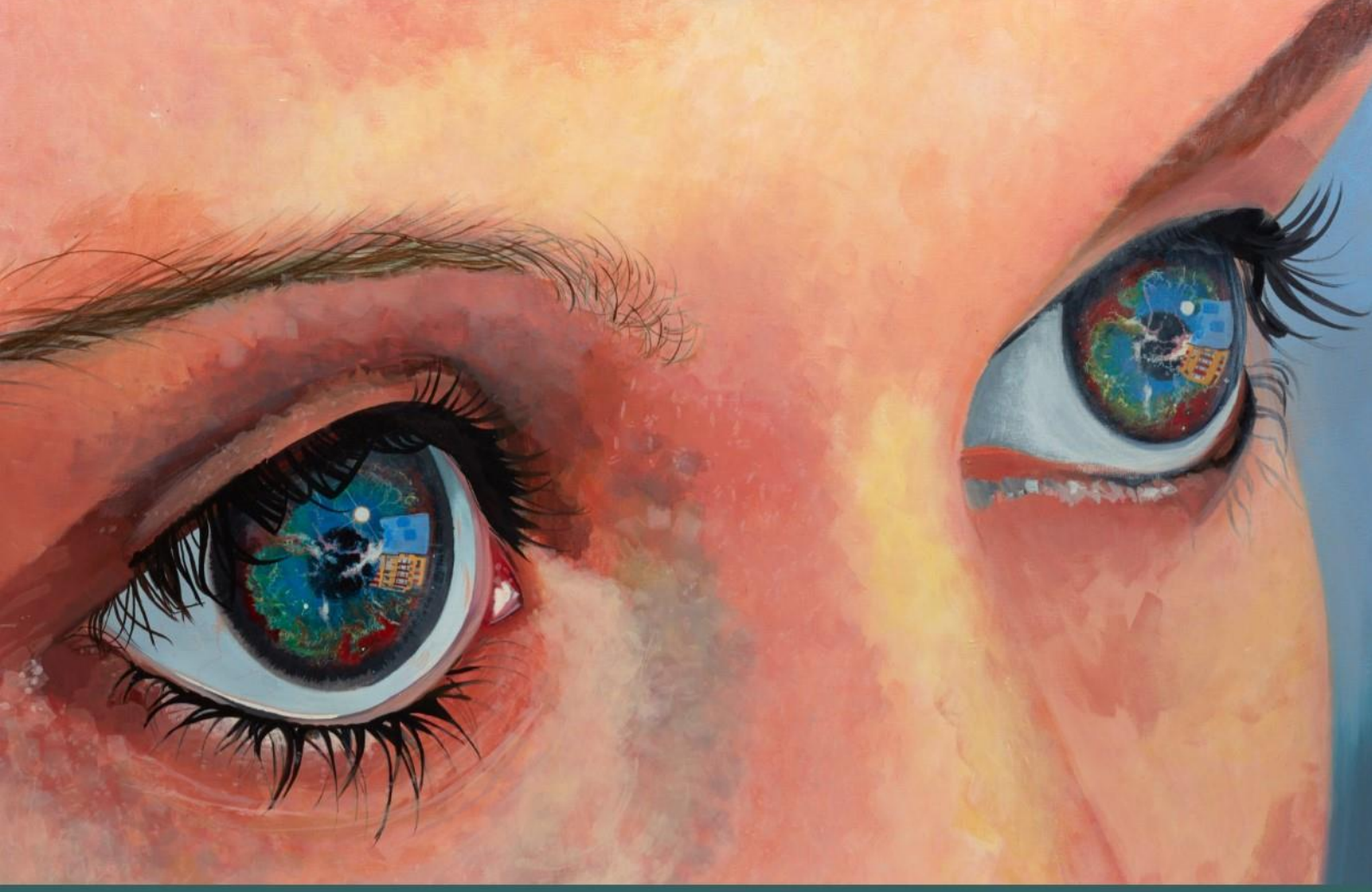

Quality Network for Prison Mental Health Services

ANNUAL REPORT

CYCLE 4 2018-19

Editors: Megan Georgiou, Kate Townsend and Holly Hunter-Brown
Publication Number: CCQI320
Date: November 2019

PRISON
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES
CCQI

This publication is available at:
www.qnpmhs.co.uk

Any enquiries relating to this publication should be sent to us at:
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Artwork displayed on the front cover of this report:

Nebu Eye
HM Prison Nottingham
Ed King Silver Award for Painting
2018

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Acknowledgements

The Network gratefully acknowledges:

- 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

Welcome to the annual report of the fourth cycle of the Quality Network for Prison Mental Health Services.

Over the past 12 months, we have been engaging in work to further develop prison mental health services, such as drafting guidance on the Care Programme Approach in prisons and publishing our first research paper looking at the first three years of aggregated data from the peer-review process (see *Network Developments* for more information).

The situation in our prisons continues to be very concerning. Safety in prisons has deteriorated significantly over the past seven years. Deaths in prison have almost doubled over the past decade, assaults and serious assaults are at the highest level ever recorded and assaults on staff have almost tripled in five years. Recently the government has announced that £1.3bn will be invested in modernising prisons and has decided to build 10,000 new prison places by 2020. This is despite the fact that we already have the highest rate of imprisonment in western Europe and the increasing calls to reduce the number of people in prison who are low risk, having committed non-violent offences (nearly 70% of the people sent to prison in 2018). As the excellent Bromley Briefings from the Prison Reform Trust (the definitive facts about our prisons) repeatedly shows, there is no proven link between prison populations and crime, despite what politicians will tell you.

Recent surveys have confirmed the fact that people with Intellectual Disability (ID) are overrepresented in the prison population. But, the HMIP has found that more than 50% of prisons are now actively identifying and supporting prisoners with ID, which is a marked improvement on previous years.

Suicide in prison continues to be a concern. Death by suicide is over 6 times more likely in prison compared to the population in the community. Although 70% of people who died by suicide in prison had been identified as having mental health needs, these had only been identified at reception, in just over half of these cases, suggesting that there needs to be more improvement in reception/early days screening for mental disorder. In addition, the Prisons and Probation Ombudsman investigations showed that 20% of prisoners who died by suicide and had a mental health problem were not under the care of the mental health teams, which suggests that more needs to be done in prison to recognise mental disorder and treat it effectively.

All of this gives strength to the need for prison mental health teams to be members of the Quality Network so that they are able to demonstrate the quality of the care they provide; allow their services to benchmark practice against other similar services; share best practice and promote their quality improvement work.

Dr Huw Stone
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 cycle's reviews was presented at the Network's annual forum (July 2019) 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

48 mental health services across 50 establishments in the UK and Ireland participated in the fourth 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 316 mental health team staff, 857 prison staff and 537 patients.

On the review visits, 172 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:

- Prison transfer and remission: Improving practice, 27 November 2018
- Safety in prisons, 14 March 2019
- Care Programme Approach (CPA) in Prisons: Consultation Event, 11 April 2019
- QNPMHS 4th Annual Forum, 2 July 2019
- Bi-annual newsletter, available online at: www.qnpmhs.co.uk
- Online discussion platform: prisonnetwork@rcpsych.ac.uk or www.khub.net

Programmes for each of the events listed above can be found in appendix 4.

Network developments

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

Journal article: Reviewing the quality of mental health provision in prisons

The Quality Network summarised the key findings from the first three years of reviews (2015 – 2018) in the form of a journal article. The paper explores whether any changes were observed in the average compliance of the quality standards during this period. The paper can be accessed via the Journal of Forensic Psychiatry and Psychology website https://www.tandfonline.com/doi/full/10.1080/14789949.2019.1637918 or via the online discussion platform.

Care Programme Approach (CPA) in prisons

Together with Tees, Esk and Wear Valleys NHS Foundation Trust, we are working to standardise the Care Programme Approach in prisons. We have conducted telephone interviews with mental health professionals working in prisons, hosted a consultation event, and facilitated an e-consultation to gather the views of our member services and key stakeholders. The outcomes of the consultation are due for publication in Autumn/Winter 2019.

Patient involvement

Earlier this year we invited John, a QNPMHS patient reviewer, to join a peer-review team at HMP Pentonville. This was the first time that someone with lived experience of prison mental health services was able to participate in a review day. John made an excellent addition to the team and his feedback was greatly valued by the host team. John chaired the meeting with the patient group and they fed back how much they valued him being there. We hope to include the patient voice in more of our reviews. If you would be interested in having a patient reviewer on your review team, please get in touch.

Meetings with our members

We offered meetings with our member services to listen to their feedback about how we could develop the Network. Three NHS trusts invited us to meet with their teams and we have created an action plan based on their feedback. The QNPMHS Advisory Group will monitor our progress against this plan.

Knowledge Hub

To improve communication between individuals working within member services and other key stakeholders, we have introduced Knowledge Hub. This is an online platform which supports networking, the sharing of information and good practice, the uploading of documents and the opportunity to keep updated with upcoming events and initiatives. To join the group, email 'join' to prisonnetwork@rcpsych.ac.uk or create an account on www.khub.net and search for the Quality Network for Prison Mental Health Services.

This report

This is the fourth annual report published by the Quality Network for Prison Mental Health Services. This document summarises the findings from the 48 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

Some services are also reviewed against a small set of additional standards:

- 24-Hour Mental Healthcare (optional)

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 fourth 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 67% 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 not met criteria per service. The range of met criteria achieved spans from 92% to 35%. The average compliance across the 48 services is 67%, as indicated by the final bar marked 'TNS' (total number of services) on the graph.

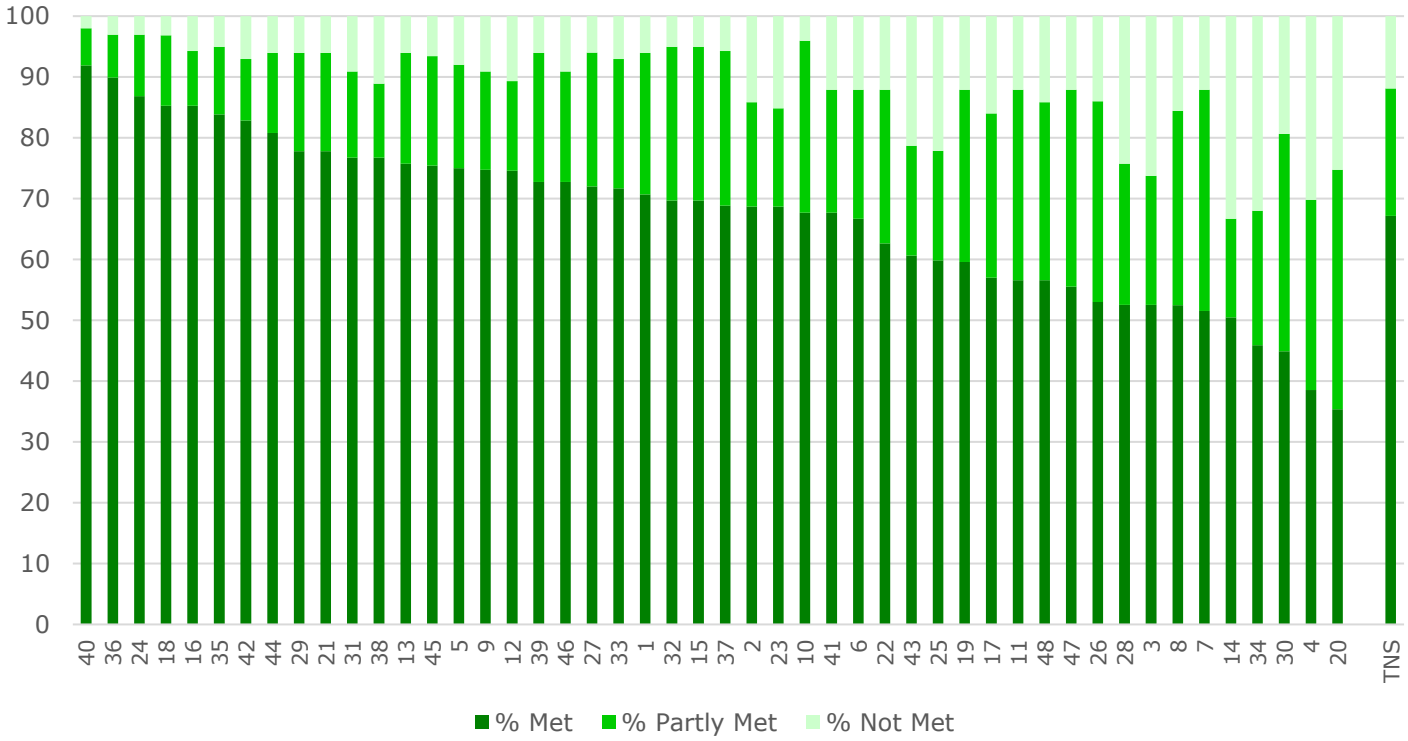


Figure 1: Percentage of met criteria by service

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 24-Hour Mental Healthcare, Case Management and Treatment, and Workforce Training, CPD and Support.

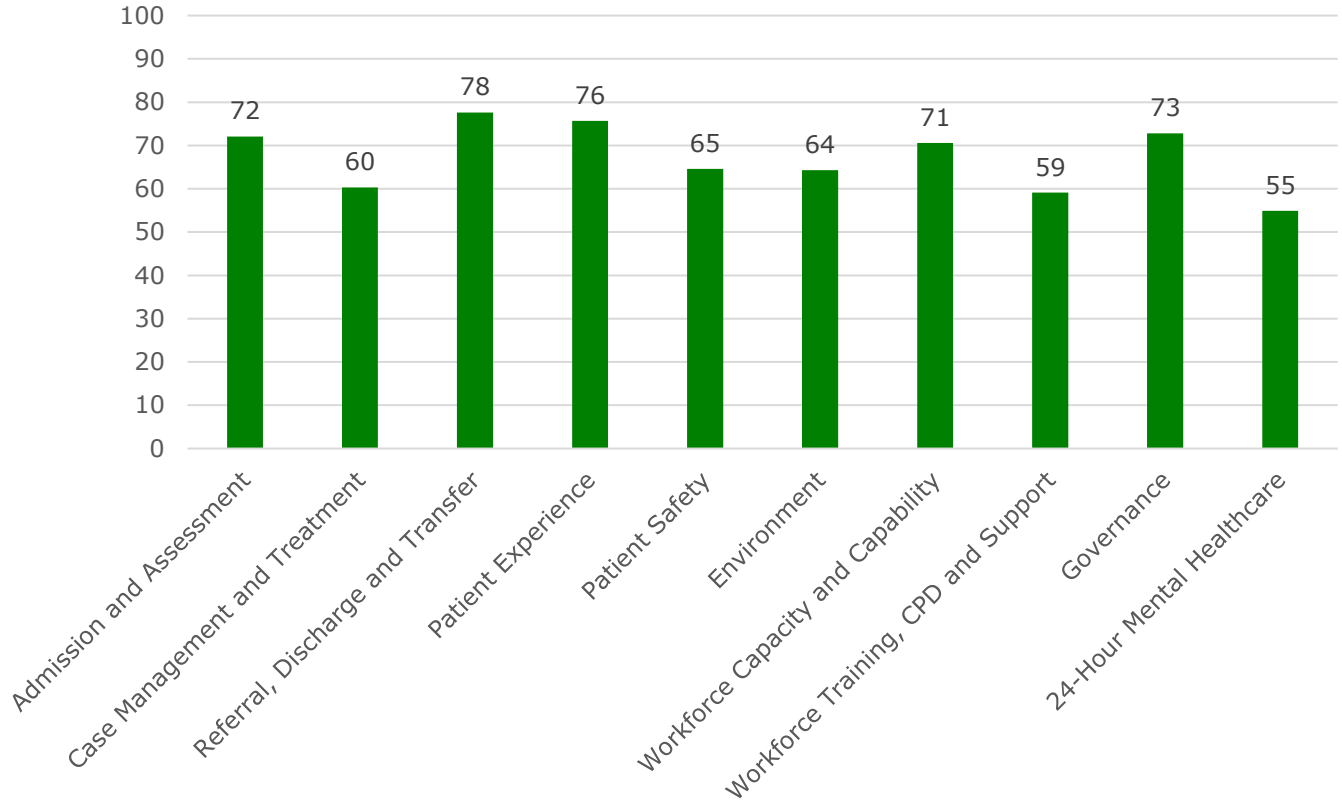


Figure 2: Average percentage of met criteria per section

Admission and Assessment

On average, services fully met 72% of standards in this area.

- In 42% of services, a competent mental health professional with experience of the criminal justice system is not conducting the mental health screening assessment.
- 40% of services are not undertaking urgent assessments within 48 hours and routine assessments within five working days.
- Patients in the majority of services reported that healthcare professionals communicate clearly and avoid the use of jargon.
- The provision of information to patients remains poor, with a large percentage of services not offering a clear description of the service and its functions, or information relating to patients' rights and how to access supporting services.
- The process of referring patients to the mental health team is not clear in 29% of services.

Case Management and Treatment

On average, services fully met 60% of standards in this area.

- Patients in 60% of services reported not receiving written and verbal information about their mental illness.

