



Quality Network for Forensic Mental Health Services

AGGREGATED REPORT

LSU CYCLE 6 2017-19

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FORENSIC
QUALITY NETWORK FOR FORENSIC
MENTAL HEALTH SERVICES



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Artwork displayed on the front cover of this report:

Untitled

Patient from The Spinney

2019

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- The staff in member services who organised and hosted peer-review visits.
- Those individuals who attended visits as part of a peer-review team.
- The patients and family and friends that participated in the review process.

Preface

I am pleased to introduce the 6th LSU aggregated report from the Quality Network for Forensic Mental Health Services (QNFMS). This report covers 112 low secure services across the UK and Ireland and is therefore a comprehensive picture of care delivery across a key segment of the secure mental health pathway.

Through the programme of peer reviews we regularly observed the extraordinary commitment of frontline staff in supporting patients toward recovery whilst managing well recognised challenges, such as workforce shortages. This report therefore not only describes how individual services have fared according to the described standards, but also the innovations in care across secure providers that may benefit patients and the wider forensic system. The contact details of each service are presented in the appendix of this report to allow for interested parties to find out more about a particular area of practice.

This has been an exciting year for QNFMS, with plenty of highlights. We are absolutely committed to supporting services through collaboration, and I am particularly pleased that our new interactive platform, Knowledge Hub, has rapidly garnered strong engagement from members seeking information on areas of best practice. We fully expect Knowledge Hub to become a valued resource across the Network. This year has also seen the launch of our latest secure standards which have been developed with the considerable input of member services, the advisory board, patients and carers.

Finally, I wanted to personally thank the many healthcare professionals, patients and carers who have taken part as reviewers for QNFMS. Being part of a review team is hugely rewarding and an opportunity to learn fresh perspectives. We could not engage in the work of the Network without the fantastic commitment of our reviewers, and we always welcome those who want to join us.

I hope you find this report helpful.



Dr Quazi Haque, Consultant Forensic Psychiatrist and Chair of the Quality Network for Forensic Mental Health Services

Who We Are and What We Do

The Quality Network for Forensic Mental Health Services: Medium Secure (QNFMHS – MSU) was established in 2006 to promote quality improvement within and between medium secure forensic mental health services. It is one of over 20 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 forensic mental health services¹.

Our purpose is to support and engage individuals and services in a process of quality improvement as part of a review cycle. We report on the quality of forensic mental health services and allow members to benchmark their practices against other similar services. We promote the sharing of best practice and support services in planning improvements for the future. We review both low and medium secure services in the UK and Ireland. Participation in the Quality Network is part of NHS England commissioning guidelines for secure services and members pay a fee to be a part of the process.

The Quality Network is governed by a group of professionals who represent key interests and areas of expertise in the field of forensic mental health, as well as patients and carers who have experience of using these services. The group is chaired by Dr Quazi Haque with representatives from NHS England, CQC, Royal College of Nursing, Ministry of Justice and other organisations.

The review process

The review cycle is structured in two stages over a two-year period; the first stage is a full review visit and the second is a developmental review visit.

Stage 1: Full review visit

The diagram below illustrates the first stage of the two-year review cycle.



¹ www.qnfmhs.co.uk

At the beginning of each cycle the **standards** are reviewed, either by a wide consultation exercise or a minor revision, before being issued for use.

As part of the full review, services complete a comprehensive **self-review** document. They are asked to provide a self-rated score and commentary against each standard and submit accompanying evidence. It is also expected that questionnaires are distributed to service staff, patients, and family and friends.

The information collected at the self-review phase is compiled to form the basis for a **peer-review visit**. A visiting peer-review team follow a structured timetable to ensure that meetings are conducted with those working in and using the service to validate the information provided at self-review. A service tour and a check of the perimeter are also conducted to form part of an environmental checklist. At the end of the peer-review visit, the visiting team will provide preliminary findings to the host service, drawing on any key areas of achievement or challenge.

