PRISON CCQI
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Prison Mental Health Services – Fifth Edition

Quality Network for Prison Mental Health Services

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Artwork courtesy of Koestler Arts. The national charity has been running the Koestler Awards for arts in criminal justice and other secure settings since 1962. The artwork is from the Koestler Awards 2020:
Japanese Mountains,
Cheshire Youth Justice Services,
Lord Ramsbotham Commended Award for Painting

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Foreword

Welcome to the Fifth edition of the Quality Standards for Prison Mental Health Services. Due to the COVID pandemic there was no revision of the standards for 2020-2021. The Fifth edition is the first major revision of the quality standards since the pilot version in 2015-2016 although there have been minor revisions every cycle.

The COVID pandemic has been very difficult for prison mental health services. Teams have coped with large number of staff absences, due to illness and self-isolating, and numerous COVID outbreaks in prisons. Whilst some of the initial anxiety has been allayed by widespread vaccination and testing, the pandemic continues to impact on services, currently manifesting as the 'pingdemic' leading to further staff absences. For our patients, 2020-2021 has seen many of them confined to their cells for over 23 hours a day. With prison regimes not yet back to normal the full impact of this on inmates' mental health are still playing out. In remand prisons difficulties for patients accessing community mental health services and court backlogs have impacted on workloads. Prison mental health teams, along with the NHS as a whole, have shown tremendous resilience over the last 18 months but I'm sure everyone is looking forward to returning to some kind of normality.

In the initial lockdown the QNPMHS ran a series of webinars which many found invaluable in adapting to the pandemic. Face to face peer review visits had to be suspended due to COVID and were replaced with full or developmental reviews undertaken remotely. Whilst a useful stop gap measure, the QNPMHS is planning to return to face-to-face peer reviews and has scheduled reviews from January 2022 with this in mind. All special interest days, the Annual Forum, steering group meetings and the Standards Event have run online since March 2020. Hopefully these initiatives enhanced a sense of being part of a network adapting rather than individual services coping in isolation.

The standards review has been informed by peer review visits, individual feedback, a day long consultation workshop in March 2021 and electronic consultation on the final version. Hopefully standards difficult to assess against on peer reviews have been updated, obsolescent standards removed, and new standards included. There are new standards on: strengthening collaborative working with primary care and substance misuse services; with specialist prison programmes such as therapeutic communities and offender PD pathways; and knowledge of the principles of trauma informed care. Several relevant standards from the CCQI

standards for community-based mental health services (Royal College of Psychiatrists, 2019) have been incorporated.

Over the first six years the QNPMHS has gone from a pilot version of standards with 18 prisons to having the standards incorporated into NHS England Service specification for English and Welsh prison mental health services. Our network now has over 50 members with services from Eire, England, Northern Ireland, Scotland and Wales. We hope you will find the Fifth edition of the quality standards a useful development in assessing the quality of your prison mental health services and that your services and the quality network are as successful in the next six years as the first.

Dr Steffan Davies
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Co-chair of the Quality Network for Prison Mental Health Services' Advisory Group

Introduction

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 27 quality network, accreditation and audit programmes organised by the Royal College of Psychiatrists' Centre for Quality Improvement.

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.

We review mental health services in adult male and female prisons, and young offender institutions, in the UK and Ireland. 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 service-users who have experience of using these services. The group is led by Dr Huw Stone and Dr Steffan Davies.

Standards

The standards act as a framework by which to assess the quality of prison mental health services via a process of self and peer review. The first edition of the standards was published in June 2015 following an extensive process of consultation with stakeholder groups, including prison mental health staff, patients and commissioners. Information was collated from a wide range of sources and a review of key literature and documents was undertaken. The full publication is available on our website (see appendix).