- A large proportion of services do not have policies in place to formalise joint working processes between criminal justice, social care, physical healthcare and third sector agencies.
- A majority of services engage with the prison and other healthcare providers to manage self-harm and suicidal ideation.
- Over half of services do not have written care plans in place for every patient and only 38% of services develop care plans in collaboration with the patient.
- Patients in around half of services are encouraged and supported to be fully involved in their Care Programme Approach meeting.

Referral, Discharge and Transfer

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

- The process for referral and transfer of patients to outside hospitals is not formalised in half of services.
- The majority of services have systems in place to support patients who require continued care and follow-up support following release.
- Only 25% of services contact the patient and/or new service provider within 14 days of release/transfer from the establishment.

Patient Experience

On average, services fully met 76% of standards in this area.

- Patients in the majority of services reported being treated with compassion, dignity and respect by mental health team staff.
- Patients in the majority of services reported staff listening to them and having a good understanding of their needs.
- Patients do not always feel involved in decisions about their care, treatment and discharge/release planning.
- Mechanisms are not in place for patients to feed back about their experiences of using the service in just over half of services.

Patient Safety

On average, services fully met 65% of standards in this area.

- Mental health awareness training supported by the mental health team is only available in 42% services.
- 81% of services evidenced joint working practices to ensure information that might affect a patient's safety is communicated across all relevant agencies.
- Under half of services have formal policies in place on the team's engagement in Multi-agency Public Protection Arrangements (MAPPA).

Environment

On average, services fully met 64% of standards in this area.

- The safety of interview rooms remains a concern with less than half of services having suitable spaces to conduct interviews and clinics.
- Around half of services are using interview and clinic rooms that are not private.

- Around one-third of services struggle with finding suitable spaces to run clinics, one-to-one sessions and group sessions.
- IT resources were reported as not being adequate in around one-third of services.
- One-quarter of services reported difficulties with patients attending scheduled appointments with the mental health team.

Workforce Capacity and Capability

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

- Almost 80% of services reported accessing staff from different backgrounds to enable them to deliver a full range of treatments, including specialist support where required.
- Two-thirds of services are not conducting annual reviews of the staff members and skill mix of the team to identify gaps.
- 40% of services do not have capacity management plans in place to ensure continuity of service delivery in the event of leave or sickness.

Workforce Training, CPD and Support

On average, services fully met 59% of standards in this area.

- Staff support systems are variable; monthly clinical and managerial supervision is available in just 46% of services and 40% of services are not providing access to monthly reflective practice sessions.
- Staff in three-quarters of services reported accessing processes to support their health and wellbeing.
- Around half of services could not evidence that staff members are receiving training on risk assessment and risk management, such as safeguarding, management of suicide risk and self-harm, and the prevention and management of violence and aggression.
- The majority of services are not providing training to all staff within the prison on the prevention, assessment and management of mental health problems in people with learning disabilities.

Governance

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

- Systems around reporting incidents and sharing lessons learned are well embedded.
- Engagement in service research and academic activity is limited, with only one-third of services managing to achieve this.
- Audit activity is taking place in around half of services.
- Most services engage in clinical governance and quality processes, including the dissemination of information between team members and the organisation's board.
- Less than one-third of services involve patients in the governance and development of the team.

24-Hour Mental Healthcare

On average, services fully met 55% of standards in this area.

- Three-quarters of inpatient units are staffed by permanent staff members.
- Only 38% of services have agreed minimum staffing levels that include at least one qualified nurse being present on all shifts.

- One quarter of services provide activities to patients seven days a week.
- Only 13% of services offer patients pre-arranged one-hour sessions at least once a week with their key worker.

Key recommendations

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

Recommendation 1: Identification and awareness of mental ill-health

- In collaboration with the prison, ensure a competent mental health professional with experience of the criminal justice system is conducting the mental health screening assessment, as part of the second stage screening.
- Include information of how to refer patients to the mental health team within the prison induction for new starters and in refresher training. Display referral information in staff and resident areas.
- Enhance the presence and visibility of the mental health team within the establishment to enable optimal joint working and information sharing.
- 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.
- In collaboration with the prison, devise a package to train all staff in the prevention, assessment and management of mental health problems in people with learning disabilities.

Recommendation 2: Provision of information

- Increase the distribution of written information about the service within the prison.
- Identify mental health staff and patient champions to enhance awareness of mental health and the services available.
- Devise literature in accessible formats, for instance easy-read versions or information in different languages.
- Offer all patients written and verbal information about their mental illness.
- Ensure all patients are informed of the risks and benefits of interventions.

Recommendation 3: Formalisation of procedures and policies

- Formalise and embed procedures and policies to ensure consistency of practice.
- Develop joint working protocols with the prison and other health agencies.

Recommendation 4: Care planning

- Ensure all patients are aware of their care plan, that 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.
- In women's services, formalise the care pathway for the care of women in the perinatal period.

Recommendation 5: Continuity of care

- 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 6: Patient involvement

- Provide patients with feedback mechanisms to enable them to share their experiences of using the service.
- Appoint mental health patient representatives that can contribute to service development and governance processes.

Recommendation 7: 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 8: Staff support

- 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 monthly reflective practice group.

Recommendation 9: Service development

- Introduce protected time for interested staff to engage in relevant research and academic activity.
- Develop a programme of audit activity and a strategy for service quality improvement to ensure the care provided is routinely subject to evaluation and review.

Quality Network for Prison Mental Health Services

Key findings

Cycle 4 2018-19

Admission and Assessment

On average, services fully met 72% of standards in this area, ranging from 33% to 100% compliance.

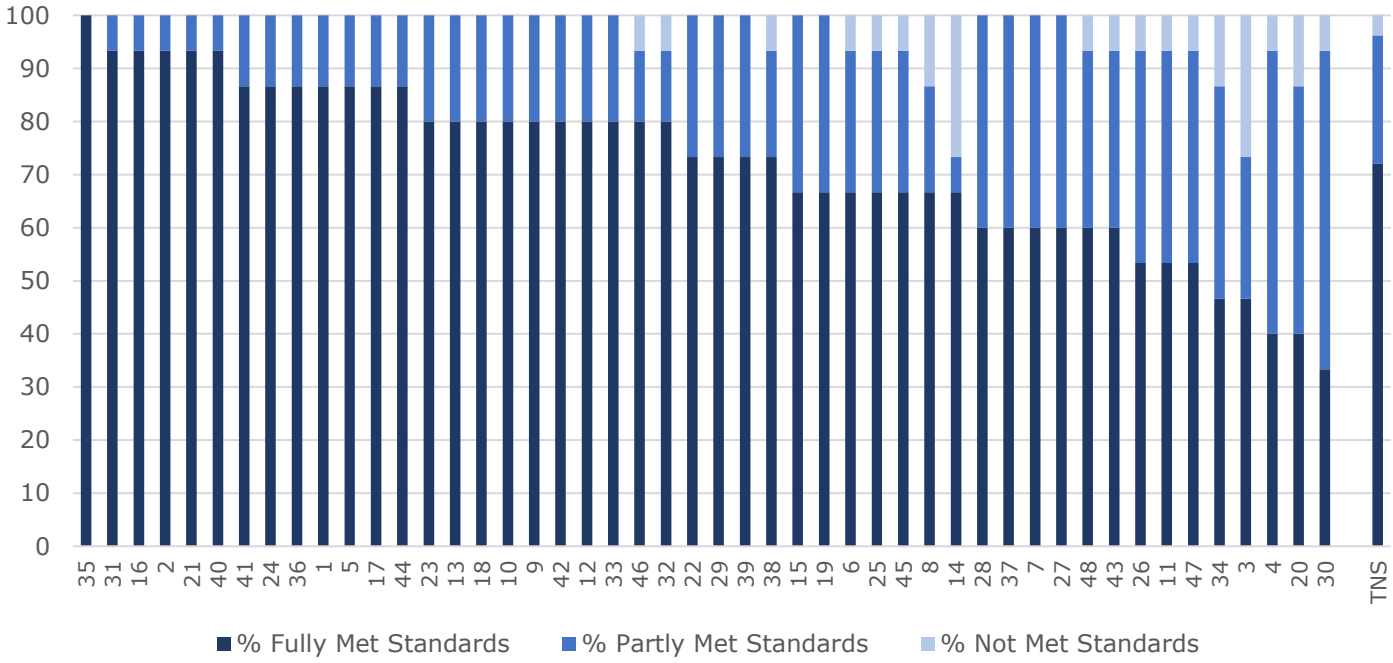


Figure 3: Service compliance for admission and assessment

Screening and admission

The mental health screening assessment is carried out by a competent mental health professional with experience of working with people within the criminal justice system with mental health problems in only 58% of services.

In 98% of services, the role of the team in the first and second reception screening process is clearly defined and in agreement with other health providers in the establishment.

Urgent assessments are undertaken within 48 hours and routine assessments within five working days in 60% of services.

Good practice examples

All prisoners receive a learning disability screening (LDSQ) at reception on admission to the prison. This allows the mental health team to identify potentially vulnerable people and meet the specific needs of learning disability patients.
Aylesbury

Good practice examples

The service has set up a generic mailbox for liaison and diversion services and local courts to communicate any relevant information relating to mental health before the individual arrives at the prison.
Woodhill

The first night reception screening is completed by the mental health nurses that work on the inpatient unit. This means that the team are aware of anyone at risk as soon as they come into the prison. The team has received funding from the Trust to recruit two extra nurses for 12 months to be based on reception permanently, for six days a week. This will take pressure off the current inpatient team and ensure a more robust follow-up takes place after reception.
Lewes

Communication with patients

Half of services discuss the purpose and outcome of the risk assessment with each patient and jointly formulate a management plan.

In the majority of services, patients reported that health professionals communicate clearly, avoiding the use of jargon.

In just 19% of services, patients are provided with 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; and how to access their own health records.

Almost two-thirds of services do not have clear information 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 or contact details for the service.

Good practice examples

Information about the inreach team was observed around the establishment in the form of leaflets and posters. Patients confirmed receiving the welcome booklet and feeling informed and knowledgeable on the team and what is available to them.
Elmley

Patients referred to the information provided to them about the mental health team as helpful and engaging. The service continues to use the booklet they have produced that includes games and puzzles, as well as detailed information about what the service has to offer.
Pentonville

Good practice examples

Information and communication with patients is impressive. Patients described information regarding the mental health team, interventions on offer and links to the community services as brilliant and accessible. Patients referred to easy read information for those with learning disabilities and to a clear and concise directory of services that patients may find helpful upon release.
North Sea Camp

A large amount of information is available to the men informing them of mental health conditions. Trust wide information is available which informs men on how to ensure their continuity of care following release from prison. This includes accessing their community mental health and substance misuse teams.
Bristol

Patients commented on communication being good during times of crisis and that staff avoided the use of jargon.
Lancaster Farms

Referral process

In all services, a clinical member of staff is available to discuss emergency referrals during working hours.

71% of services have a clear and consistent process for staff to refer individuals directly to the mental health team.

There is a clear system for the management of referrals in 88% of services.

Good practice examples

Staff from partner agencies commented that there are a range of avenues available for raising referrals to the team, such as forms and by email. Feedback is offered by the team following a referral. Referrals are assessed by the team daily.
Lancaster Farms

The team are responsive and quick to react to the needs of the patients. There is a duty worker role, active seven days a week. 'Very urgent' referrals are seen within four hours and triaged within 24 hours, and routine assessments are seen within four working days.
Low Newton

Good practice examples

The service has an effective referral process. Staff understand the steps required to submit a referral, who to contact and where to find information. There is a mental health functional mailbox in which all referrals are sent. Staff can also refer to a referral flowchart informing them of the process.
Nottingham

There is a robust system in place to manage referrals. The administrator in the team will collect information from NOMIS about the patient before their first assessment, so the nurse has this information to hand before the assessment. Referrals will then be allocated out during the daily referrals meeting.
Durham

The team engages in a strong partnership model of working within the prison. Individuals spoken to from partner agencies described a positive relationship with the team and they have a good knowledge of who to contact and referral processes. The referral process is organised under the Threshold Assessment Grid (TAG) model; a completed assessment results in a score which identifies the severity of the case and helps guide the appropriate level of response.
Berwyn

The mental health team has a strong presence within the prison, which was reflected in both partner agency and patient feedback. Patients and partner agency staff both reported that mental health staff are well-known within the establishment and are approachable. Partner agency staff further stated that the referral process is very clear and easy to follow.
Deerbolt

A duty service has been introduced for the team to effectively and efficiently manage urgent referrals. A different duty professional is allocated daily and is responsible for accepting urgent referrals and completing an assessment within 48 hours.
Brinsford

Case Management and Treatment

On average, services fully met 60% of standards in this area, ranging from 24% to 94% compliance.

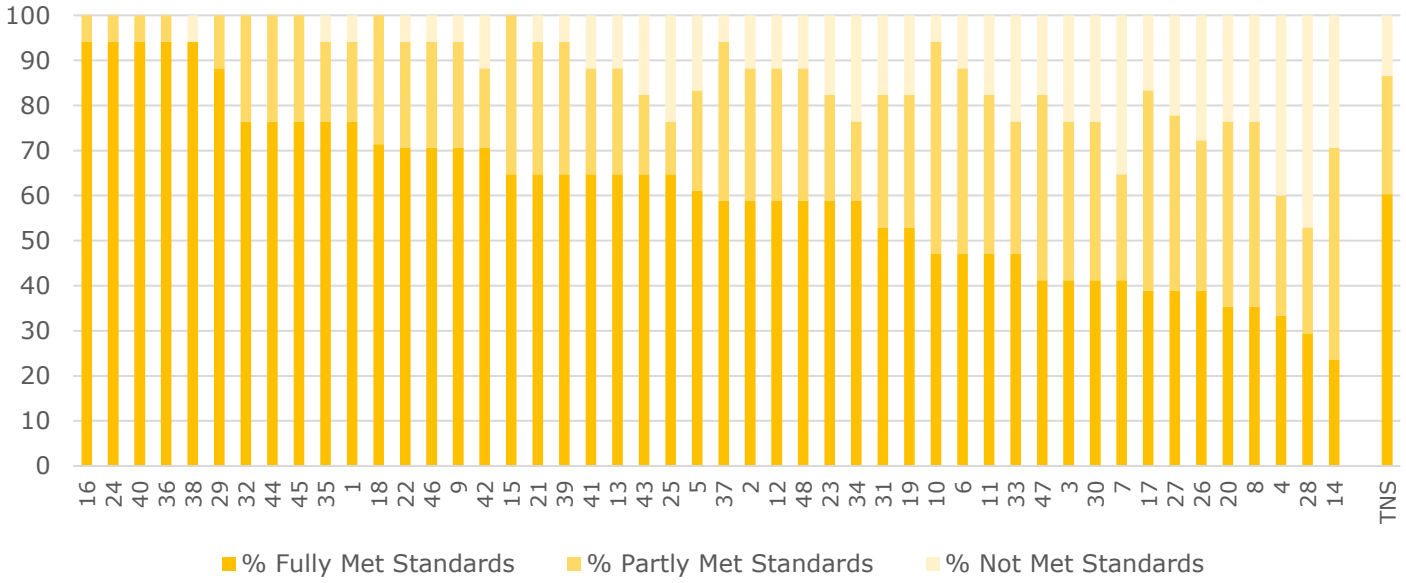


Figure 4: Service compliance for case management and treatment

Treatment and interventions

79% of services manage patients under the Stepped Care Model for People with Common Mental Health Disorders.

Patients in 60% of services reported not being offered written and verbal information about their mental illness.

In 88% of services, patients are offered evidence based pharmacological and psychological interventions and any exceptions are document in case notes.

Good practice examples

Whenever a new patient is referred to the team with a repeat prescription of antipsychotics, the team will ensure this is reviewed by a psychiatrist before any repeat prescriptions take place.
Birmingham

Specialist clinics have helped individuals to be identified and treated for ADHD, as well as helped patients gain an understanding of the diagnosis. The psychotherapist attends a monthly veteran meeting held in the establishment which can help identify individuals in need. The psychiatrist and psychotherapist specialise in trauma and PTSD.
Cardiff

Good practice examples

The psychologist specialises in trauma and is trained to deliver eye movement desensitisation and reprocessing therapy. Dream intervention sessions are available, individually or as a group intervention, as well as acupuncture.
Bullingdon

An impressive psychologically-informed service provides sessions on anxiety, mindfulness and emotional coping skills.
Isle of Wight

There is a 'holistic recovery' group in place, which aims to tackle multiple problems patients might face, including substance misuse and mental health issues. The group covers courses on general wellbeing, cannabis, novel psychoactive substances (NPS) and steroids awareness, emotional regulation and relaxation.
Swinfen Hall

The team's psychological wellbeing practitioner has developed a 'Bullet Journal Club'. This was observed as creative and an innovative way of assisting patients in expressing themselves and gaining benefit from group work.
Lincoln

Care coordination and collaboration

There is a timetabled meeting at least once a week to discuss the allocation of referrals, current assessments and reviews, in most services.

In 60% of services, there is no policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within the limits of patient consent, cofidentiality and risk management.

83% of services work collaboratively with other health care providers and the prison to manage self-harm and suicidal ideation, including active participation in the ACCT process.

In 48% of services, 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.

