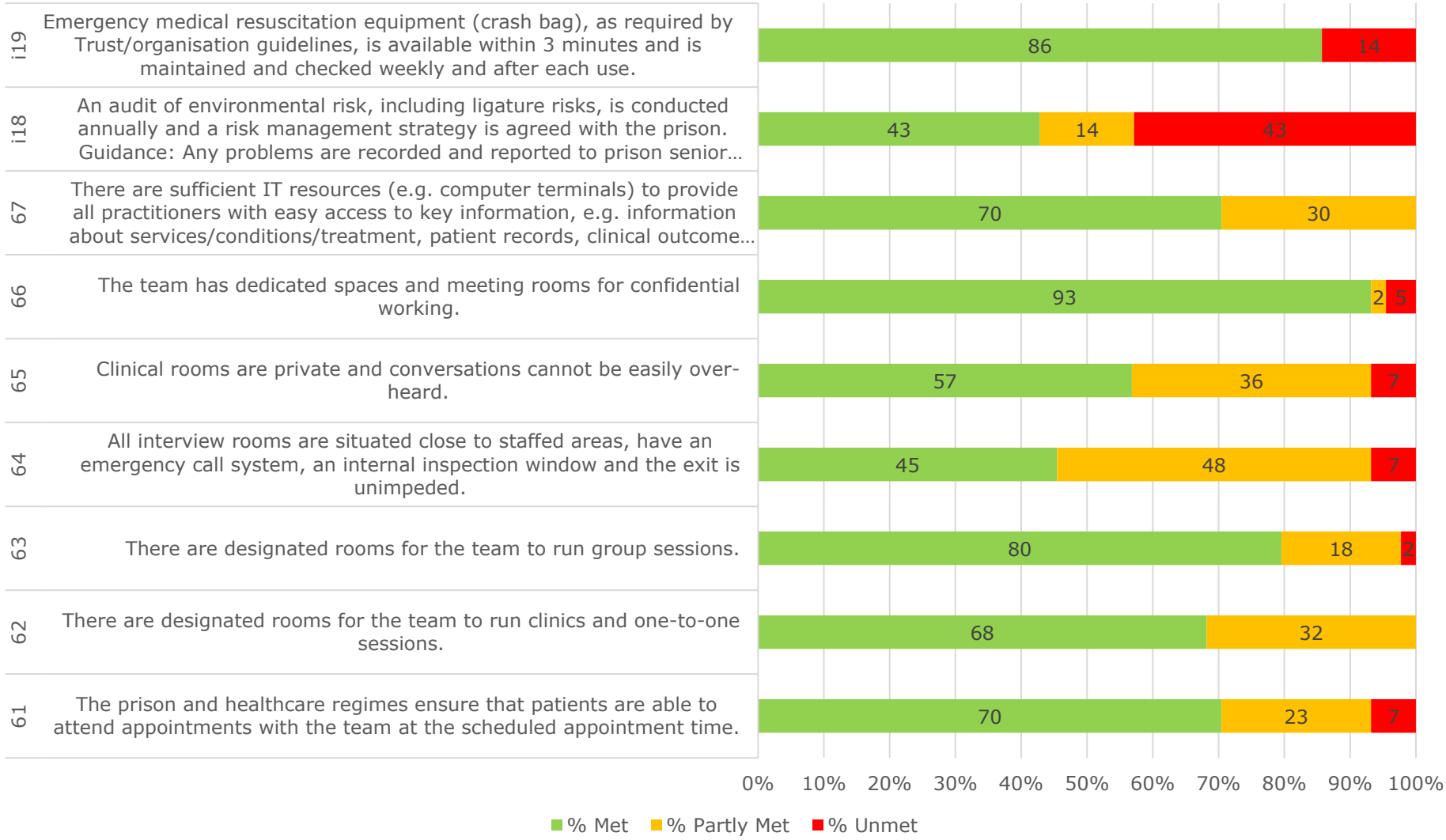
Patient experience



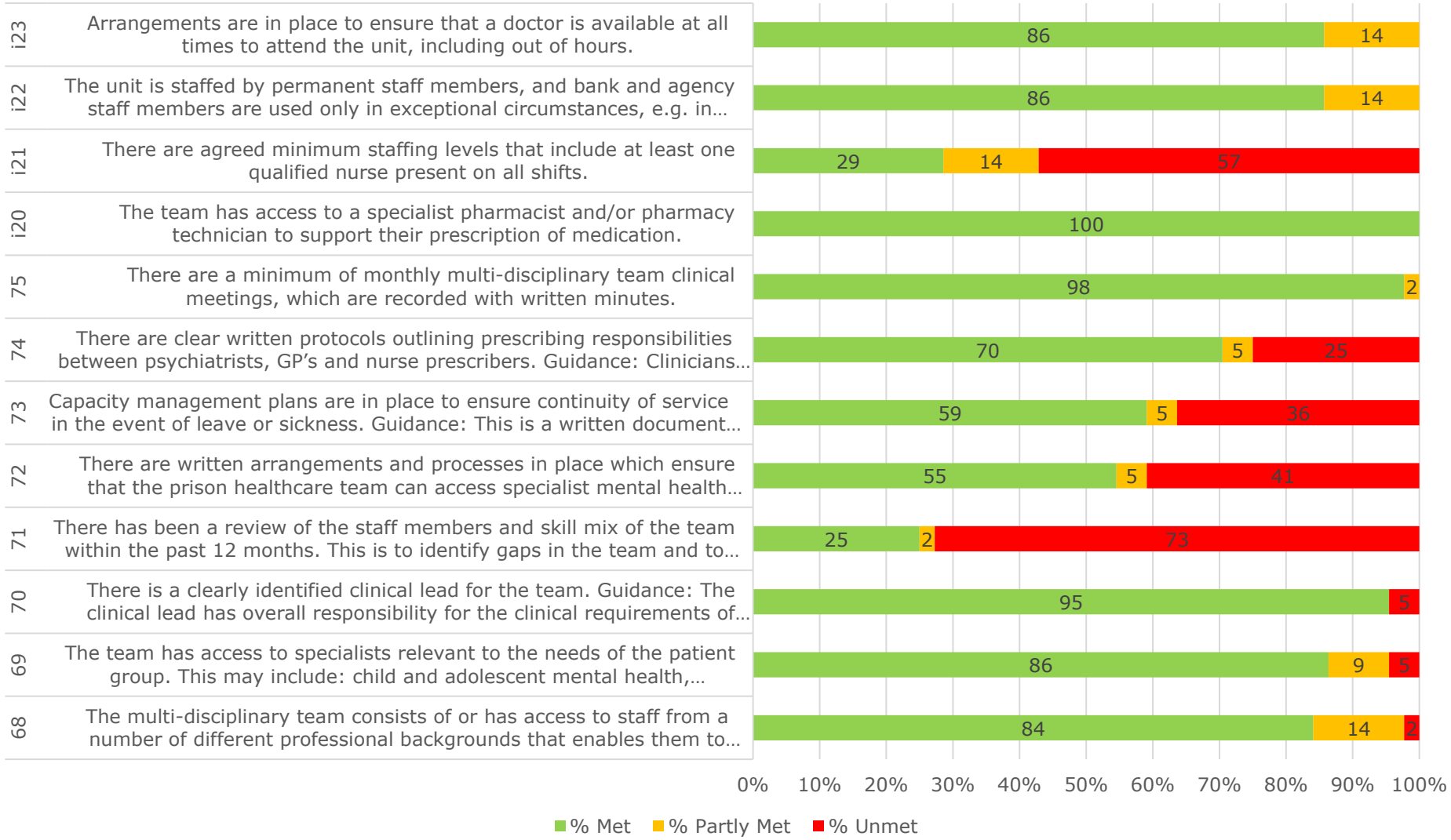
Patient safety



Environment



Workforce capacity and capability



Workforce training, CPD and support

Governance


i24
The operation of the unit is explicitly included in the commissioning specification from NHS England.
14
86
99
The team engages in service relevant research and academic activity.
48
23
30
98
Staff members feel able to raise any concerns they may have about standards of care. Guidance: Staff members should follow their Trust or…
84
16
97
Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident…
84
11
5
96
Lessons learned from incidents are shared with the team and disseminated to the wider organisations. Guidance: This includes audit…
84
5
11
95
Team members and patients who are affected by a healthcare related serious incident are offered a debrief and post incident support.
66
23
11
94
Staff members can quickly and effectively report incidents. Managers encourage staff members to do this and staff members receive…
82
16
2
93
When staff undertake audits they; Agree and implement action plans in response to audit reports; Disseminate information (audit findings,…
68
27
5
92
In conjunction with partner agencies, the team reviews its progress against its own local plan/strategy, which includes objectives and…
70
16
14
91
Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may…
55
7
39
90
The team attends local business meetings that are held at least monthly. Guidance: Business meetings address strategic matters and the general…
91
2
7
89
Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy…
91
9
88
Patients are involved in the governance and development of the team. Guidance: This may include representation from a patient or a patient…
14
39
48
87
A representative of the team is part of the prison clinical governance and quality processes.
98
2
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% Met
% Partly Met
% Unmet

Appendix 4 – Mental health in prisons: Screening, assessment and identification, 13 November 2017.
Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction
Dr Luke Birmingham, QNPMHS Advisory Member

10:35 Screening for mental illness in prisons
Professor Jenny Shaw and Dr Andrew Forrester, Offender Health Research Network

11:05 Tackling substance dependence and primary mental health problems among UK prisoners – an integrated approach
Katie Smithsbury, Senior Research & Development Officer, The Forward Trust

11:35 Refreshments

11:45 Integrated prison mental health and learning disability service specification stakeholder consultation
Kate Morrissey, National Programme Lead, Health and Justice Commissioning, NHS England

12:15 Screening for suicide risk in prisoners
Dr Seena Fazel, University of Oxford

12:45 Q & A and panel discussion

13:15 Lunch

14:00 Workshops: Session one

The health and wellbeing model – HMP Belmarsh
Tracey Abberline and Sunita Arjune, Oxleas NHS Foundation Trust

Veterans care through custody
Dr Jane Jones, Nottinghamshire Healthcare NHS Foundation Trust

14:50 Afternoon refreshments

15:00 Workshops: Session two

CHAT 4 and 5 assessments in a young offenders' institution