The standards have been revised on a regular basis to date, to acknowledge feedback collated from member services and to account for new developments within the field of prison mental health. This standards revision was the first large review of the standards since they were first implemented. The standards revision involved a QNPMHS standards event, where experts in specialist fields of mental health within the criminal justice system presented, and discussions were held about the topic in the context of the Quality Network standards. This event was recorded and made available on our online platform Knowledge Hub (www.KHub.net). The first draft of the standards went out to e-consultation to all QNPMHS

members. The QNPMHS advisory group went through the final edits and feedback received.

The specialist standards also incorporate the CCQI standards for community-based mental health services (Royal College of Psychiatrists, 2019). All core standards have been marked adjacent to the standard number in brackets, followed by the letter 'C' and the core standard number as it appears in the CCQI standards for community-based mental health services publication [e.g. (C3.4)].

The final section includes the standards for 24-hour mental healthcare in prisons, for services with inpatient provisions or enhanced care facilities, that were originally published in July 2017. More information can be found on our website.

All criteria are rated as Type 1, 2 or 3

> **Type 1:** Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.
>
> **Type 2:** Expected standards that all services should meet.
>
> **Type 3:** Desirable standards that high performing services should meet.

Standards for Prison Mental Health Services – Fifth Edition

Reception and Assessment		
No.	**Standard**	**Type**
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 their risk of self-harm and/or suicide, learning disabilities and neurodevelopmental disorders.*	1
2	All practitioners carrying out mental health assessments are competent to assess problems that commonly arise, and have knowledge and awareness of mental health diagnoses and pathways within the service (NICE guidelines 66, 2017).	1
3	During the initial mental health assessment, individuals over 50 years old are offered an older adult assessment, and reasonable adjustments are made where required. *Guidance: Patients may need a full physical health review by a GP or further full mental health assessment by a psychiatrist to identify long-term conditions, early cognitive impairment or referral to social care team for long term care planning.*	2
4	There is a clear and consistent process for staff to refer individuals directly to the mental health team.	1
5 (C1.4)	A clinical member of staff is available to discuss emergency referrals during working hours.	1
6	Urgent assessments are undertaken by the team within 48 hours and routine assessments within five 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.*	1
7 (C3.2)	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Risk to self and others; • Intellectual and developmental disabilities; • Substance misuse; *Guidance: Standard mental health assessment tools are used and they are compliant with NICE guidelines.*	1

8	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.*	3
9 (C3.4)	Patients have a risk assessment and management plan which is updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.	1
10	Patients are involved in the development of their risk assessments and management plans.	3
11 (C3.5)	All secondary care patients have a diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised. *Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*	1
12	All information is provided to patients in a format they can easily understand. *Guidance: This includes different languages, and easy-to-read/pictorial formats. Inclusive communication approaches are used to ensure patients understand key information.*	1
13 (C1.3)	The service provides information about how to make a referral and waiting times for assessment and treatment. *Guidance: This information is provided to the patient and to agencies who regularly refer.*	1
14 (C2.3)	Patients are given accessible written information which staff members talk through with them as soon as it is practically possible. The information includes: • Their rights regarding consent to treatment; • Rights under the Mental Health Act/Mental Health Order/Capacity Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	1
15	There is a clear system for the management of referrals.	1

Treatment and Recovery		
16 (C5.3)	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients when developing the care plan and they are offered a copy. *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.*	1
17	Patients are offered information about their mental health conditions and treatment in a way that is understood and retained. *Guidance: This could be verbal, written or digital. Verbal information could be provided in a one-to-one meeting with a staff member or in a psycho-education group. All written information should be written using inclusive communication approaches.*	1
18	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.	1
19 (C3.3)	A physical health review takes place as part of the initial assessment, or as soon as possible. *Guidance: This may be completed by the physical health team, or as part of the reception process.*	1
20	Patients are managed under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011). *Guidance: The model presents an integrated overview of the key assessment and treatment interventions that are service specific.*	3
21	Patients have access to low-level interventions (this includes steps 1 and 2 of the Stepped Care Model) and a range of psychological therapies. These interventions are delivered by an adequately trained and supported mental health professional. *Guidance: The interventions and therapies are adapted to the needs of the patient and environment. For example, a remand environment delivers standalone sessions and psychoeducation support.*	2