Good practice examples

Primary and secondary healthcare is well integrated and multi-disciplinary team meetings are conducted together, ensuring good communication and management of patients' needs and treatments.
Mountjoy

Good practice examples

The team run weekly multi-professional complex clinical case (MPCCC) meetings, involving other agencies, to discuss patients and complex needs. This is clinically focused and discusses a range of topics from medication to therapies and other interventions. This has streamlined the joint-working relationships in the prison.
Brixton

There is a multi-agency approach to managing self-harm and suicidal ideation. The ACCT process is well embedded, with the team attending all ACCT reviews. Discussions take place after ACCT reviews to agree who will be attending the next meeting, allowing for continuity of professionals attending the reviews.
Preston

Care planning

44% of services have a written care plan in place for every patient, reflecting their individual needs. Half of services reported reviewing and updating care plans according to clinical needs.

Only 38% of services develop the care plan collaboratively with the patient.

Patients are encouraged and supported, where applicable, to be fully involved in their CPA meeting in around half of services.

Where applicable, 40% of services have a care pathway for the care of women in the perinatal period that includes: assessment; care and treatment; and referral to a specialist perinatal team/unit.

Almost all services pro-actively follow up with patients who have not attended an appointment/assessment or who are difficult to engage.

Good practice examples

Patients feel involved in developing their care plans collaboratively and feel staff 'treat them well at all times'.
Thameside

Patients are involved in ward rounds and community meetings, and benefit from weekly group sessions and one-to-one sessions with a nurse.
Woodhill

The team is proactive with following up with any patients that did not attend their appointment, including going onto the wings or calling patients on their personal phones within their cells.
Lowdham Grange

Referral, Discharge and Transfer

On average, services fully met 78% of standards in this area, ranging from 13% to 100% compliance.

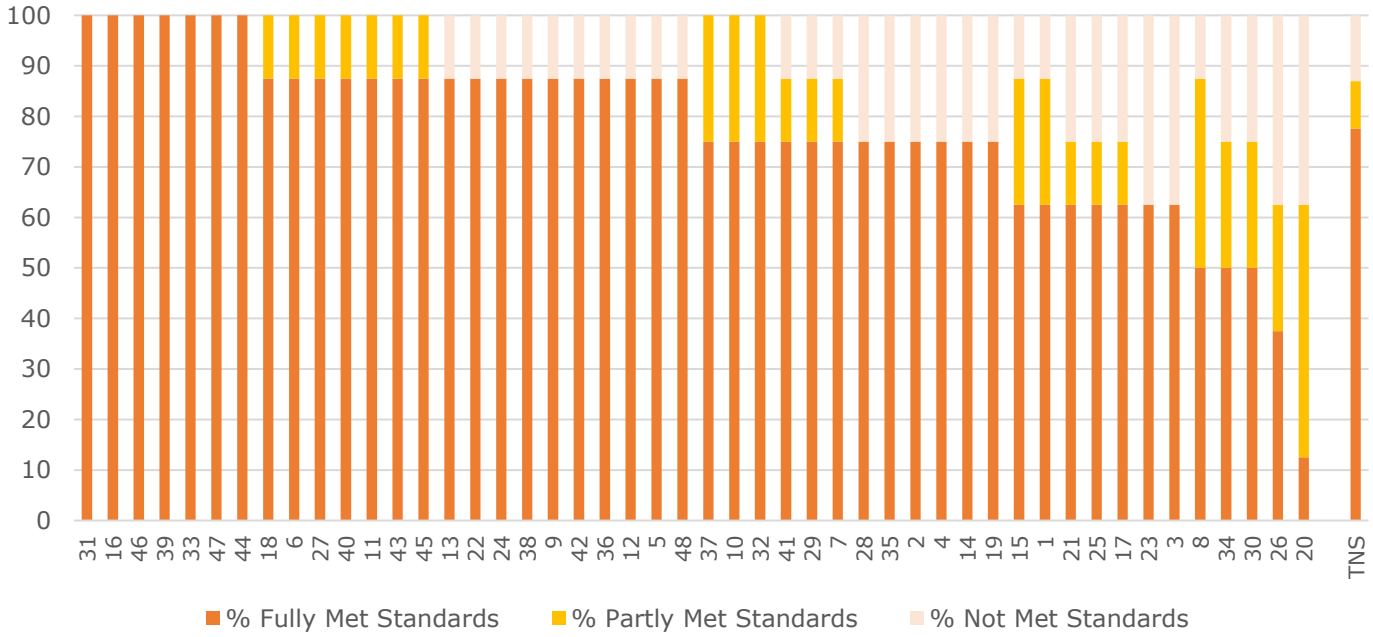


Figure 5: Service compliance for referral, discharge and transfer

Hospital transfers

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.

The Good Practice Procedure Guide (DH, April 2011) is followed by 71% of services during the process for referral and transfer of patients under Part 3 of the Mental Health Act.

Continuity of care

When a patient is transferred to another establishment, the mental health team provides a comprehensive handover to the receiving establishment's mental health team before the transfer takes place in 81% of services.

When a patient is discharged from the team, most services provide information to the receiving primary care or mental healthcare service.

75% of services do not contact the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from the establishment.

The majority of services make referrals to community mental health services for those patients who require continued care and follow-up support following release.

Good practice examples

All disciplines in the mental health team share the responsibility for liaising with community mental health teams regarding the transfer, referral and discharge of patients. This includes frequent communication with the teams regarding patients' needs and the care provided at the establishment, which is conveyed through numerous letters and phone calls.
Mountjoy

There is a daily conference call with local prisons under the same Trust to discuss new transfers and share clinical or risk information.
Northumberland

One of the STAR workers within the team collects a list of daily transfers and releases from the prison, allowing the allocated practitioner to prepare a handover to the receiving establishment and provider. There is also an allocated transfer coordinator in the team. This practice allows the team to prepare as far as possible for any daily transfers.
Elmley

Where discharge is known, an in-depth plan, involving family members and probation services, is developed. Patients were fully informed of the steps and goals in place regarding their discharge from the mental health team and the prison establishment.
Cardiff

The team are dedicated to contacting patients, care co-ordinators or service providers within 14 days of transfer/release from the establishment. This is diarised to ensure it happens and the team reported being proactive about finding a way to contact a patient if they have not been transferred to another service.
Channings Wood

The team has strong links with the community services within the local area. This ensures a comprehensive handover is always completed and enables the patient to continue receiving care within the community when discharged. Staff will ensure a follow-up is conducted when a patient is released.
Parc

Patient Experience

On average, services fully met 76% of standards in this area, ranging from 17% to 100% compliance.

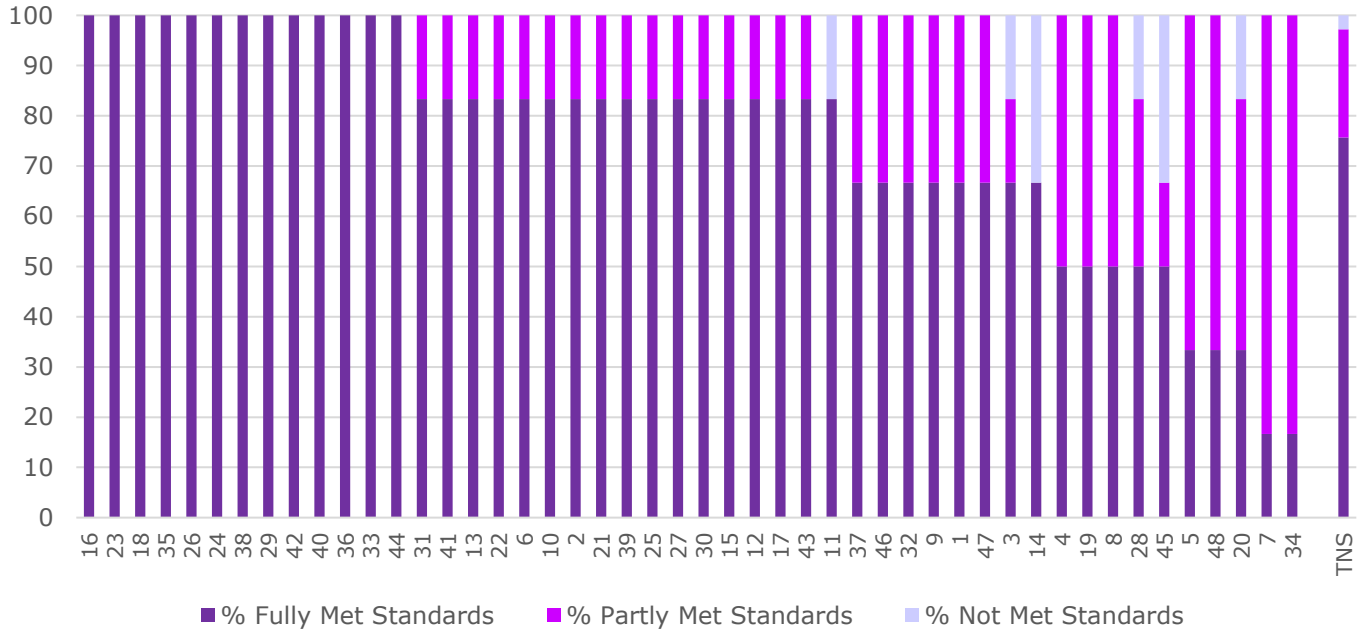


Figure 6: Service compliance for patient experience

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:

This mental health team should go and show the other mental health teams how it's done.

I think it is now a very good service. I wouldn't change it at all.

I feel happy and safer knowing that they are here to try to help me.

It will stop me from reoffending and coming back to prison.

[They] broke everything down for me…it wasn't rushed, and I didn't feel pressured.

They listen to you and they do what they say they will do.

[They] helped me to open up and deal with problems myself.

Patient involvement

65% of patients feel involved in decisions about their care, treatment and discharge/release planning.

Patients in just over half of services reported being given the opportunity to feed back about their experiences of using the service.

Patients in the majority of services reported staff listening to them and having a good understanding of their needs.

Consent and confidentiality

Patient consent to the sharing of clinical information is obtained and recorded in 85% of services.

Confidentiality and its limits are explained both verbally and in writing to patients in 60% of services.

Good practice examples

Patients reported feeling listened to and understood, as well as being treated with compassion, dignity and respect by all staff within the team. One patient described a situation where he was being bullied on his wing and one member of staff from the mental health team was able to quickly help. Staff continually chased this issue and made sure the patient was moved to another wing by the next day. Patient forums have been newly introduced, which patients feel positively about.
Dartmoor

Patients reported feeling well supported by the team, especially during a crisis, and described staff as being caring and compassionate.
Eastwood Park

Patient Safety

On average, services fully met 65% of standards in this area, ranging from 25% to 92% compliance.

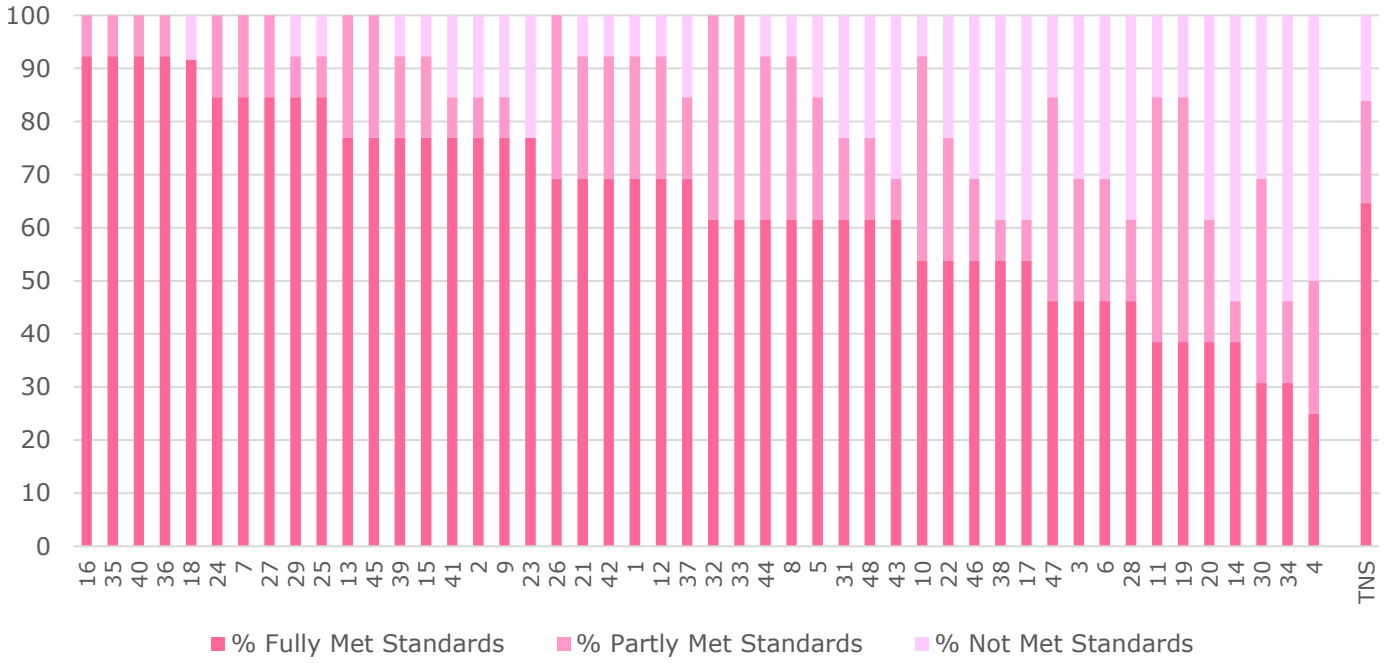


Figure 7: Service compliance for patient safety

Medication

In 94% of services, staff proactively follow up with patients who fail to collect or take their medication. However, in only half of services there is a system for recording non-compliance with medication.

Compliance with medication is recorded as part of the patient's care plan and reviewed at least monthly, in 60% of services.

Only 27% of services conduct an annual audit on the safe use of high-risk medication at a service level.

Mental health awareness

Mental health teams support prison staff with the provision of mental health awareness training in just 42% of services.

Staff in the majority of services have a good understanding of policies on food refusal and mental capacity assessments.

Good practice examples

The team is involved in the delivery of mental health training to prison staff. It was reported that mental health first aid training is also available and delivered by the mental health team. Residents within the establishment can attend the training provided by the team.
Birmingham

The team has developed a successful initiative of having 'mental wellbeing representatives' on each wing of the prison. These individuals may or may not be seen by the mental health team but are trained on how to make a referral and on awareness of detecting signs in other prisoners on each wing. These representatives can also feed into governance meetings and provide their input in service improvement and development. This has received positive feedback from patients and staff and has also brought the mental health team closer to individuals on the wings.
Brixton

Mental health awareness training is available to prison staff at least once a month during lockdowns.
Haverigg

Joint working practices and communication

Information that might affect a patient's safety is communicated across relevant agencies in 81% of services, within the limits of confidentiality and patient consent.

Only 42% of patients reported being given information on the interventions being offered to them, including the risks and benefits.

Less than half of teams have a joint working policy between the establishment, primary care, substance misuse services and the mental health team on the control and management of substance misuse and substances.

Just under half the teams understand and engage in policies on Multi-agency Public Protection Arrangements (MAPPA).

Good practice examples

The mental health team share positive working relationships with prison colleagues. Staff from partner agencies spoke highly of their part in managing vulnerable prisoners, particularly through the ACCT process and providing staff with specific expertise around mental health issues.
Frankland

Good practice examples

The team has a positive working relationship with partner agencies operating within the prison. The governor highly regarded the team and the care that is delivered. There is a 'trigger database' held by safer custody that the mental health team feed into, that informs all teams in the prison of any patients who may be experiencing an anniversary of a stressful event.
North Sea Camp

Partner agencies within the prison were complimentary of the mental health team. They reported being aware of how to make a referral and that the team is accessible.
Styal

The service has 'recovery champion' roles, which involves patients mentoring other patients in the prison to spread mental health awareness, break down barriers and address the stigma towards mental health, as well as provide patients with referral forms. The recovery champions are also trained on how to spot signs if someone is distressed or may need help and this is in accordance with confidentiality and its limits.
Swinfen Hall

Relationships and joint working with partner agencies was observed as strong. The team is highly regarded by partner agency staff for their consistent visibility within the establishment and for their constant support. There is regular input at the Assessment, Care in Detention and Teamwork (ACDT) reviews. The team attends safer custody meetings and works closely with other agencies in relation to complex cases.
Morton Hall

The mental health service is well integrated with the Prisoner Safety and Support Team (PSST) to ensure the safe management of individuals subject to the Supporting Prisoners at Risk (SPAR) process. A representative of the team now attends all SPAR reviews and the prison has seen a reduction in the number of open SPAR documents since this practice was introduced. Staff members from PSST reported that the process is more consistent, and that information sharing is improved.
Maghaberry

Environment

On average, services fully met 64% of standards in this area, ranging from 14% to 100% compliance.