The data collected is collated in the form of a **service report**, summarising areas of good practice and areas in need of improvement. It also reflects on any progress made since the previous review visit.

It is expected that the service engages in an **action planning** phase to promote service development. A template is provided to ensure plans are completed consistently across the Network and to introduce a more targeted approach to quality improvement.

At the end of each year, an **annual forum** is hosted by the Network to celebrate the successes of member services and to provide learning opportunities for areas in need of development. The day comprises of presentations, project updates, good practice workshops and poster presentations.

Stage 2: Developmental review visit

The diagram below illustrates the second stage of the two-year review cycle.



Following on from the full review visit received the year previously, the outcomes from the visit will be reviewed. This is an opportunity for a **focused self-review** and reflects on the

progress made as part of action planning. A brief update document is used as a tool to structure the discussions on the development review visit.

The **developmental review visit** takes place over a day period. It is designed to allow time for meaningful discussion and to provide services with the opportunity to maximise the knowledge and expertise within the Network to develop their practices. Meetings are conducted with service managers, frontline staff, patients, family and friends. The day closes with a feedback session to reflect on progress since the previous full review and to offer guidance over the coming year.

A short **developmental report** is produced summarising the actions taken since the previous review and key discussions from the day.

Services engage in a further **action planning** phase to reflect on the feedback received. The original action plan is reviewed and built upon to encourage continual development ahead of the next full review visit.

Benefits of membership

- 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 report;
- The ability to benchmark practices with 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 online platform for those working in forensic mental health services;
- A regular newsletter and the opportunity to contribute articles;
- Valuable networking opportunities.

Introduction

Membership

112 low secure forensic mental health services from across the UK and Ireland participated in cycle 6 of the Network (appendix 1). Within the below map, purple flags denote low secure services and red flags denote a service that provides both medium and low secure services. For the purposes of this report, only aggregated data from low secure services are presented.



Participation

As part of peer-review visits, 890 staff from forensic mental health services participated as reviewers. The Network held several training sessions on how to participate in a peer-review visit. A representative from the Network attended all visits for guidance and consistency in the review process. Additionally, a patient reviewer and/or a family and

friends representative attended a large proportion of reviews to ensure the patient and carer experience was captured.

Network initiatives

The Quality Network organised several initiatives for our member services during this cycle (full programmes are available in appendix 3):

- Communicating with Family and Friends, August 2017
- Revisiting See Think Act, November 2017
- Secure Mental Health Carers Toolkit Launch, March 2018
- Patient Engagement and Involvement in Secure Services, April 2018
- LSU Annual Forum, June 2018
- Prison Transfer and Remission, November 2018
- Managing a Healthy Weight, February 2019
- LSU Annual Forum, June 2019

Network developments

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

Standards revision

Following an extensive period of consultation, we published the third edition of standards for forensic mental health services (low and medium secure care) in May 2019. This new edition includes a categorisation system to denote whether a standard is essential, expected or desirable in relation to patient care, and a key is provided to identify themes between standards.

Adult secure new care models

To encourage the sharing of information and collaborative action planning, the Network now provides a consolidated report for each adult secure new care model, on request. The reports are not anonymised and aggregate findings across a footprint, using both qualitative and quantitative data.

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 forensics@rcpsych.ac.uk or create an account on www.khub.net and search for the Quality Network for Forensic Mental Health Services.

Secure Carers' Toolkit

We have worked closely with NHS England to support the launch and implementation of the secure carers' toolkit. We have embedded the toolkit into our standards and supporting materials to support services to develop this within their own services.

Physical security

We received feedback during the standards consultation that the physical security standards would be more useful in a separate document that can be adapted locally. We

have established a small working group to develop this and we hope to have it ready to pilot next year, before going live in 2021. The document will eventually replace the physical security section of the standards when the standards are next revised.