22 (C6.1.1)	Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within an agreed timeframe. Any exceptions are documented in the case notes.	1
23 (C5.2)	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.*	1
24	Where applicable, patients on secondary care caseload should receive a formalised review of their care within the first 28 days, at three months and every six months thereafter, or whenever a significant transition occurs. *Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.*	1
25	Where applicable, patients are supported to be fully involved in their own assessment of secondary mental health needs during the formal review process. (RCPsych, 2020) *Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.*	3
26	For any formalised review of patients on the secondary care caseload, as a minimum there should be a representative from the prison mental health team and the prison. The local community mental health team should be invited. *Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.*	1
27 (C4.1)	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. This is clearly documented in the multi-disciplinary team meeting and patient records.	1
28 (C10.3)	In female establishments, there is 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.	1
Discharge and Transfers		
29	The process for referral and transfer of patients under Part 3 of the Mental Health Act follows the Good Practice Procedure Guide (NHSE, 2021).	1

30	When a patient is transferred to another establishment, the mental health team provides a comprehensive handover to the receiving establishment's mental health team before the transfer takes place. *Guidance: Where a transfer is not known, the handover is provided to the receiving team as soon as they are made aware.*	1
31	An identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning meetings. This includes a formalised review of care for patients on secondary care caseload. *Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.*	1
32	There is a robust transfer process to either a receiving prison or the community mental health team for patients who require continued care and follow-up support following release or transfer.	1
33	On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service.	1
34	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. This can be an administrative task.*	3
Safety		
35	The mental health team are actively involved in the prison process managing self-harm and suicide. They will attend review meetings for all newly opened cases, for all reviews for anyone on their caseload, and where required and relevant to attend. *Guidance: This refers to ACCT, SPAR Evolution or equivalent processes.*	1
36	There is a representative from the mental health team who attends the prison governance meeting to support the prison with self-harm and suicide, e.g. Safety and Intervention Meeting (SIM).	2
37	There is a clear process to follow when visiting patients outside of clinical rooms to ensure the staff are safe when working with patients.	1

38	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.	1
39	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.	1
40	The team understands and engages in policies on food refusal and mental capacity assessments.	2
41	The team understands and engages in relevant policies on sharing information and working across agencies to manage serious offenders. *Guidance: For example, Multi-Agency Public Protection Arrangements (MAPPA), Public Protection Arrangements Northern Ireland (PPANI) or equivalent.*	2
42 (C7.3)	Team members, including bank and agency staff, are able to identify and manage an acute physical health emergency. *Guidance: such as initial CPR.*	1
43 (24.2)	When mistakes are made in care this is discussed with the patient themselves in line with the Duty of Candour agreement (or equivalent).	1
Patient Experience		
44 (C12.3)	Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.	1
45 (C12.1)	The service asks patients for their feedback about their experiences of using the service and this is used to improve the service. *Guidance: This might include patient surveys or focus groups.*	2
46 (C14.1)	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.*	1
47 (C14.2)	Patients feel listened to and understood by staff members. *Guidance: Efforts and adjustments are made for patients with communication difficulties.*	1
48 (C16.1)	Confidentiality and its limits are explained to the patient verbally and written information is offered. Patient preferences for sharing information with third parties are respected and reviewed regularly.	1
49	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.	1

50 (C5.1)	Patients know who is co-ordinating their care and how to contact them if they have any questions.	1
51 (C16.1)	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation.	2
Collaborative Partnerships		
52	The team has a policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within limits of patient consent, confidentiality and risk management. *Guidance: Where integrated healthcare models are in place, the policy will detail effective multi-professional working and collaboration.*	2
53	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.*	2
54	There a regular complex care or multi-pathway meetings involving mental health, primary care and substance misuse to share information and develop management plans.	3
55	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. *Guidance: Where integrated healthcare models are in place, there are clearly outlined roles and responsibilities in place for patients with co-morbid conditions.*	2
56	The team understands and engages in policies on reporting intelligence according to the establishment's security reporting system.	2
57	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. *Guidance: Where integrated healthcare models are in place, there are clearly outlined roles and responsibilities in place for patients who are under the care of various teams.*	2