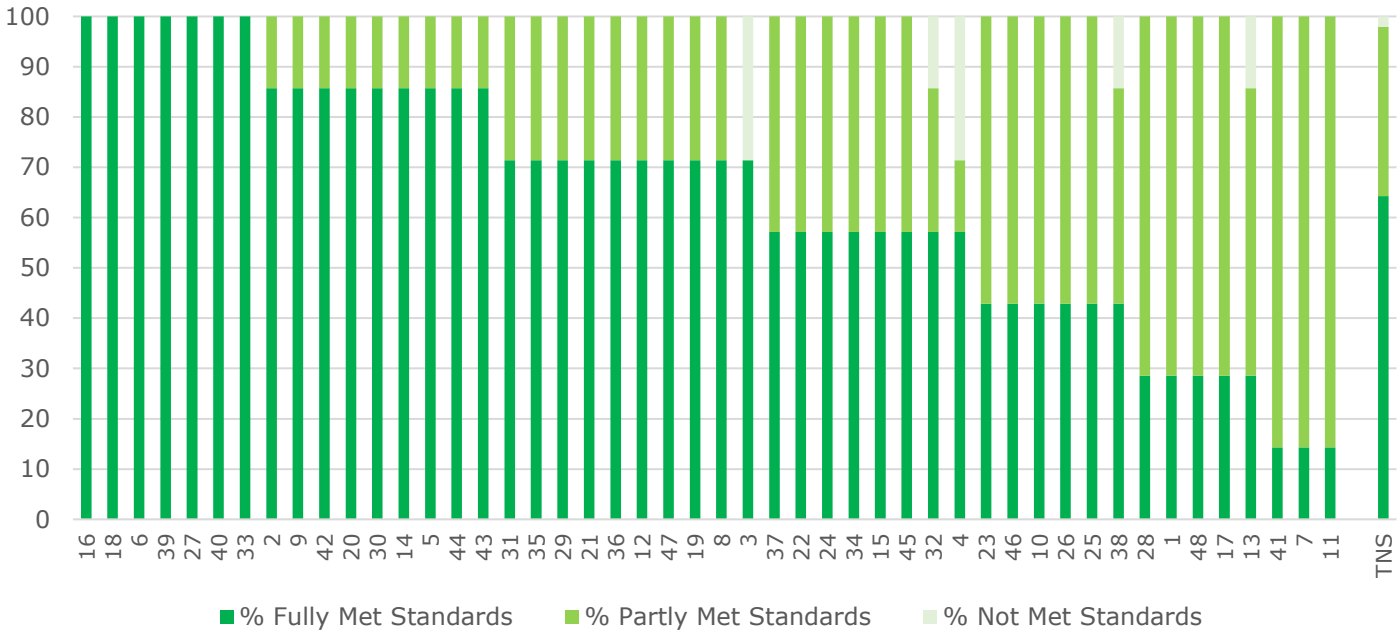


Figure 8: Service compliance for environment

Environment

Less than half of services have access to interview rooms that are situated close to staffed areas, have an emergency call system, an internal inspection window and unimpeded exits.

81% of services have dedicated spaces and meeting rooms for confidential working. However, only 56% of services have clinical rooms that are private, where conversations cannot easily be over-heard.

63% of teams have designated rooms to run clinics and one-to-one sessions, and 67% of teams have designated spaces to run group sessions.

Good practice examples

By converting disused rooms and storage space, the prison has created safe, private and therapeutic rooms that are conducive to the needs of the mental health team and partner agencies. The mental health staff are no longer struggling to find space, and often do not need to book a room as availability is reliable. All rooms are equipped with a suitably placed alarm and are close to staffed areas. Some group rooms have comfortable seating, cushions and are decorated in a calming manner.
Low Newton

Good practice examples

On walking around the prison, it is evident that attempts have been made to support good mental health. Positive messages are displayed on the walls and artwork can be found in places. The arrangement of prisoner reception was commended for being so spacious, with good sized waiting areas, making arrival at the prison less chaotic. Within this area was a dedicated office for an Insider; it is positive to see a peer support service being given a protected office space and being available to prisoners as soon as they arrive at the prison. Moreover, the safer cells include a direct phone line to the Samaritans.
Maghaberry

The environment is well presented, clean and bright. There is the 'high street', which is a large open environment, where during free-flow, people can access the chapel, recreational area and the healthcare unit. There are trees growing inside and has positive messages printed on the walls. This is mirrored both on the male and female environment. The women's healthcare unit is also bright and colourful, with paintings throughout and has been awarded as an Enabling Environment. Both the women's main wing and in the healthcare unit there is an abundance of display boards, including information on the mental health team.
Peterborough

The service's wellbeing centre has undergone a fantastic refurbishment. There is: a resource room, including a smart board to increase multi-media activity for patients; an impressive music room with 'studio' facilities available for music making; a large new kitchen for cooking activities; and an improved pottery workshop with further plans to add Moroccan style tiling. There is a range of activities available for patients, such as cooking, pottery, music and arts and crafts. There are psycho-education groups available, and the service has just received approval to begin a knitting group.
Pentonville

The culture of HMP Berwyn is grounded in a rehabilitative framework. The environment is welcoming, light and bright, and the terminology has shifted to refrain from using punitive language such as 'prisoner' and 'cells', to 'men' and 'rooms'.
Berwyn

The wellbeing centre contains beanbags, a ball pit, a device emitting birdsongs and low lighting. Although this room is still in development, it looks to provide a calm and therapeutic environment for patients to relax. A group room will be available where 'living with distress' and 'stress management' groups will take place. Leaflets have been developed to encourage individuals to attend.
Nottingham

Good practice examples

There is a wide array of facilities available to patients within the Seacole Day Centre and on the inpatient unit, including: art rooms, a music room and a library. In addition to this, there are numerous rooms within the centre which can be used for psycho-educational group sessions, one-to-one sessions, education and psychology groups, including a trauma group, a hearing voices group, and an emotional regulation group. The centre is run largely by OT and psychology staff, and patients who can access this space have access to a vast number of activities. This is reflected in the activity timetable displayed on the walls of the centre.
Wormwood Scrubs

IT resources

63% of services reported having adequate IT resources to provide all practitioners with easy access to key information. This includes information about services, conditions, treatments, patient records, clinical outcome and performance measurement data.

Appointments

In 73% of services, patients can attend appointments with the mental health team at the scheduled appointment time.

Good practice examples

Patients receive phone call reminders the day before their appointments. This is valued by patients and the team reported that it has decreased the rate of missed appointments.
Northumberland

The team provides patients with appointment cards which act as a reminder, as well as informing prison staff of who needs to be escorted. Patients found these cards particularly helpful and felt that it gave them a sense of responsibility, despite not always being able to attend the appointment due to circumstances out of their control.
Perth

The electronic CMS appointment system means that healthcare appointments take priority over other activities such as the gym, so patients cannot cancel healthcare appointments once they have been booked.
Thameside

Workforce Capacity and Capability

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

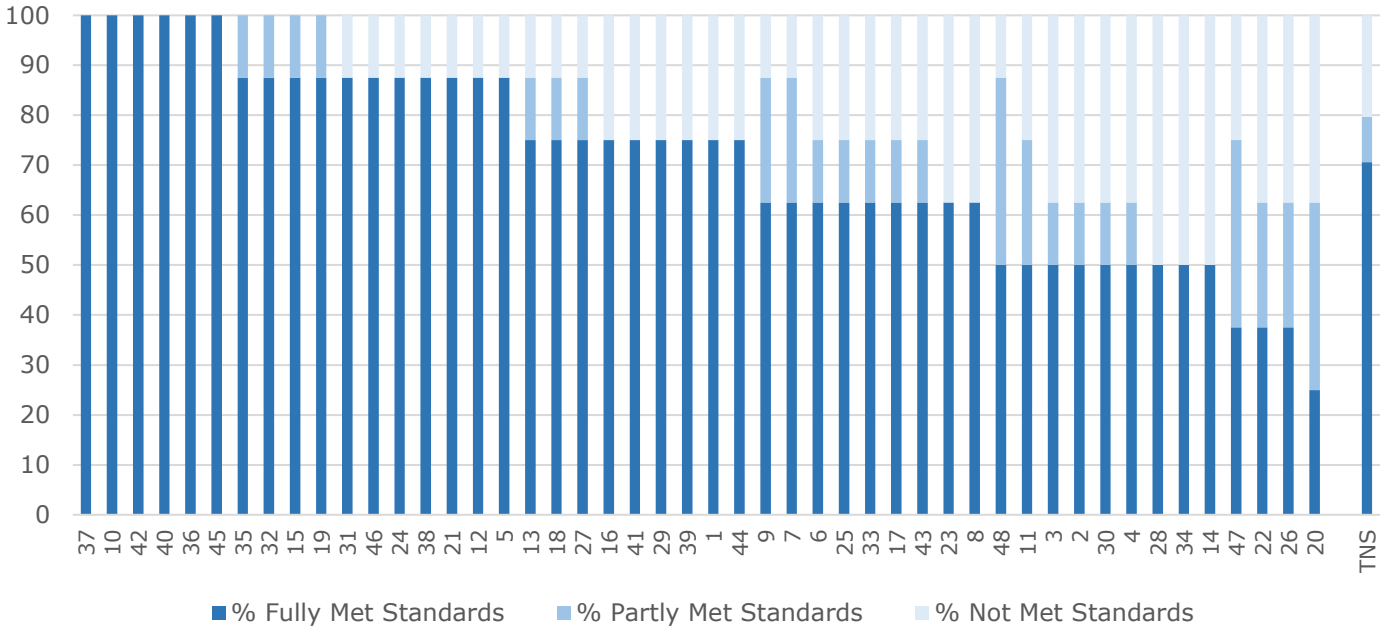


Figure 9: Service compliance for workforce capacity and capability

Staffing group

The multi-disciplinary team (MDT) consists of, or has access to, staff from a number of different backgrounds in 79% of services. This enables them to deliver a full range of treatments and therapies that are appropriate to the patient population.

79% of teams have access to specialists relevant to the needs of the patient group. This could include intellectual disabilities, autistic spectrum disorder, neuropsychiatric disorders and cognitive impairment.

Only one-third of services review the staff members and skill mix of the team every 12 months, to identify gaps in the team and develop a balanced workforce.

Good practice examples

The service has a well embedded learning disabilities pathway and an older age pathway. Staff across the establishment are well informed on learning disabilities and regular training is provided to prison staff for this. The service has recently approved a new wing specifically for patients on the older age pathway.
Belmarsh

An ADHD pathway has been developed and a group has recently begun. The group has been created to promote awareness of ADHD and to provide support for those with a diagnosis. ADHD care plans have also been created on NOMIS to ensure that officers are aware of people requiring support.
Ranby

The team is running a new stepped care model focusing on psychosocial aspects. These sessions, which include group sessions through to high intensity complex care treatment, work alongside the prison support services. The psychology team has expanded to provide the full model. Additionally, the psychosocial substance misuse service is provided by Oxleas NHS Trust.
Isis

Team capacity

In 60% of services, there are capacity management plans in place to ensure the continuity of the service in the event of leave or sickness.

58% of services have written arrangements in place to ensure specialist mental health advice can be accessed out of working hours.

Good practice examples

A seven-day service has been introduced to assist the prison in managing individuals under their care, as well as assist with new referrals. A late shift has also been introduced, which sees a member of the mental health team on shift until 6:30pm to assist the prison with patients returning from the court or late receptions. A member of the team is allocated to the First Night Centre for individuals who may not have been picked up during reception screening.
Lincoln

Communication

Almost all services have a minimum of monthly MDT clinical meetings, which are recorded with written minutes.

The majority of services have a clearly identified clinical lead for the team.

63% of services have a clear written protocol for the prescribing responsibilities between psychiatrists, GPs and nurse prescribers.

Workforce Training, CPD and Support

On average, services fully met 59% of standards in this area, ranging from 8% to 92% compliance.

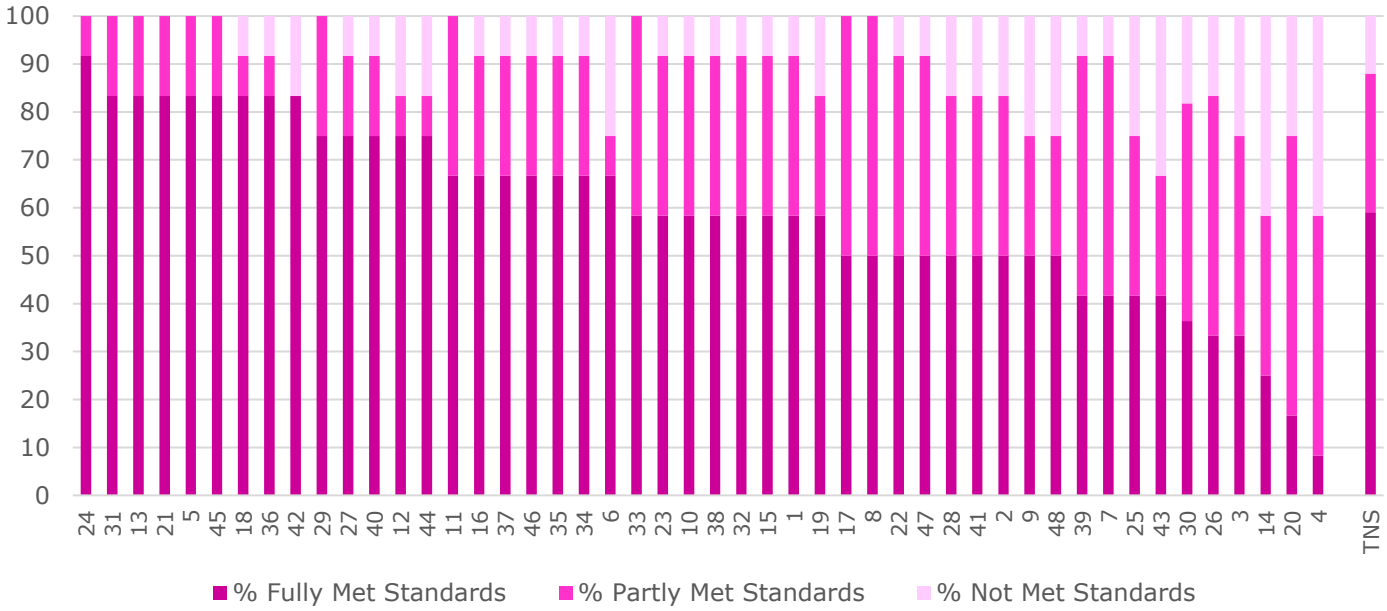


Figure 10: Service compliance for workforce training, CPD and support

Staff support and wellbeing

Staff in 77% of services reported accessing processes to support their health and wellbeing.

Monthly clinical supervision and monthly line management supervision are only available to staff in 46% of services.

Staff in 60% of services are not provided with access to reflective practice sessions monthly.

The majority of staff receive an annual appraisal and personal development planning.

Permanent mental health team staff in 35% of services did not receive a full local prison induction within 28 days of commencing employment.

Good practice examples

Nursing and trainee medical staff spoken to feel that they are well supported by their managers and that they have access to clinical supervision and managerial supervision on a monthly basis. Staff receive formal reflective practice on a weekly basis, which is facilitated by psychiatric and nursing practitioners from the Central Mental Hospital.
Cloverhill

Good practice examples

Staff reported strong leadership and good peer-support. The management team was described as supportive and staff were highly appreciative of the team manager, stating she brings a "real positivity" to the team. In addition, the team manager delivers groups and has a caseload, which staff felt positively about.
Exeter

Wellness recovery action plans (WRAP) plans are in place for staff members, in addition to "thankful Friday" in which staff use a jar to put any notes about something they are grateful for within the team that week. These notes are randomly selected and read out to the team. There is a "good deed feed" displayed in the Hub, showcasing good practice of staff members and acknowledging staff achievement or innovative work conducted. Away days are in place for the staff and the team noted that managers have an open-door policy and are approachable at all times.
Holme House

Reflective practice occurs fortnightly and is facilitated by an external professional from Tavistock. Alongside this, staff are receiving monthly clinical and line management supervision, as well as group supervision. Staff benefit from a wellbeing day hosted by the prison that focuses on staffs' health and team-working.
Wandsworth

Staff can access weekly reflective practice sessions, counselling support and a member of staff acting as a wellbeing champion, who attends wellbeing meetings and brings back new ideas to the team on how to support staff health and wellbeing.
Swansea

The team has access to counselling services and regular away days.
Deerbolt

The team has a wellbeing day every Wednesday, regular away days, and other activities to bond as a team. There is a team wellbeing champion who is trained in mindfulness and sessions are facilitated for staff on a monthly basis. Through the Trust, staff also have access to mindful retreats and occupational health.
Durham

There is a wellbeing wall in the office to keep staff motivated, and the team will take part in events and initiatives throughout the year such as 'Cake Thursday' and colour runs.
Haverigg

The team support general prison staff with reflective practice sessions.
Feltham

Training and development

83% of mental health staff receive training that is consistent with their role, and in line with their professional body. However, only 54% of staff receive training on risk assessment and risk management, such as safeguarding, management of suicide risk and self-harm, and prevention and management of violence and aggression.

Staff in 81% of services reported receiving Continuing Professional Development (CPD) in line with their personal development plans.

Only 8% of services have mechanisms in place to fully inform all staff within the establishment about the prevention, assessment and management of mental health problems in people with learning disabilities.

Under half of services are providing full training in SystmOne to ensure staff competency in its use.