Hannah Lukacs, Bola Odesola, Rob Durie and Michelle Speakman, Barnet, Enfield and Haringey NHS Trust

Crisis Team: Referral, response and provision in the prison setting
Laura Woods, Sussex Partnership Trust

15:50 Final plenary

16:00 Close

Appendix 5 – Improving the care and treatment of people with an intellectual and/or developmental disability in prison, 15 March 2018. Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction
Dr Steffan Davies, Consultant Forensic Psychiatrist and QNPMHS Advisory Co-Chair

10:35 People with learning disabilities in prison
Jenny Talbot OBE, Director, Care not Custody, Prison Reform Trust

11:05 Improving outcomes for autistic offenders in custody and the community
Clare Hughes, Criminal Justice Manager, National Autistic Society

11:35 Refreshments

11:45 Rationale and experience for computer screening for learning difficulties and disabilities in the Scottish Prison Service
Lillian Dougan, Scottish Prison Service and Professor Amanda Kirby, University of South Wales

12:30 Q & A and panel discussion

13:00 Lunch

14:00 Workshops: Session one

A: Learning Disability Pathway at HMPYOI Feltham
Rob Durie and Joanne Hourihan, HMPYOI Feltham, Barnet, Enfield and Haringey Mental Health Trust

The ADHD Pathway at HMYOI Feltham; management of ADHD in male prisoners aged 15-21yrs
Dr Michelle Speakman, HMPYOI Feltham, Barnet, Enfield and Haringey Mental Health Trust

B: An update of clinical work within the neurodevelopmental pathway in HMP Wandsworth
Dene Robertson and Tracey Lewis, HMP Wandsworth, South London and Maudsley NHS Foundation Trust