58	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.*	2
59	Where specialist interventions exist within prisons, a joint working protocol exists and meetings are in place. *Guidance: This could be Offender Personality Disorder (OPD) pathways, Psychologically Informed Planned Environments (PIPES) and Therapeutic Communities.*	2
Medication Management		
60 (C6.2.1)	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	1
61	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, gabapentinoids and stimulants for ADHD.*	1
62	Psychotropic prescribing rates (antidepressants, anti-psychotics, ADHD, anxiolytics, hypnotics) are regularly monitored and reviewed. *Guidance: This includes regular reports from the pharmacy team, with findings being discussed at a local or directorate meetings.*	3
63	For patients prescribed medication, annual medication reviews are in place (NICE guidelines 5, 2015; NICE guidelines 87, 2018).	2
64	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.*	1
65	Compliance with medication is recorded as part of the patient's care plan and this is reviewed on a monthly basis, or more frequently where required. *Guidance: The team proactively follows up with patients who fail to collect or take their medication and this is included in their care plan.*	1

66	There are clear written protocols outlining prescribing responsibilities between psychiatrists, GPs and nurse prescribers. *Guidance: Clinicians refer to 'Safer Prescribing in Prisons: Guidance for Clinicians, Second Edition' (RCGP, 2019).*	2
Environment		
67	Patients are able to attend appointments with the team at the scheduled appointment time.	2
68	There are designated rooms for the team to run clinics and one-to-one sessions.	2
69	There are designated rooms for the team to run group sessions.	2
70	All interview rooms are safe. This includes the rooms being situated close to staffed areas, having an emergency call system, an internal inspection window and the exit is unimpeded. Objects cannot easily be used as weapons.	2
71 (C17.2)	Clinical rooms are quiet, private and conversations cannot be easily over-heard.	1
72	The team has dedicated spaces and meeting rooms for confidential working.	1
73	There are sufficient IT resources (e.g. computer terminals, adequate data speeds) 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. Staff also have access to online conferencing applications (e.g., Microsoft Teams) to facilitate remote meetings and videocalls.	1
Workforce		
74	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. *Guidance: This should include specialists who can undertake assessments and provide treatment/therapy relevant to the needs of the patient group.*	1

75 (C19.1)	The service has a mechanism for responding to safer staffing issues, including: • A method for the team to report concerns about staffing; • Access to additional staff members; • An agreed contingency plan; • An overdependence on bank and agency staff members results in action being taken.	1
76 (C19.2)	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.	1
77 (C6.2.3)	Prescribers can contact a specialist pharmacist to discuss medications.	1
78	There is a clearly identified clinical lead for the team. *Guidance: The clinical lead has overall responsibility for the clinical requirements of the service*.	1
79	There are written arrangements and processes in place which ensure that specialist mental health advice can be accessed out of hours.	2
80	There is a minimum of monthly multi-disciplinary team clinical meetings, which are recorded with written minutes.	2
81 (C21.1)	There are processes and initiatives in place to support staff health and well-being. *Guidance: This includes:* • *Providing access to support services;* • *Monitoring staff sickness and burnout;* • *Encouraging staff to take scheduled breaks;* • *Assessing and improving morale;* • *Providing wellbeing programmes;* • *Monitoring turnover;* • *Reviewing feedback from exit reports and taking action where needed*.	1
82	All permanent full-time staff within the team receive a full local prison induction within 28 days (or equivalent pro-rata) of commencing employment and before being issued with keys. *Guidance: This includes: key security, prison awareness, the prison processes on managing self-harm and suicide (such as ACCT, SPAR Evolution) and personal protection, or equivalent*.	1
83 (C20.2)	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met*.	1