Good practice examples

Partner agency teams value the delivery of training on a range of mental health related topics, which has a particularly high uptake from uniformed staff.
Belmarsh

All staff are trained in HCR20 and enhanced suicide prevention training. This is part of the Trust's zero suicide target. Also, there are opportunities to gain nurse prescriber qualifications.
Peterborough

Staff members can access training on a variety of topics, including personality disorder (PD) and autism diagnostic observation schedule (ADOS). Some staff are due to attend cognitive behavioural therapy (CBT) training and undertaking nurse prescriber qualifications.
Aylesbury

Personal development is well embedded across the team, with examples of staff receiving funding to do further training and courses.
Lewes

The Trust reportedly encourages staff to develop their careers and are provided with in-house trainers when required and, if staff are required to attend training that is far away, a hire car is provided.
Preston

Learning opportunities are provided between partner agencies and the team. A training session is put in place by either partner agencies or the mental health team on a quarterly basis. This provides a learning opportunity on certain topics and themes that are relevant within the current issues faced at the prison as well as developing and maintaining good working relationships between teams.
Mountjoy

Governance

On average, services fully met 73% of standards in this area, ranging from 38% to 92% compliance.

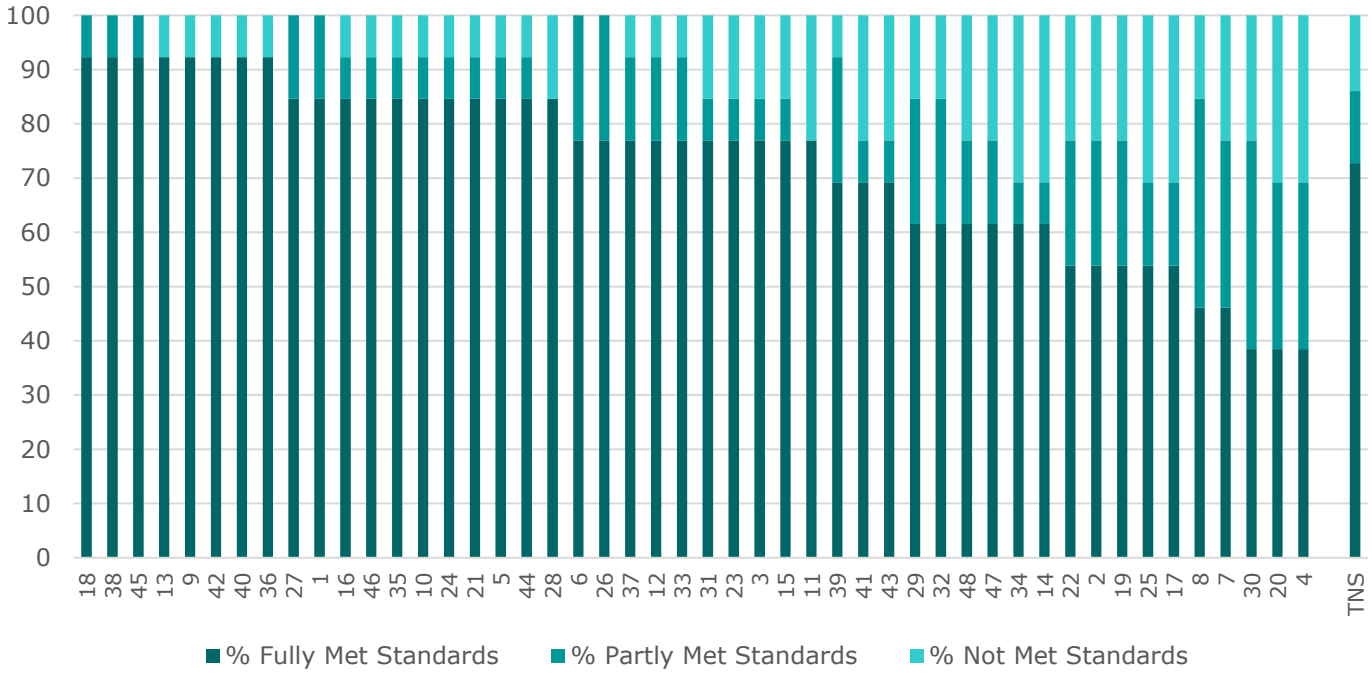


Figure 11: Service compliance for governance

Incidents and lessons learned

Staff members in the majority of services feel they can quickly and effectively report incidents.

Staff members who are affected by a healthcare related serious incident are offered a debrief and post incident support in 77% of services.

90% of services share 'lessons learned' from incidents with the team and the wider organisation. This includes audit findings and action planning.

Service development, audit and research

Just over half of services review data on missed appointments on an annual basis to identify where engagement difficulties may exist.

In 52% of services, staff undertake audits, and agree and implement action plans, which are then disseminated to the team.

Only one third of services are engaging in service relevant research and academic activity.

Good practice examples

Using outcome measurement data, the team is actively engaged in research and academic activity. A recent study explored clinical activity and outcomes for a combined prison in-reach and court liaison service.
Cloverhill

The service is proactive in identifying gaps for service improvement and developing actions plans to address these. For example, based on the needs of the service, two new posts were created when the service was restructured in April 2018.
Eastwood Park

The team has established strong links with the wider Trust; they are learning from good practice present in other prisons to improve their service and they are working closely with the local medium secure unit to enhance continuity of care for patients.
Leicester

The team is highly active in research and academic activities; including a long-term ADHD randomised control trial that started in 2011. This is a National Institute for Health Research (NIHR) funded trial monitoring ADHD within the young adult prison environment. This trial is coming to an end this year and so the team are looking at how to continue the provision of high quality ADHD care. Alongside this, the Trust encourages staff to undertake their own quality improvement (QI) projects, and there is currently a review of the antipsychotic prescribing between primary care and the pharmacy team to streamline the process for prescribing between the two agencies.
Isis

Lessons learned are discussed during monthly clinical governance meetings. Members of the team will meet with other prisons in the cluster to share lessons learned on any serious or untoward incidents to encourage shared learning.
Feltham

The service has partnered with the University of Nottingham in undertaking research into self-harm and suicide. This is contributing towards developing a pathway at the prison to improve interventions and identify risk.
Nottingham

Clinical governance and quality processes

In almost all cases, there is a representative of the mental health team that is part of the establishment's clinical governance and quality processes.

83% of teams review their progress in conjunction with partner agencies. This is done against its own local plan/strategy and includes objectives and deadlines in line with the organisation's strategy.

94% of services share their key clinical/service measures and reports between the team and the organisation's board.

Policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use in 92% of services.

Good practice examples

The team's governance processes are well embedded and there are various avenues for communication, review, learning lessons and action planning in place. The systems and performance lead oversees and manages data which is shared monthly and covers a variety of measures.
Berwyn

There is an open line of communication within the team and with the wider organisation, with the intent of sharing good practice and improving the service at every turn. There are daily meetings attended by staff and a daily conference call with the other six prisons within the cluster, which the staff team reported on positively.
Holme House

The mental health team has a 'good practice board' within their main office to highlight any areas of good practice.
Peterborough

Patient involvement

Only 27% of services involve patients in the governance and development of the team.

Good practice examples

A mental health representative/champion is on each wing. They have a range of leaflets that all inmates can access, including distraction kits with various crafting activities. The representatives can relay information to the mental health team if an individual wishes to speak to them.
Dartmoor

24-Hour Mental Healthcare

On average, services fully met 55% of standards in this area, ranging from 26% to 74% compliance. Eight services were assessed against the standards for 24-hour mental healthcare in prisons.

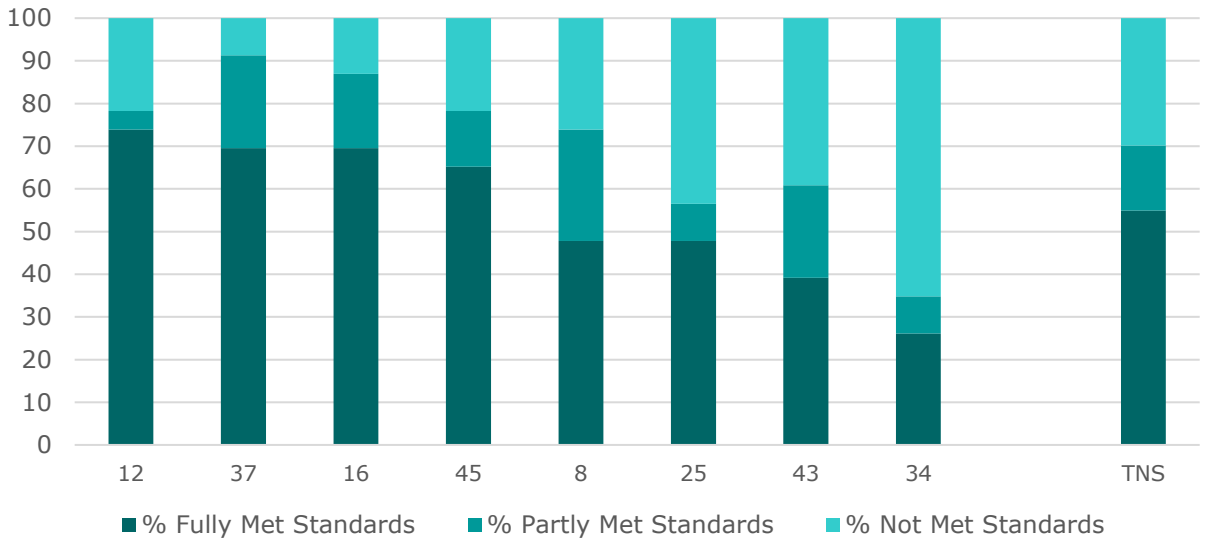


Figure 12: Service compliance for 24-hour mental healthcare

Care and treatment

Just over one-third of patients reported having the purpose of the admission explained to them, with a capacity assessment performed within 24 hours of admission.

63% of inpatient units conduct a comprehensive assessment that is started within four hours and completed within 48 working hours. This involves the MDT and the patient themselves.

Three-quarters of inpatient units update risk assessments and management plans according to clinical need or monthly at a minimum. The same amount of services have their patients' medication reviewed at least weekly.

Discharge planning begins at the first review and outcomes for discharge are agreed within 63% of inpatient units.

Staffing

The unit is staffed by permanent staff members, with bank and agency staff only being used in exceptional circumstances, in 75% of services.

Only 38% of services have agreed minimum staffing levels that include at least one qualified nurse being present on all shifts.

All services have access to a specialist pharmacist to support their prescription of medication.

Patient engagement

All services reported engaging patients in active conversation at least twice a day, and 88% of services reported that patients can access safe outdoor space every day.

One quarter of services provide activities to patients seven days a week.

Only 13% of services offer patients pre-arranged one-hour sessions at least once a week with their key worker. The same percentage of services have a weekly minuted community meeting that is attended by both patients and staff.

Good practice examples

The "Green Pages" newsletter available to patients in the inpatient unit is outstanding. This newsletter includes an array of information and activities for patients, such as information about the team, sessions available, Samaritans information, anger management information and various in-cell activities, such as crosswords and colouring. This newsletter was developed, and is managed and updated by, one of the officers within the inpatient unit.
Birmingham

The inpatient unit, Addison, is growing more towards a therapeutic environment. There are now 22 dedicated prison staff working on the ward, and a team manager is in place. The additional staff are making it possible to facilitate activities seven days a week and a weekly psychology group, although the prison regime will sometimes interrupt this. The yoga sessions are particularly popular with the patients. There is a therapeutic garden and outside area with chickens roaming.
Wandsworth

Policies and procedures

All teams keep medications in a secure place, and in line with the organisation's medicine management policy.

63% of services have a clear policy in place for the use of rapid tranquilisation within the unit. This includes the issue of consent.

There are arrangements in place to ensure that a doctor is available at all times to attend the unit, including out of hours, in half of services.

Appendix

Appendix 1 – Member Services' Contact Details and Information

Service	Contact Details	Information
Aylesbury *Barnet, Enfield and Haringey Mental Health NHS Trust*	Lynn Glassup Service Manager lynn.glassup@justice.gov.uk 01296444075	Prison provider: Public Population size: 444 Type: Male & Young Adult Category: High Secure Patients on caseload: 35
Belmarsh *Oxleas NHS Foundation Trust*	Suraj Persand Mental Health/Substance Misuse Service Manager s.persand@nhs.net 0207 147 5012	Prison provider: Public Population size: 900 Type: Male Adult Category: A Patients on caseload: 38 Dedicated beds: 33
Berwyn *Betsi Cadwaladr University Health Board*	Robert Lightburn Deputy Head of Healthcare robert.lightburn@wales.nhs.uk 01978 523040	Prison provider: Public Population size: 1231 Type: Male Adult Category: C Patients on caseload: 130
Birmingham *Birmingham and Solihull Mental Health NHS Foundation Trust*	Tracey Fisher Mental Health Service Manager tracey.fisher2@nhs.net 0121 598 8009	Prison provider: Private Population size: 950 Type: Male Category: B Patients on caseload: 131 Dedicated beds: 15
Brinsford *Midlands Partnership NHS Foundation Trust*	Nicola Black Team Manager Nicola.black@mpft.nhs.uk 01902 533465	Prison provider: Public Population size: 577 Type: Young Adults, Adults Category: C Patients on caseload: 148 Dedicated beds: 10
Bristol *Inspire Better Health (Avon and Wiltshire mental Health Trust and Bristol Community Health)*	Jane Anderson Service Manager jane.anderson12@nhs.net 07825256866	Prison provider: Public Population size: 614 Type: Male remand Category: B Patients on caseload: 50 Dedicated beds: 8
Brixton *Barnet, Enfield and Haringey Mental Health NHS Trust*	John Martins Team Manager John.martins01@hmps.gsi.gov.uk 020 8588 6125	Prison provider: Public Population size: 798 Type: Male Adult Category: C Patients on caseload: 123

Bullingdon *Midlands Partnership NHS Foundation Trust*	Joanne Rowsell Clinical Lead Oxon Prison Cluster joanne.rowsell@mpft.nhs.uk 01869 353425	Prison provider: Public Population size: 1,114 Type: Male Category: B, C Patients on caseload: 43 Mental Health Inreach Team; 43 Primary Care Mental Health Team
Cardiff *Cardiff and Vale University Health Board*	Tim Nagle Team Leader Timothy.Nagle2@wales.nhs.uk 029209 23157	Prison provider: Public Population size: 824 Type: Male, Adult Category: B Patients on caseload: 65
Channings Wood *Devon Partnership Trust*	Gregg Smith Business Administrator gregorysmith@nhs.net 01626 884 583	Prison provider: Public Population size: 724 Type: Male Category: C Patients on caseload: 51
Cloverhill *Health Service Executive*	Conor O'Neill Consultant Forensic Psychiatrist cjoneill@irishprisons.ie 035312157585	Prison provider: Public Population size: 400 Type: Male Category: Remand Patients on caseload: 34 Dedicated beds: 28
Dartmoor *Devon Partnership Trust*	Gregg Smith Business Administrator gregorysmith@nhs.net 01626 884 583	Prison provider: Public Population size: 640 Type: Male Category: C Patients on caseload: 86
Deerbolt *Tees, Esk and Wear Valleys NHS Foundation Trust*	Tracey Keaveney Mental Health Team Manager tkeaveney@nhs.net 01833 633406/633407	Prison provider: Public Population size: 513 Type: Sentenced male young adult Category: YOI closed Patients on caseload: 95
Durham *Tees, Esk and Wear Valleys NHS Foundation Trust*	Kayleigh Parris Team Manager kayleigh.parris@nhs.net 0191 332 3597	Prison provider: Public Population size: 998 Type: Adult and YOI Male Reception Category: B Patients on caseload: 269 Dedicated beds: 11
Eastwood Park *Inspire Better Health (Avon and Wiltshire Mental Health Trust and Bristol Community Health)*	Fiona Banes Community Services Manager and Consultant Psychiatrist fiona.banes@nhs.net 01275 796297	Prison provider: Public Population size: 368 Type: Female Category: Closed Patients on caseload: 251

Elmley *Oxleas NHS Foundation Trust*	Kevin Valydon Mental Health Manager kevin.valydon@nhs.net 01795 802000	Prison provider: Public Population size: 1250 Type: Adult Male Category: B Patients on caseload: 122 Dedicated beds: 10
Exeter *Devon Partnership Trust*	Gregg Smith Business Administrator gregorysmith@nhs.net 01626 884 583	Prison provider: Public Population size: 469 Type: Male Category: B Patients on caseload: 59
Feltham *Barnet, Enfield and Haringey Mental Health NHS Trust*	Brian Ashley Deputy Head of Healthcare brian.ashley@nhs.net 0208 844 5250	Prison provider: Public Population size: 540 Type: Young adults and young people - 15 to 21 years of age, male only Category: B Patients on caseload: 130 Dedicated beds: 12
Frankland *Tees, Esk and Wear Valleys NHS Foundation Trust*	Claire Hammal Team Manager chammal@nhs.net 0191 3765221	Prison provider: Public Population size: 845 Type: Male Category: A Additional Specialisms: N/A Patients on caseload: 225
Haverigg *Tees, Esk and Wear Valleys NHS Foundation Trust*	Gary Atkinson Team Manager gary.atkinson@nhs.net 01229 713031	Prison provider: Public Population size: 264 Type: Male Category: C Patients on caseload: 58
Holme House/ Kirklevington Grange *Tees, Esk and Wear Valleys NHS Foundation Trust*	Kali Penfold Team Manager kali.penfold@nhs.net 01642 744134	Prison provider: Public Population size: 1210 Type: Male convicted adults and young persons Category: C Patients on caseload: 274
Isis *Oxleas NHS Foundation Trust*	Pamela Mandaza Inreach Manager pamela.mandaza@nhs.net 0203 3564263	Prison provider: Public Population size: 620 Type: Male Category: C Patients on caseload: 58
Isle of Wight *Care UK*	Jane Manning Team Leader jane.manning@careuk.com 01983 635360	Prison provider: Public Population size: 1110 Type: Closed training establishment, High secure and Longer-term Estate Category: B Patients on caseload: 260