This report

This report is structured around the four key domains of the Quality Network for Forensic Mental Health Services' Standards for Medium and Low Secure Care: Second Edition (2017). The findings are broken down into the following 14 sections:

Patient Safety

- Physical Security
- Procedural Security
- Relational Security
- Safeguarding

Patient Experience

- Patient Focus
- Family and Friends
- Environment and Facilities

Clinical Effectiveness

- Admission
- Treatment and Recovery
- Medication
- Leave and Discharge
- Physical Healthcare
- Workforce

Governance

- Governance

The body of the report highlights areas of good practice and provides recommendations to common challenges identified for each section.

The benchmarking graphs provide an overview of how services have performed in relation to the national average as well as each other. The graphs are coded to display the percentage of standards met, partly met and not met for each section. Graphs are ordered by the level of compliance within that standard area, highest to lowest, and the average score has also been highlighted. The final bar on the graph (TNS – total number of services) provides the average compliance across the 112 participating services.

For anonymity purposes, each service has been assigned a unique data label. The key contact for each service has been provided with this.

Executive Summary

This section provides an overview of the findings from this cycle. It will explore the key findings identified in terms of how services are performing against the 14 sections, as well as reporting on the main areas of challenge and achievement across the Network.

Overview

On average, member services fully met 80% of standards.

Figure 1 offers a breakdown of how each member service performed this cycle, in order of strongest compliance. The range of met criteria achieved, ranges from 47% to 97%.