84	All staff who use an electronic patient recording system receive formal training and are competent in its use. For example, SystmOne training.	1
85	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.	1
86	Staff have an understanding of the principles of Trauma Informed Care and have the opportunity to access training on this practice. *Guidance: Where staff have received the training, they are able to demonstrate how this has influenced their practice.*	3
87 (C22.1)	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.	1
88 (C22.1a)	Staff receive training on the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1
89 (C22.1f)	Staff receive statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.*	1
90	Team members are trained and fully informed about the assessment and management of mental health presentations in people with learning difficulties and neurodiversity.	1
91	All staff members receive an annual appraisal and personal development planning or equivalent. *Guidance: This contains clear objectives and identifies development needs.*	1
92 (C20.3)	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.*	1

93 (C20.4)	All staff members receive monthly line management supervision. *Guidance: Supervision forms a part of individual performance management and discusses organisational, professional and personal objectives.*	2
94 (C6.1.9)	All staff members who deliver therapies and activities are appropriately trained and supervised.	1
95 (C18.1)	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	2
96 (C21.2)	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	1
Leadership and Governance		
97	A representative of the team is part of the establishment's clinical governance and quality processes.	1
98	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.*	2
99	The service has a strategic managerial meeting, at least annually, with all stakeholders to consider topics such as referrals, the clinical model, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders should include staff member representatives from across the care pathway, as well as patient representatives.*	2
100	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use. *Guidance: Where trust policies are used, these are accessible to staff when working in the prison.*	1
101 (C24.1)	Staff members can quickly and effectively report incidents. Managers encourage staff members to report this and staff members receive guidance on how to do this.	1

102 (C21.3)	Staff members who are affected by a healthcare related serious incident are offered a debrief and post incident support.	1
103 (C24.3)	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	1
104	There is a widely accessible complaints policy, for staff and patients, that clearly sets out the ways in which a complaint can be made, the process for investigation and how communication is managed throughout.	2
105	Complaints are reviewed on a quarterly basis to identify themes, trends and learning.	2
106 (C18.2)	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	1
107	Services collect information and data to evaluate their own performance and measure improvements. This data is shared with key stakeholders, the organisation's board and staff. *Guidance: This could include KPIs, diagnosis timeframes, transfer and remission timeframes, diversity and accessibility etc. This information could be gathered as part of the contract review data.*	2
108 (24.4)	The team engages in service relevant research and academic activity.	3
24 Hour Mental Healthcare		
109	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.	1

110	Patients have a comprehensive assessment which is started within four 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.	1
111	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*.	1
112	Managers and practitioners have agreed weekly clinical review meetings.	1
113	Activities are provided seven days a week. *Guidance: This can include occupational therapy, art/creative therapies, non-therapeutic activities and in-cell activities.*	1
114	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.	2
115	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	1
116	Discharge planning begins at the first review and outcomes for discharge are agreed.	1
117	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*.	1
118	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*.	3
119	Risk assessments and management plans are updated according to clinical need or monthly, at a minimum.	1
120	Patients are able to access safe outdoor space every day and should be encouraged and supported to do so.	1

121	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.*	1
122	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	1
123	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.	1
124	There is a clear policy regarding the use of rapid tranquilisation within the unit, which includes the issue of consent. *Guidance: This includes PRN medication.*	1
125	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.*	1
126	There are agreed minimum staffing levels that include at least one qualified nurse present on all shifts.	1
127	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.*	2
128	Arrangements are in place to ensure that a doctor is available at all times to attend the unit, including out of hours.	1
129	Patients are not discharged from the inpatient facility without the consultation of a mental health professional and/or duty healthcare manager.	1
130	The operation of the unit is explicitly included in the commissioning specification. *Guidance: This is from NHS England, NHS Scotland, Health Service Executive, Health and Social Care or NHS Wales.*	2

131	Patients who are affected by a healthcare related serious incident are offered a debrief and post incident support.	1

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