Lancaster Farms *Tees, Esk and Wear Valleys NHS Foundation Trust*	Sally Newport, Team Leader sally.newport@nhs.net 01524 563577	Prison provider: Public Population size: 560 Type: Adult resettlement prison Category: C Patients on caseload: 60
Leicester *Nottinghamshire Healthcare NHS Foundation Trust*	Jenny White Head of Healthcare jenny.white@nottshc.nhs.uk 0116 228 3052	Prison provider: Public Population size: 340 Type: Male Category: B Patients on caseload: 78
Lewes *Sussex Partnership NHS Foundation Trust*	Denise Bowden Business Manager denise.bowden@nhs.net 0127 378 5138	Prison provider: Public Population size: 712 Type: Male local remand prison Category: B
Lincoln *Nottinghamshire Healthcare NHS Foundation Trust*	Suzan Lilley Clinical Matron Suzan.lilley@nottshc.nhs.uk 01522663321	Prison provider: Public Population size: 523 Type: Male Category: B Patients on caseload: 221
Low Newton *Tees, Esk and Wear Valleys NHS Foundation Trust*	Phil Flanagan Team Manager philip.flanagan@nhs.net 0191 376 4226	Prison provider: Public Population size: 332 Type: Female Category: Closed Patients on caseload: 92
Lowdham Grange *Nottinghamshire Healthcare NHS Foundation Trust*	Trish Johnson Clinical Matron trish.johnson@nottshc.nhs.uk 0115 966 9270	Prison provider: Private Population size: 988 Type: Male Category: B Patients on caseload: 133
Maghaberry *South Eastern Health and Social Care Trust*	Helen McNally Prison Healthcare Mental Health Lead prisonhealthcare.LVH@setrust.hscni.net 02892633594	Prison provider: Public Population size: 818 Type: Adult Male Category: A Patients on caseload: 200
Morton Hall (IRC) *Nottinghamshire Healthcare NHS Foundation Trust*	Jacqueline Stephens Clinical Matron Jacqueline.Stephens@nottshc.nhs.uk 01522 666919	Prison provider: Public Population size: 392 Type: Immigration removal centre; Adult Male Category: N/A Patients on caseload: 40

Mountjoy (Dochas Centre) *Health Service Executive*	Dr Ronan Mullaney Consultant Forensic Psychiatrist ronan.mullaney@hse.ie 035312989266	Prison provider: Public (Irish Prison Service) Population size: Operational capacity 105; Currently 142 Type: Female; sentenced and remand Category: Closed medium secure Patients on caseload: 23 Dedicated beds: 10
North Sea Camp *Nottinghamshire Healthcare NHS Foundation Trust*	Suzan Lilley Clinical Matron Suzan.Lilley@nottshc.nhs.uk 01522 663321	Prison provider: Public Population size: 406 Type: Male Category: D Patients on caseload: 82
Northumberland *Tees, Esk and Wear Valleys NHS Foundation Trust*	Eunice Waddell Team Manager eunice.waddell@nhs.net 01670 383541	Prison provider: SODEXO Justice Service (Private) Population size: 1354 Type: Adult Male Category: Cat C training Patients on caseload: 150
Nottingham *Nottinghamshire Healthcare NHS Foundation Trust*	Caroline Caston Clinical Matron Mental Health caroline.caston@nottshc.nhs.uk 0115 872 4052	Prison provider: Public Sector Population size: 1,060 Type: Male Category: B-Remand Patients on caseload: 260
Parc *Swansea Bay Health Board*	Donna Stuckey Service Manager Donna.Stuckey@wales.nhs.uk 01792 516689	Prison provider: Private Population size: 1,650 Type: Male Category: B Patients on caseload: 64
Pentonville *Barnet, Enfield and Haringey Mental Health NHS Trust*	Junaid Dowool Team Leader jdowool@nhs.net 0207 023 7380	Prison provider: Public Population size: 1310 Type: Male Remand Category: B
Perth *NHS Tayside*	Airlie Dewar Mental Health Team Leader Airlie.dewar@nhs.net 01738458228	Prison provider: Scottish Prison Service Population size: 706 Type: Male adult remand and convicted high secure Category: A Patients on caseload: 98
Peterborough *Cambridgeshire and Peterborough NHS Foundation Trust*	Antony Katsukunya Team Manager Antony.Katsukunya@cpft.nhs.uk 01733217544	Prison provider: Sodexo Justice Service Population size: Male: 868, Female: 372 Type: Male, Female, YOI Category: B Patients on caseload: 99

Preston/Kirkham *Tees, Esk and Wear Valleys NHS Foundation Trust*	Tina Jones-Parry Team Leader tina.jones-parry@nhs.net 01772 444 760	Prison provider: Public Population size: 811 Type: Adult Male Category: B local Patients on caseload: 82
Ranby *Nottinghamshire Healthcare NHS Foundation Trust*	Adeline Hunt Mental Health Matron adeline.hunt@nottshc.nhs.uk 01777 862158	Prison provider: Public Sector Population size: 1050 Type: Male sentenced Category: C Patients on caseload: 190
Styal *Greater Manchester Mental Health NHS Foundation Trust*	Simon Plunkett Clinical Lead for Health and Justice simon.plunkett@gmmh.nhs.uk 01613581935	Prison provider: Public Population size: 480 Type: Female Category: Closed Patients on caseload: 111
Swansea *Swansea Bay Health Board*	Donna Stuckey Service Manager Donna.Stuckey@wales.nhs.uk 01792 516689	Prison provider: Public Population size: 381 Type: Male adult local remand Category: B Patients on caseload: 7
Swinfen Hall *Midlands Partnership NHS Foundation Trust*	Alexis Fairclough Clinical Lead alexis.fairclough@mpft.nhs.uk 07794 022 213	Prison provider: Public Population size: 700 Type: Males aged 18-28 Category: C/YOI Patients on caseload: 137
Thameside *Oxleas NHS Foundation Trust*	Victor Benson Service Manager victor.benson@nhs.net 020 8317 9777	Prison provider: SERCO Private Population size: 1250 Type: Male Category: B and C Patients on caseload: 60
Wandsworth *South London and Maudsley NHS Trust*	Tracey Lewis Service Manager Tracey.lewis@slam.nhs.uk 0208 588 4576	Prison provider: Public Population size: 1550 Type: Male Category: B and C Patients on caseload: 142 Dedicated beds: 12
Woodhill *Central and North West London NHS Foundation Trust*	Helen Spencer-Hicks Deputy Head of Healthcare helen.spencer-hicks@nhs.net 01908 722254	Prison provider: Public Population size: 819 (currently reduced due to current renovations) Type: Male; Adult; YOI; Local prison Category: A Patients on caseload:150 Dedicated beds: 8

Wormwood Scrubs *Barnet, Enfield and Haringey Mental Health NHS Trust*	Angela Smith Mental Health Team Manager angela.smith88@nhs.net 020 8588 3385	Prison provider: Public Population size: 1279 Type: Male Category: B Patients on caseload: 83

Appendix 2 – Standards for Prison Mental Health Services (4th Edition)

No.	Standard
1	As part of the formal reception and induction process, every person receives a first and second stage health assessment that incorporates a mental health screen (NICE guideline 66, 2017). *Guidance: This includes questions and actions relating to learning disabilities and neurodevelopmental disorders.*
2	The mental health screening assessment is carried out by a competent mental health professional with experience of working with people within the criminal justice system with mental health problems (NICE guideline 66, 2017).
3	The role of the team in the first and second reception screening process is clearly defined and in agreement with other health providers and the establishment.
4	There is a clear and consistent process for staff to refer individuals 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, including those available from community services, 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 secondary care 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 in a format they can easily understand. *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	There is a clear system for the management of referrals.
16	Patients are managed under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).
17 (C8.1.6)	Patients are offered written and verbal information about their mental illness. *Guidance: Verbal information could be provided in a one-to-one meeting with a staff member, a ward round or in a psycho-education group.*
18 (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.*
19 (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.*
20 (C7.5)	The practitioner develops the care plan collaboratively with the patient.

21 (C7.2)	The team reviews and updates care plans according to clinical need or monthly, at a minimum.
22	Where applicable, patients are encouraged and supported to be fully involved in their CPA meeting, or equivalent.
23	Patients discuss, negotiate and agree 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.
24	Patients will be shown a copy of the final draft report after the CPA meeting, or equivalent, and will have the opportunity to comment.
25	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.
26	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.*
27	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.
28	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), including active participation in the ACCT process. *Guidance: The mental health team attends or contributes to all ACCT reviews for prisoners under their care. They are involved in decisions about location, observation 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	Patients have their physical healthcare needs assessed on admission and reviewed every six months or more frequently if required. Patients are informed of the outcome of their physical health assessment and this is recorded in their notes. *Guidance: This includes past medical history and family medical history, current medication, physical observations, physical examination, blood tests, physical symptoms, lifestyle factors and lifestyle advice.*
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 establishment, the mental health team provides a comprehensive handover to the receiving establishment'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 meetings, including 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 contacts the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from the establishment. *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. *Guidance: 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 (C18.1)	Confidentiality and its limits are explained to the patient at the first assessment, both verbally and in writing.

47 (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.
48	The team communicates any information that might affect a patient's safety across relevant agencies and care settings, within the limits of confidentiality and patient consent.
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	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.*
53	The team proactively follows up with patients who fail to collect or take their medication.
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 policies on food refusal and mental capacity assessments.
57	The team understands and engages in policies on reporting intelligence according to the establishment's security reporting system.
58	There is a joint working policy between the establishment, 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 policies on Multi-agency Public Protection Arrangements (MAPPA).
60	The team supports the 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	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 specialist mental health advice can be accessed 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)	There are processes in place to support 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	All staff members are fully informed about the prevention, assessment and management of mental health problems in people with learning disabilities (NICE guideline 54, 2016). *Guidance: This includes all staff working within the establishment.*
83 (C24.1)	All staff members receive an annual appraisal and personal development planning or equivalent. *Guidance: This contains clear objectives and identifies development needs.*
84	All staff within the team receive Continuing Professional Development (CPD) in line with their personal development plan and revalidation requirements.
85 (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.*
86 (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.*
87 (C25.3)	Staff members have access to monthly reflective practice groups.
88	A representative of the team is part of the establishment's clinical governance and quality processes.

89	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.*
90 (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.
91 (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.*
92 (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.*
93 (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.
94 (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.
95 (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.
96 (C30.3)	Staff members who are affected by a healthcare related serious incident are offered a debrief and post incident support.
97 (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.*
98 (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.
99 (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.*
100	The team engages in service relevant research and academic activity.

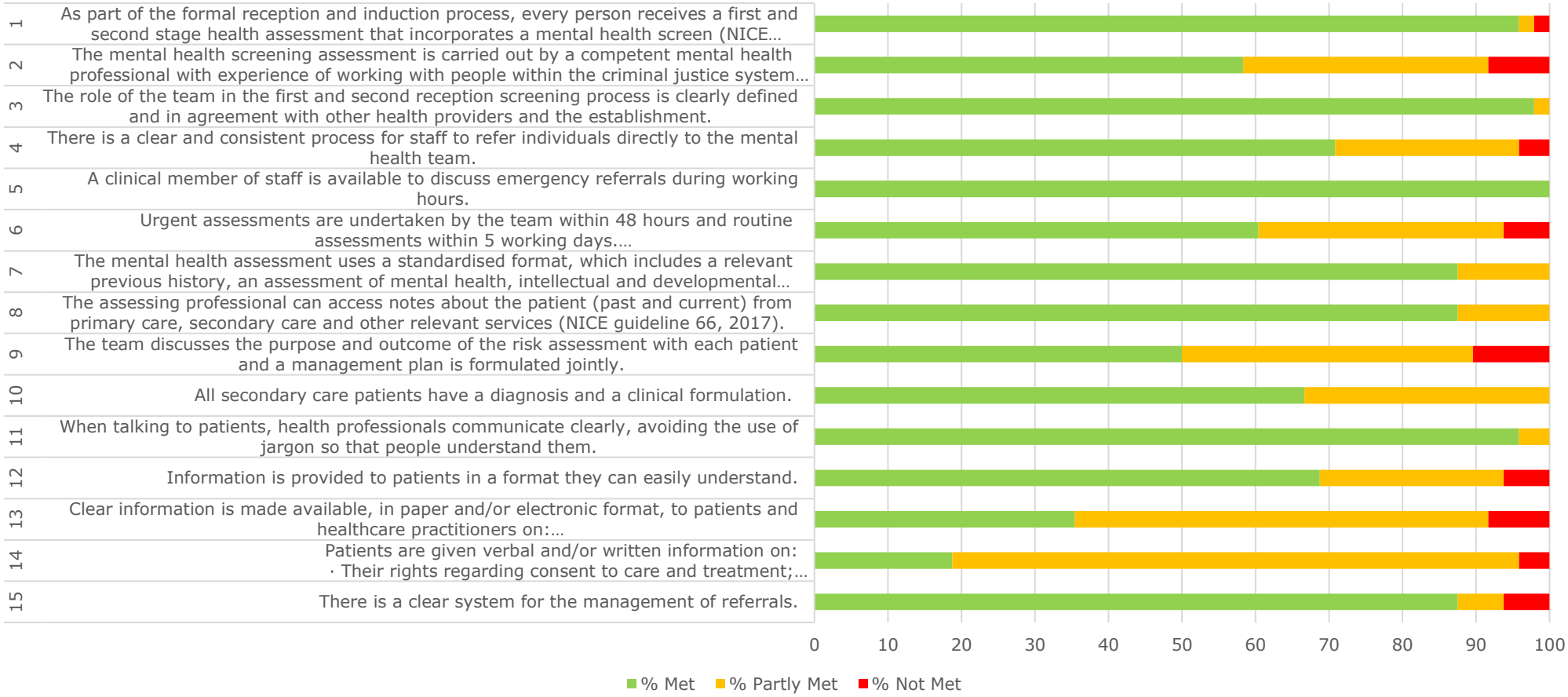
24-Hour Mental Healthcare in Prisons	
101	There is an agreed operational policy which includes the following areas: • admission and discharge criteria; • admission decision making, including out of hours; • leadership of the unit, including clinical and discipline; • the clinical model of the service, 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.
102	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.
103	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. *Guidance: This relates to mental health admissions only.*
104	Managers and practitioners have agreed weekly clinical review meetings.
105	Activities are provided seven days a week. *Guidance: This can include occupational therapy, art/creative therapies, non-therapeutic activities and in cell activities.*
106	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.
107	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.
108	Discharge planning begins at the first review and outcomes for discharge are agreed.
109	Every patient is engaged in active conversation at least twice a day by a team member and this should be recorded in patient notes. *Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.*
110	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.*
111	Risk assessments and management plans are updated according to clinical need or monthly, at a minimum.

112	Patients are able to access safe outdoor space every day and should be encouraged and supported to do so.
113	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.*
114	The team keeps medications in a secure place, in line with the organisation's medicine management policy.
115	There is a clear policy agreed with the establishment 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.
116	There is a clear policy regarding the use of rapid tranquilisation within the unit, which includes the issue of consent.
117	An audit of environmental risk, including ligature risks, is conducted annually and a risk management strategy is agreed with the establishment. *Guidance: Any problems are recorded and reported to the establishment's senior management personnel.*
118	The team has access to a specialist pharmacist and/or pharmacy technician to support their prescription of medication.
119	There are agreed minimum staffing levels that include at least one qualified nurse present on all shifts.
120	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.*
121	Arrangements are in place to ensure that a doctor is available at all times to attend the unit, including out of hours.
122	The operation of the unit is explicitly included in the commissioning specification from NHS England.
123	Patients who are affected by a healthcare related serious incident are offered a debrief and post incident support.