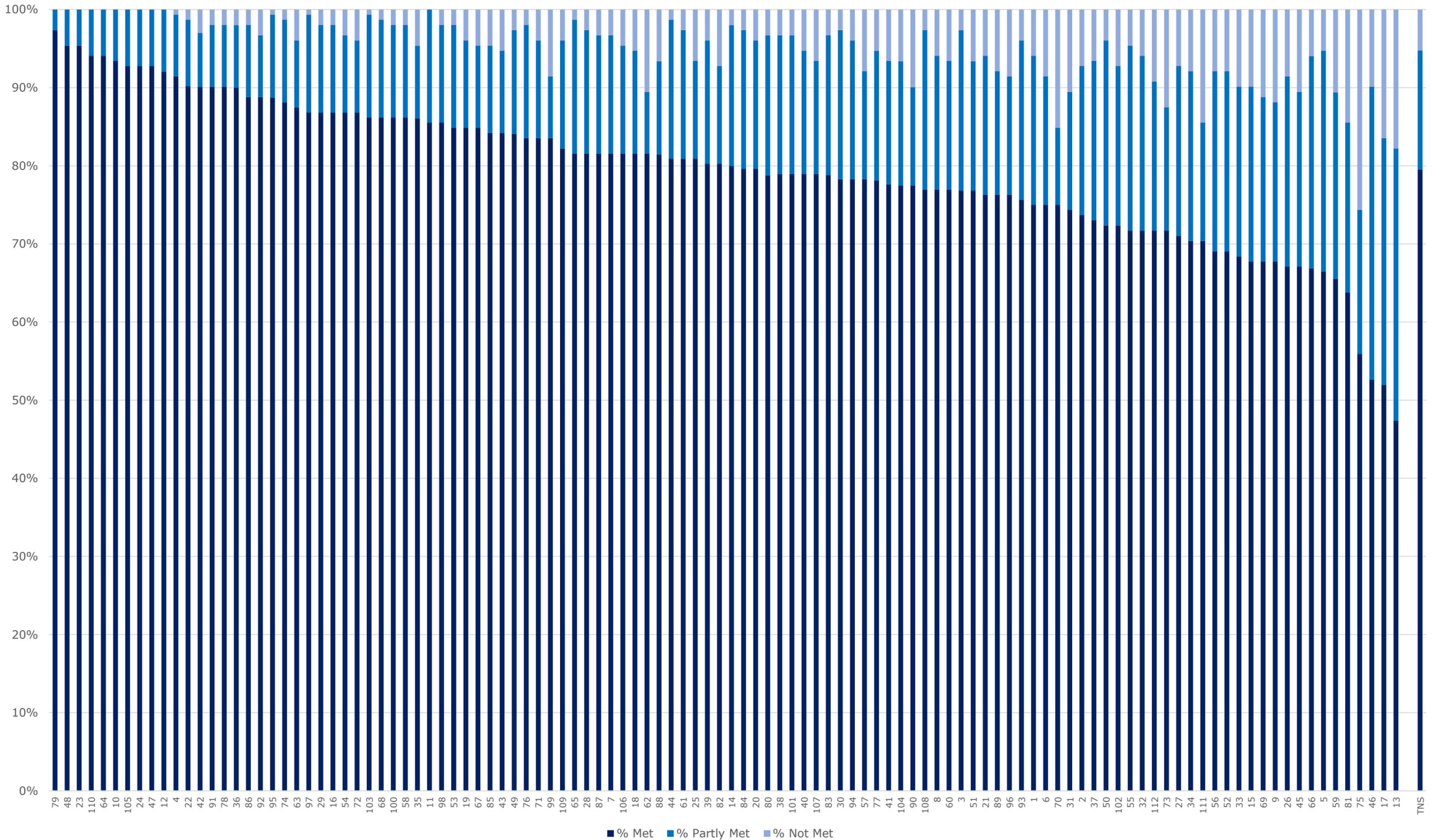


Figure 1: Percentage of criteria met, partly met and not met by service

Figure 2 displays the average percentage of met criteria for each section. Member services scored most highly in the areas of Leave and Discharge and Admission. The areas in most need of improvement are Workforce and Patient Focus.

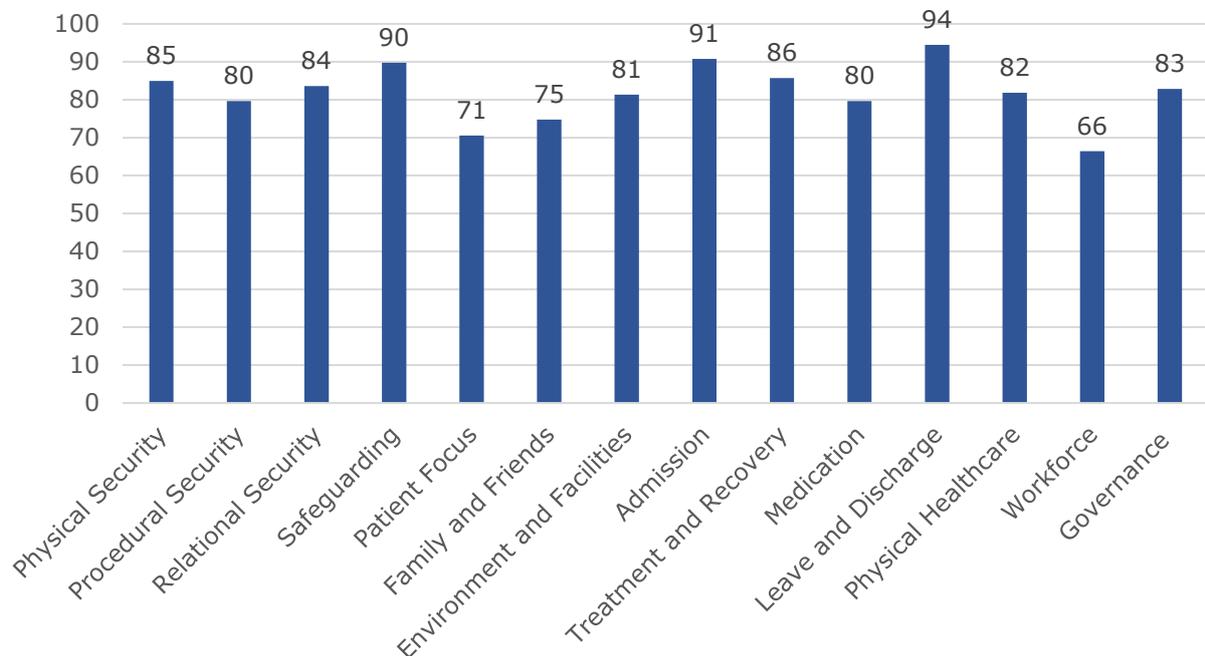


Figure 2: Average percentage of met criteria per section

Physical Security

On average, services fully met 85% of standards in this area.