14:50 Afternoon refreshments

15:00 Workshops: Session two

A: Developing learning disability practice in Greenwich prisons
Antony Hawkins, Practice Development Nurse for Learning Disabilities, HMP Belmarsh, Oxleas NHS Foundation Trust

B: Engaging the LD offender
Alan Moore, Therapy Manager, HMP Grendon TC+

15:50 Final plenary

16:00 Close

Appendix 6 – Quality Network for Prison Mental Health Services' 3rd Annual Forum Programme, 3 July 2018.
Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction
Dr Conor O'Neill, Consultant Forensic Psychiatrist and QNPMHS Advisory Group Member

10:35 Preliminary findings from the third cycle
Megan Georgiou, Programme Manager, Quality Network for Prison Mental Health Services

10:55 Thematic review of social care provision in prisons
Zoe Oliphant, NHS National Medical Director's Clinical Fellow to Prof Steve Field, Chief Inspector of General Practice & Integrated Care, and Professor Ursula Gallagher, Deputy Chief Inspector, Primary Medical Services and Integrated Care, Care Quality Commission

11:20 The development of a dementia care pathway for older prisoners
Katrina Forsyth, Research Associate, Offender Health Research Network

11:45 Refreshments

12:00 Workshops: Session one

Health, safety and wellbeing:

A: Options for using the relational security model 'See Think Act' in prisons
Liz Allen, Founder, FrontFoot

B: Losing and finding your mind at Her Majesty's pleasure
Deborah Murphy, Lead Occupational Therapist/Wellbeing Centre Manager, HMP Pentonville, Barnet, Enfield and Haringey NHS Trust

Substance misuse:

A: Spiralling out of control – solutions to our spice epidemic
Dr Abu Shafi, Core Trainee in Psychiatry, South Camden Drug Services, and Hattie Moyes, Research Manager, The Forward Trust

B: Diagnoses of prisoners in a secure setting
Martin Saberi, Patient Reviewer, QNFMHS

Managing the older prisoner population:

A: How do we manage old age in prisons?
Dr Faisal Mudathikundan, Associate Specialist in Forensic Psychiatry, HMP Belmarsh, Dr Rachel Daly, Consultant Forensic Psychiatrist, HMP Belmarsh, Oxleas NHS Foundation Trust, and Dr Seema Sukhwal, HMP Wormwood Scrubs, Barnet, Enfield and Haringey NHS Trust

12:55 Lunch

13:45 Prison safety programme
Christopher Barnett-Page, Prison Safety, Her Majesty's Prison and Probation Service

14:10 Inside gender identity
Dr Jon Bashford, Senior Partner, Community Innovations Enterprise

14:35 Peer-led improvements to mental health services
Laura Manders, Engagement Team Leader for Kent Sussex and Surrey Prison Health Council, User Voice

15:00 Afternoon refreshments

15:15 Workshops: Session two

Women in prison:

A: Evaluation of recovery café in a female prison setting
Marc Kerry, Higher Assistant Psychologist, and Lianne Jamfrey, Clinical Lead, HMP YOI Low Newton, Tees, Esk and Wear Valleys NHS Foundation Trust

B: Collaborative case formulations within the offender personality disorder pathway, service user's perspectives
Jessica Moules, Higher Assistant Psychologist, HMP YOI Low Newton, Tees, Esk and Wear Valleys NHS Foundation Trust

Integrated approaches to mental health:

A: Mental awareness peer support (MAPS) at HMP Ranby
Tom Rees, Senior Mental Health Nurse, and Katie Merrills, Senior Mental Health Nurse, HMP Ranby, Nottinghamshire Healthcare NHS Trust

B: Inclusion and CARE UK integrated working
Thandeka Moyo, Integrated Mental Health Team, HMP Oakwood, South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Developing outcome measures:

A: QNPMHS outcome measures consultation workshop
Dr Conor O'Neill and colleagues, QNPMHS

16:10 Final plenary

16:15 Close

Appendix 7 – Project contact details and information

Project team

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Email discussion group

prisonnetwork@rcpsych.ac.uk

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