Appendix 3 – Aggregated Data by Standard

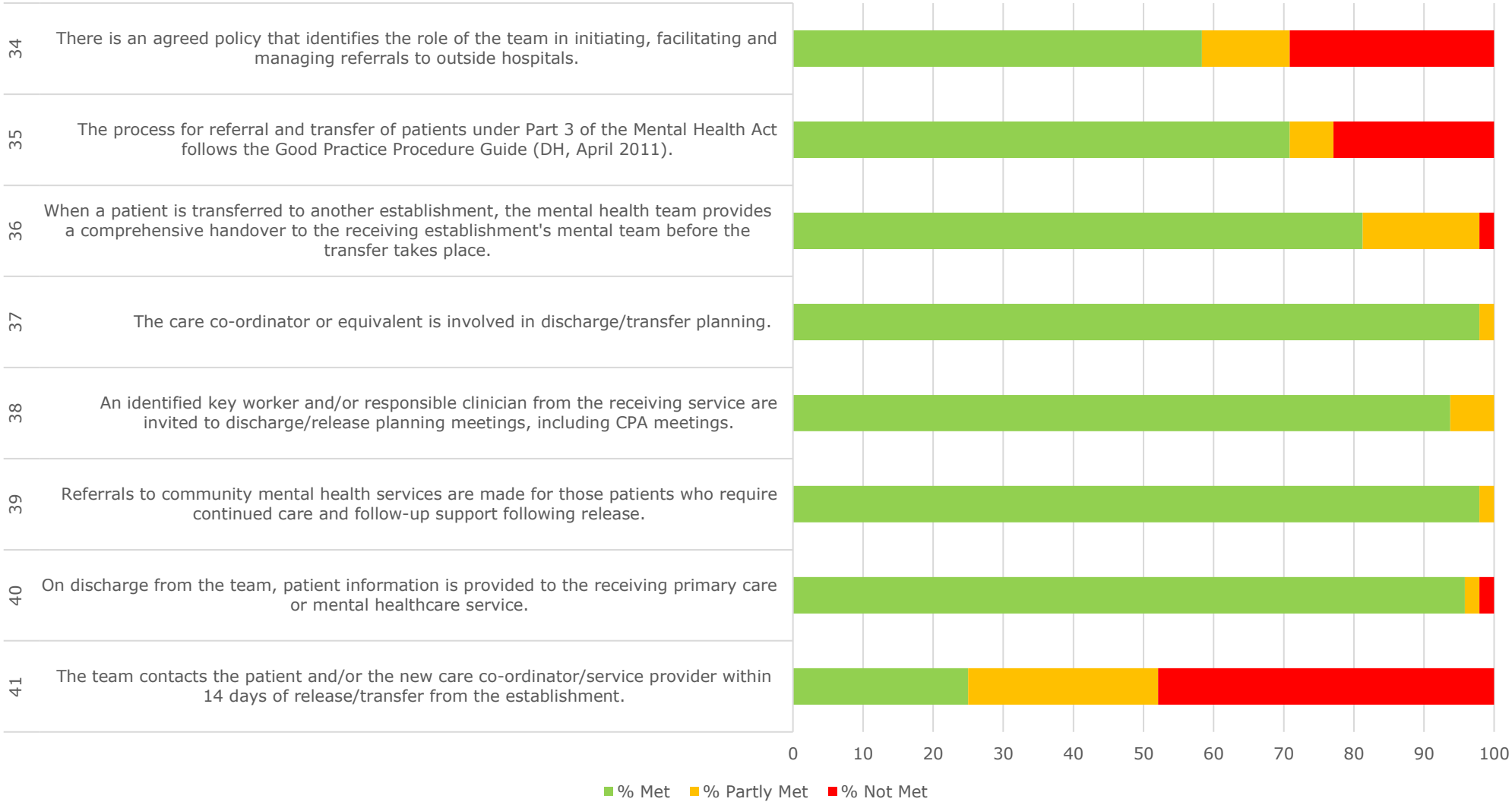
The following tables illustrate overall service compliance for each standard. The wording of the standards in this section has been condensed for the purposes of presentation. A full list of standards used in cycle 4 can be found in appendix 2.