- The majority of services have systems in place to manage prohibited and restricted items.
- Almost 40% of services do not have measures in place to ensure secure keys are on a sealed ring, secured to staff at all times and prevented from being removed from the perimeter.

Procedural Security

On average, services fully met 80% of standards in this area.

- A large proportion of services have systems in place to assess staff knowledge of policies critical to their role.
- Around one-third of services do not have a policy on restrictive practices.

Relational Security

On average, services fully met 84% of standards in this area.

- Only 14% of services do not have an induction and annual training programme on relational security.

- Staff in most services reported having clear and effective systems for communication and handover.
- One quarter of services do not monitor how they are performing against items relevant to relational security.

Safeguarding

On average, services fully met 90% of standards in this area.

- The majority of services have procedures in place to report and respond to safeguarding concerns.
- Nearly 10% of services do not have an identified safeguarding lead.

Patient Focus

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

- Opportunities for patients and carers to provide feedback are in place in 82% of services.
- Patients in one-third of services reported not being treated with compassion, dignity and respect.
- Only half of services provide patients with information relating to their care and treatment, such as their rights, accessing advocacy services, and how to raise complaints, concerns and compliments.
- In just over half of services, patients reported not being satisfied with the food provision, with concerns around choice, quantity, and dietary and cultural requirements.

Family and Friends

On average, services fully met 75% of standards in this area.

- Carers were reported to be involved in discussions about their loved one's care and treatment in the majority of services.
- Nearly 80% of services reported providing advice to carers on how to access a statutory carers' assessment.
- 22% of carers do not have access to a carer support network or group.
- Nearly 30% of services do not offer carers individual time with staff members to discuss concerns, family history and their own needs.
- 41% of carers are not provided with a carers' information pack.

Environment and Facilities

On average, services fully met 81% of standards in this area.

- Nearly half of seclusion facilities do not meet the requirements of the Mental Health Act Code of Practice.
- Three-quarters of services were reported to be homely, light, clean and bright.
- Patients in the majority of services are able to personalise their bedroom spaces.
- 31% of services do not have a dedicated visitors' room.

Admission

On average, services fully met 91% of standards in this area.

- 23% of services do not have a clinical model in place to describe the purpose of the service and its clinical approach.

Treatment and Recovery

On average, services fully met 86% of standards in this area.

- Patients in the majority of services have written care plans in place.
- 29% of care plans are not developed in collaboration with the patient and their carer.
- Patients in 77% of services reported having clear personalised outcomes.
- Patients in 29% of services did not feel that their plan of therapeutic and skill-developing activity directly correlated to their outcomes plan.

Medication

On average, services fully met 80% of standards in this area.

- In most services, patients are supported to understand the functions and side effects of their medication.
- Only 43% of services audit the safe use of high risk medication annually.

Leave and Discharge

On average, services fully met 94% of standards in this area.

- Most services support patients to access organisations which offer housing and financial support.
- Most services reported devising a leave plan jointly with the patient, addressing the key areas regarding the purpose of leave, risk and contact details.

Physical Healthcare

On average, services fully met 82% of standards in this area.

- Most patients have their healthcare needs assessed on admission and reviewed every six months thereafter.
- Almost 90% of services evidenced providing patients with targeted lifestyle advice and health promotion activities.
- Access to screening programmes, as available to the general population, is provided in the majority of services.

Workforce

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

- Monthly clinical supervision was reportedly received in 68% of services and monthly managerial supervision was reportedly received in 59% of services.
- 40% of services are not offering monthly formal reflective practice sessions.