Admission and Assessment

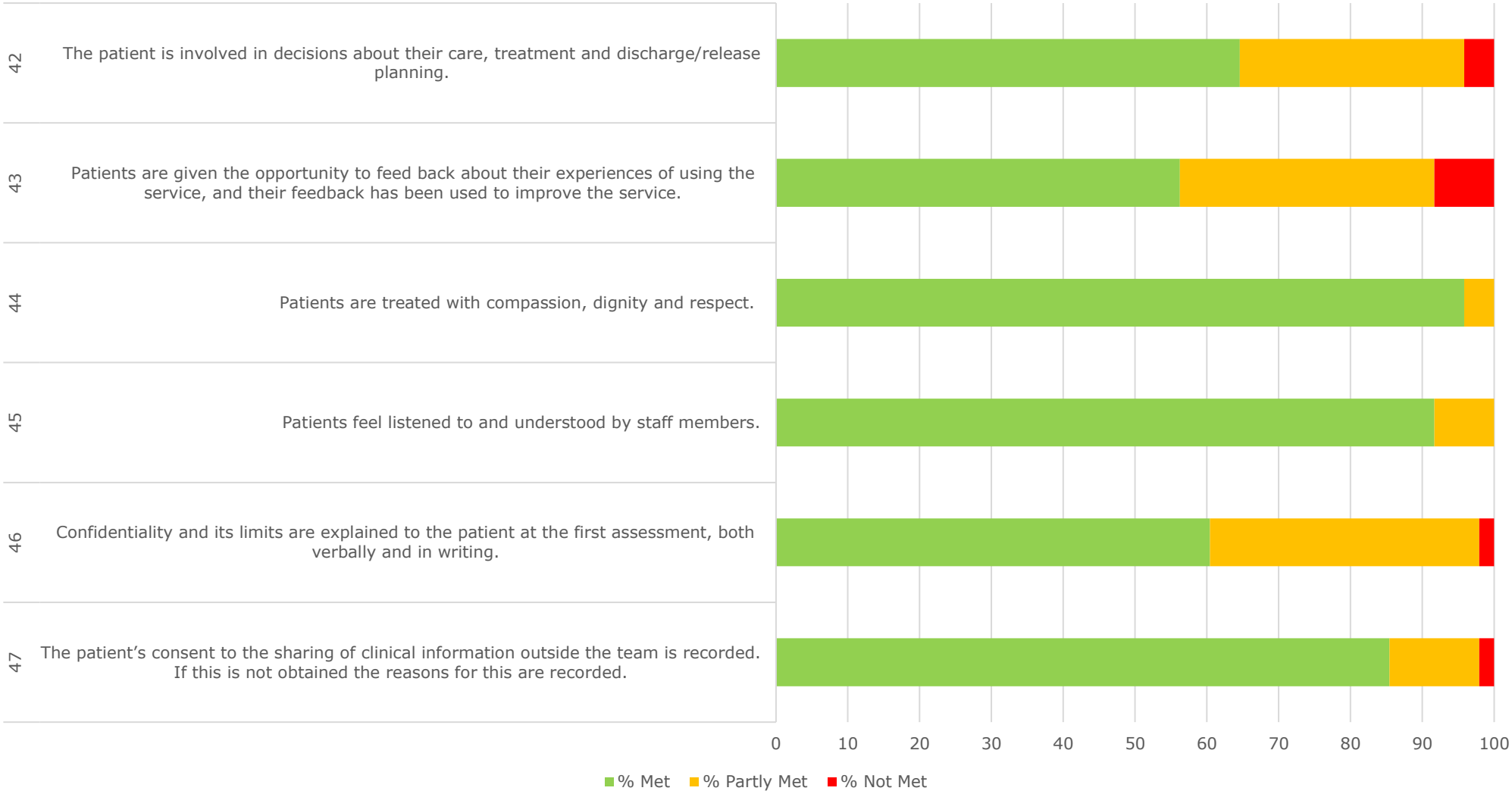


Case Management and Treatment

Referral, Discharge and Transfer

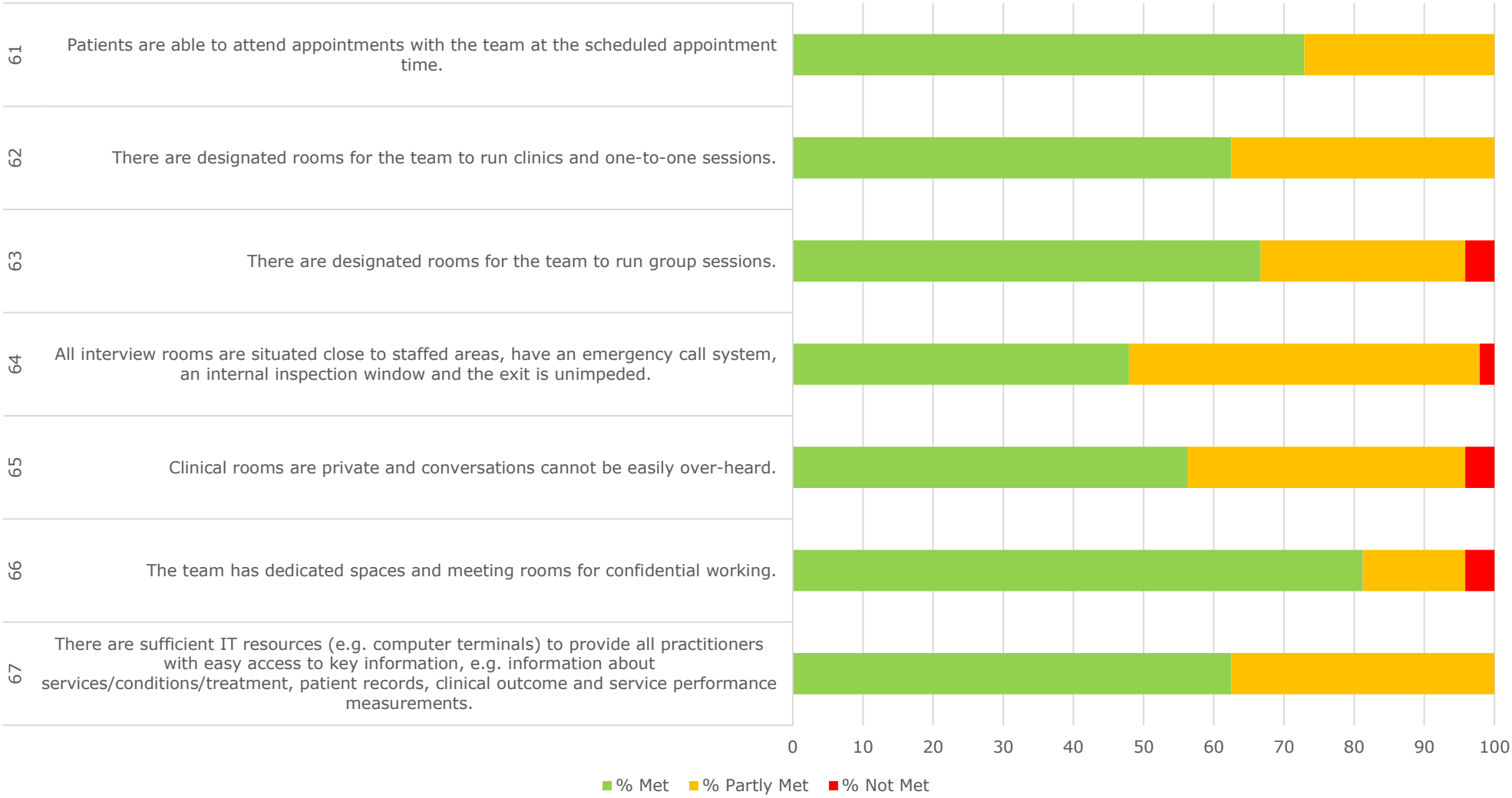


Patient Experience

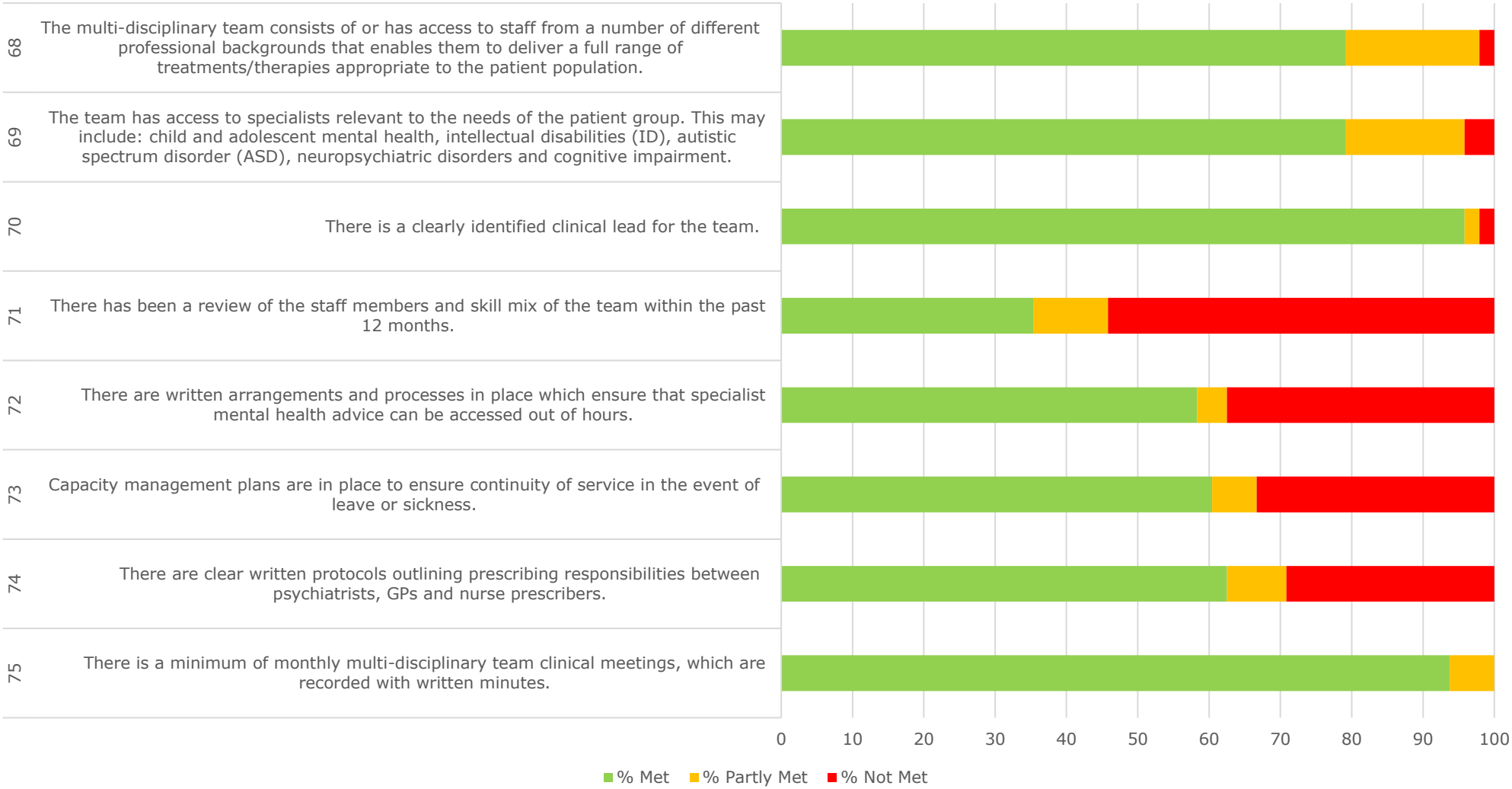


Patient Safety

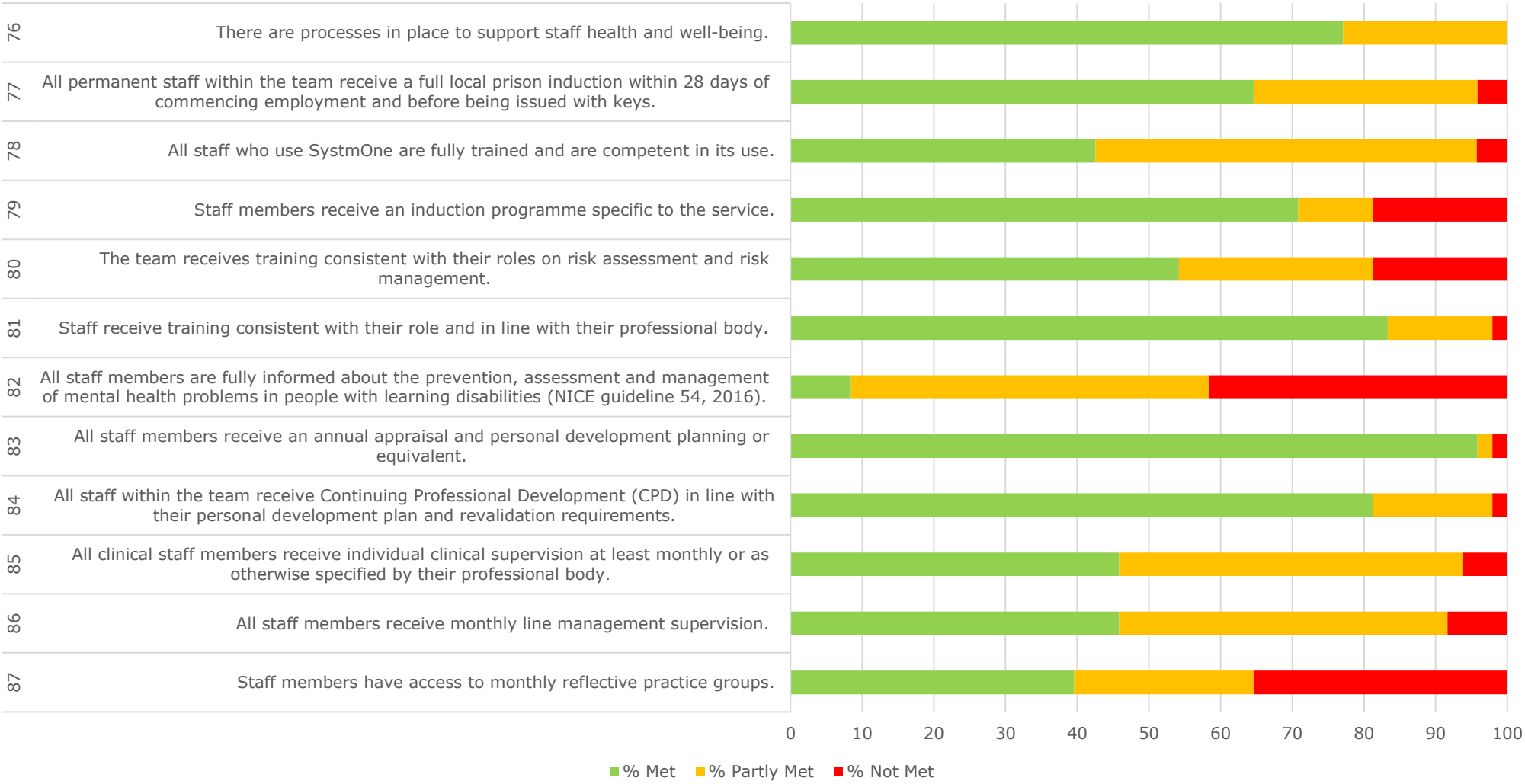
Environment



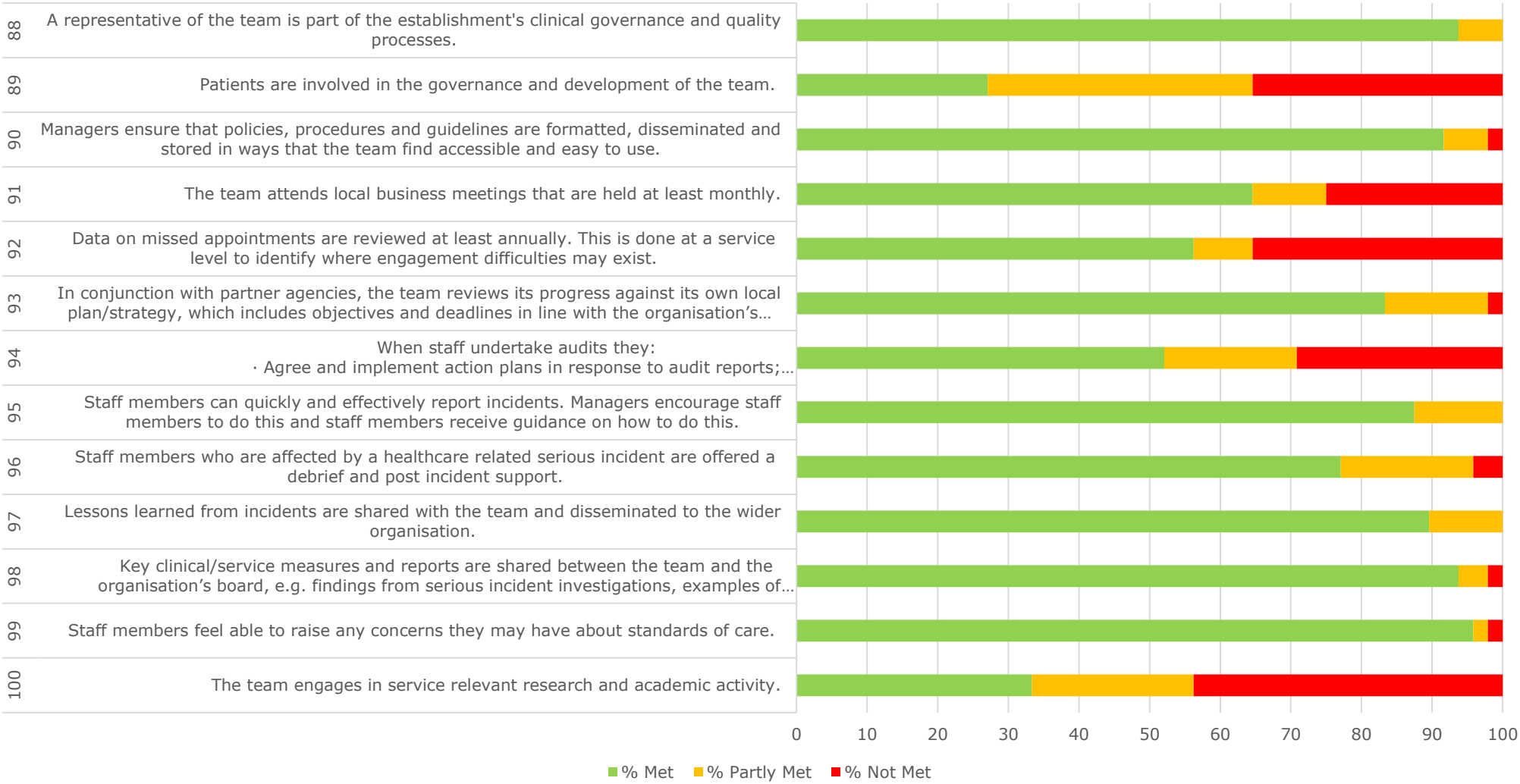
Workforce Capacity and Capability



Workforce Training, CPD and Support



Governance


88
A representative of the team is part of the establishment's clinical governance and quality processes.
89
Patients are involved in the governance and development of the team.
90
Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.
91
The team attends local business meetings that are held at least monthly.
92
Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist.
93
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…
94
When staff undertake audits they:
· Agree and implement action plans in response to audit reports;…
95
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.
96
Staff members who are affected by a healthcare related serious incident are offered a debrief and post incident support.
97
Lessons learned from incidents are shared with the team and disseminated to the wider organisation.
98
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…
99
Staff members feel able to raise any concerns they may have about standards of care.
100
The team engages in service relevant research and academic activity.
0
10
20
30
40
50
60
70
80
90
100
% Met
% Partly Met
% Not Met

24-Hour Mental Healthcare in Prisons

Appendix 4 – Event Programmes

Prison transfer and remission: Improving practice, 27 November 2018. Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction
Professor Gill Mezey, Consultant Forensic Psychiatrist, South West London and St. George's Mental Health NHS Trust, and QNFMHS Advisory Group Member

10:35 Prison transfer and remission: improving practice
Dr Linda Harris, CEO, Spectrum CIC and Chair, Health and Justice Clinical Reference Group (CRG) and Kate Morrissey, Senior National Programme Manager, Mental Health – Secure and Detained, NHS England

11:05 Managing restricted patients
Richard Modelly, Deputy Head of Casework Team 3, Mental Health Casework Section Public Protection Group, Her Majesty's Prison and Probation Service

11:35 Refreshments

11:45 Transfer Remission: A prisons perspective
Governor Tom Wheatley, HMP Wakefield and Georgina Vince, LTHSE Specialist Pathways Progression Lead Long Term and High Security Prisons Group, HMPPS

12:15 Remittal to prison from medium secure services: Access to aftercare and initial outcomes. A national prospective cohort study with a one-year follow-up
Sarah Leonard, Research Associate, Offender Health Research Network

12:45 Q & A and panel discussion
Chair: Dr Huw Stone, Consultant Forensic Psychiatrist, QNPMHS Advisory Group Member

13:15 Lunch

14:00 Workshops: Session one

A: <u>Transfer planning and escorting</u>

Transfer planning and in practice – Understanding our differences
Neil Shanks, Security Transformation Lead & LSMS, St Andrews Healthcare

Escorting in general hospitals – Help me help you
Neil Shanks, Executive Director, John Currie, Executive Director, and Martin Nicholas, Executive Director, National Association for Healthcare Security

B: <u>A patient's perspective</u>

Prison transfer and remission: Issues and possible solutions
Dr Sarah Markham, Patient Reviewer, CCQI

Strange days: Patient experiences of transfer and remission
John Murch, Patient Reviewer, CCQI

C: Young offender populations

Transfers to hospital from a YOI – experiences from Feltham Young Offenders Institute
Dr Michelle Speakman, Specialty Doctor, Wellbeing Team, HMYOI Feltham

14:50 Afternoon refreshments

15:00 Workshops: Session two

A: Patient pathways

The TEWV Jay Ward initiative: rapid prisoner transfer and assessment ward
Dr Pratish Thakkar, Deputy Medical Director, and Dr Steve Barlow, Senior Clinical Director, Tees Esk and Wear Valleys NHS Foundation Trust

Pathways to PICUs and Secure and Forensic settings for Prisoners
Dr Syed Ali and Laura Woods, Matron, Sussex Partnership NHS Foundation Trust

B: Data on transfer and remission from a remand population

Preliminary data on transfers and remissions from a London remand prison over a one-year period
Dr Oriana Chao, Consultant Forensic Psychiatrist, Dr Katherine Bartlett, Consultant Forensic Psychiatrist, and Alex Roberts, Lead Nurse MHIRT, Barnet, Enfield and Haringey Mental Health NHS Trust

C: Partnership working

A proposed model for partnership working between NHS high secure hospitals and HMPPS
Dr Callum Ross, Consultant Forensic Psychiatrist, Clinical Lead PD Pathway, Broadmoor Hospital, West London NHS Trust

15:50 Final plenary

16:00 Close

Safety in prisons, 14 March 2019.
Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction
Dr Steffan Davies, QNPMHS Advisory Group Co-Chair and Consultant Forensic Psychiatrist, Nottinghamshire Foundation NHS Trust

10:35 Safe care and treatment
Jan Fooks-Bale and Tim Byrom, Care Quality Commission

11:05 The management and prevention of self-harm and suicide in prisons in England and Wales
Verity Wainwright, Research Associate and Alice Dawson, Research Assistant, Offender Health Research Network

11:35 Refreshments

11:45 Suicide in prison – rates, risk factors and management
Professor Seena Fazel, University of Oxford and Wellcome Trust Senior Research Fellow in Clinical Science; Honorary Consultant Forensic Psychiatrist, Oxford Health NHS Foundation Trust

12:15 Workshops: Session One

A: Early days in custody – fitting the service to the need, not the need to the service
Helen Spencer-Hicks, Deputy Head of Healthcare, HMP Woodhill, Central and North West London NHS Trust

My experiences of suicide and self-harm in custody
John Murch, Patient Reviewer, QNPMHS

B: Motion: This house believes that the Gaba-Drugs have caused more harm than good
For the motion: Dr Cathy Stannard, Consultant in Complex Pain/Pain Transformation programme, NHS Gloucestershire CCG, and Dr Paul Armitage, Lead GP, HMP Winchester and Medical Director at Med Co Group.
Against the motion: Dr Dominic Adlington, Consultant in Pain Medicine, Hampshire Hospitals NHS Trust, and Dr Adrian Feeney, Consultant Forensic Psychiatrist, Central and North West London NHS Trust

13:15 Lunch

14:00 RCGP Safer Prescribing in Prisons: An overview of the 2nd edition
Dr Caroline Watson, Lead GP, HMP Bedford and RCGP Secure Environments Group

14:30 Narcotics Anonymous in UK prisons
Peter and Kevin, Narcotics Anonymous

15:00 Refreshments

15:10 Workshops: Session Two

A: T CUP- Thinking Clearly Under Pressure- Safer approaches to the management of the collapsed/unconscious individual
Dr Abu Shafi, Higher Trainee in Forensic Psychiatry, Camden and Islington NHS Foundation Trust

B: Reducing deaths in custody: a developmental initiative and case study
Chris Hart and Suraj Persand, Oxleas NHS Foundation Trust, HMP Belmarsh

C: The use of WRAPs to enhance the wellbeing within a team
Kali Penfold, Team Manager, and Lucia-Parry Newton, Higher Assistant Psychologist, HMP Holme House

D: Improving staff health and wellbeing
Megan Georgiou, Kate Townsend and Leyla Golparvar, QNPMHS

16:10 Final plenary

16:15 Close

Care Programme Approach (CPA) in Prisons: Consultation Event, 11 April 2019.
Radisson Blu Hotel, Frankland Lane, Durham, DH1 5TA.

09:30 Registration and refreshments
10:00 Welcome and introduction
Steve Barlow, Senior Clinical Director, Tees, Esk and Wear Valleys NHS Foundation Trust

10:05 Introduction to ThinkOn - Solution Focused Thinking
Tees, Esk and Wear Valleys NHS Foundation Trust Master Coaching

10:35 Improving the delivery of CPA in prisons
Megan Georgiou, Programme Manager and Jemini Jethwa, Project Officer, Quality Network for Prison Mental Health Services

10:45 Introduction and history of CPA
David Kingdon, Clinical Director (AMH), Southern Health NHS Trust

11:05 CPA – back to the foundations to help build for the future
Michael Cowan, Care Programme Approach (CPA) Lead Officer, Tees, Esk and Wear Valleys NHS Foundation Trust

11:25 Workshop: Challenges/ barriers/ areas of good practice

12:05 LUNCH
13:05 Access to aftercare upon remittal to prison: rethinking section 117 aftercare planning
Sarah Leonard, Research Associate, Offender Health Research Network

13:20 Workshop: Possibility thinking and ideas generation

14:15 REFRESHMENTS
14:35 Working with community mental health teams
Tracey Fisher, Service Manager, Birmingham and Solihull Mental Health NHS Foundation Trust

14:50 Presentation: Patient perspective

15:05 Workshop: Action planning for the next steps

15:45 Final plenary and next steps
Steve Barlow, Senior Clinical Director, Tees, Esk and Wear Valleys NHS Foundation Trust

16:00 CLOSE

Quality Network for Prison Mental Health Services' 4th Annual Forum Programme, 2 July 2019.
Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction
Huw Stone, Consultant Forensic Psychiatrist and QNPMHS Advisory Group Co-chair

10:35 Transfers and remissions guidance – Where we are now
Amelia Hardern, Senior Project Manager, Mental Health Transfers and Remissions, NHS England

11:05 Prison psychiatry in Northern Ireland – The view of the RCPsychNI
Adrian East, Consultant Forensic Psychiatrist, Belfast Health and Social Care Trust

11:30 Refreshments

11:45 Mental health in immigration removal centres
Cornelius Katona, Medical and Research Director, Helen Bamber Foundation

12:15 Workshops: Session One

A: Court liaison and diversion in Ireland
Conor O'Neill, Consultant Forensic Psychiatrist, Kezanne Tong, Senior Registrar in Forensic Psychiatry, and Philip Hickey, Forensic Community Mental Health Nurse, Cloverhill Remand Prison

B: A combination of the step model working with health and wellbeing model at HMP Belmarsh
Rachel Daly, Consultant Forensic Psychiatrist and Associate Clinical Director, Surajsing Persand, Mental Health Manager and Tracey Abberline, Health and Wellbeing Coordinator, HMP Belmarsh, Oxleas NHS Foundation Trust

C: Talk Club - a male mental fitness movement
Ben Akers, Founder/Director, Made With/Talk Club, and Rachel Turpin, Team Manager, HMP Elmley

12:45 Lunch

13:45 Preliminary findings from the fourth cycle
Megan Georgiou, Programme Manager, and Kate Townsend, Deputy Programme Manager, Quality Network for Prison Mental Health Services

14:05 CHANGING MINDS: Filming with the mental health team and service users at HMP Durham
Richard Melman and Kathy Myers, Executive Producers, Spring Films

14:35 Workshops: Session Two

A: Prisoner to hospital pathways: A retrospective study of transfers under sections 47/49 and 48/49
Syed Ali, Consultant Forensic Psychiatrist, and Harriet Clist, Ward Manager, Sussex Partnership NHS Foundation Trust

B: An expert by experience - Reviewing mental health services with those who've experienced services
Debbie Murphy, Wellbeing Centre Manager/Lead Occupational Therapist, HMP Pentonville and John Murch, Patient Representative, QNPMHS

C: Maintaining safety at HMP Woodhill with preventative measure and interventions
Danielle Simmons, Assistant Psychologist, and Rae Thomson, Associate Mental Health Practitioner, HMP Woodhill, CNWL NHS Foundation Trust

15:05 Afternoon refreshments

15:20 Workshops: Session Three

A: CPA in prisons: Reviewing the process
Megan Georgiou, Programme Manager and Dave Banks, Lead Nurse for the Intensive Support Unit, HMP Durham, Tees, Esk and Wear Valleys Foundation Trust

B: Calculating resource needs in prison mental health services
Luke Birmingham, Consultant Forensic Psychiatrist, HMP Isle of Wight

C: ADHD services in prisons: need and development
Philip Asherson, Professor and Honorary Consultant Psychiatrist, Institute of Psychiatry, and Prajakta Patil, Consultant Forensic Psychiatrist, The Trevor Gibbens Unit

15:50 Final plenary

16:00 Close

Appendix 5 – Project Contact Details and Information

Project team

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Online discussion platform

prisonnetwork@rcpsych.ac.uk or www.khub.net

Royal College of Psychiatrists Centre for Quality Improvement
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