- Nearly all services provide staff with an annual appraisal and personal development planning.
- Staff in 32% of services did not feel that their health and wellbeing is supported.
- Only 33% of services evidenced that their staff receive training consistent with their role.
- Only one-fifth of services involve patients and carers in delivering face-to-face training.

Governance

On average, services fully met 83% of standards in this area.

- 77% of services offer staff members, patients and carers post-incident support.
- Complaints are reviewed on a quarterly basis to identify themes, trends and learning in 79% of services.
- 72% of services conduct an audit of environmental risk annually.

Key Recommendations

Recommendation 1: Patient experience

- Where possible and appropriate, co-produce service initiatives and projects with patients and carers.
- Support patients and their carers to be fully involved in developing plans and making decisions relating to their care and treatment.
- Ensure patients understand their planned care and how it relates to their personalised outcomes and recovery.
- Hold regular meetings with patients to recognise where issues relating to respect exist and work together to plan how to overcome identified problems.

Recommendation 2: Involving family and friends

- Using NHS England's toolkit for carer support and involvement in secure mental health services², develop an engagement strategy co-produced with carers.
- On an individual and group basis, work with carers to understand what their preferred methods of communication are in relation to their loved one and the service provided.
- Empower carers by supporting them to understand what they should expect throughout the secure mental health pathway, providing examples of practice to demonstrate what is possible, describing the roles of different professionals and services, and explaining how they can be involved.
- Where a patient does not consent to the involvement of their loved one, ensure the patient is asked regularly whether their wishes have changed. Ensure carers are kept up-to-date with information of their loved one's wellbeing, as a minimum.

Recommendation 3: Provision of written information

² <https://www.england.nhs.uk/publication/carers-support-and-involvement-in-secure-mental-health-services/>

- Information should be readily available and offered to all patients and carers on the service, care and treatment, and all other relevant services.
- Important information should be offered both in writing and verbally, and key information should be repeated at regular intervals, for instance information relating to consent and confidentiality.

Recommendation 4: Staff support and wellbeing

- Invite staff members to provide feedback about the support they receive from their managers, peers, and the service, drawing on what works well and what could be improved.
- Offer managerial and clinical supervision to all staff on a monthly basis.
- Organise away days for staff teams on an annual basis, as a minimum.

Recommendation 5: Staff training

- Conduct a training needs analysis for individual staff teams to identify gaps or concerns relating to mandatory training requirements or relevant skill development.
- Involve patients and carers in the design and delivery of face-to-face training.

Quality Network for Forensic Mental Health Services

Key Findings

Cycle 6 2017-19

Physical Security

On average, services fully met 85% of standards in this area, ranging from 29% to 100% compliance.

Prohibited Items

Almost all services have a system in place which ensures that prohibited, restricted and patient accessible items are risk assessed, controlled and monitored.

Good practice examples

Since the introduction of the drug dog, there has been a significant reduction in the number of drugs entering the wards and all urine samples for in-patients for illicit substances have been negative for the past five years.

Ellesmere House

A successful system is in place for providing non-invasive drug testing at the service, through the use of an Ion Tracker. This can be used to detect whether patients have come into contact with drugs, such as synthetic cannabinoids. The drug can be detected within seven seconds and is constantly updated with new strains.

North London Forensic Service

Key Security

The majority of services have a management system in place which accounts for all keys and passes, however in only 64% of services, secure keys are on a sealed ring, secured to staff at all times and prevented from being removed from the perimeter.

Good practice examples

All staff are provided with a wrist-worn fob, in place of carrying keys. This makes the key security easier and more effective to manage. Fobs can be tracked, and access throughout the service is streamlined.

St Magnus Hospital

The key management system is very effective, especially as a small number of risk assessed patients also possess key passes to gain access to certain areas.

Bracton Centre

The key management system is efficient and enables increased levels of security at the service. There is a list of approved key holders which is updated regularly and staff must complete a security induction and present valid ID before being issued keys.

Priory Hospital Lincolnshire



Figure 3: Percentage of criteria met, partly met and not met by service for Physical Security.

Procedural Security

On average, services fully met 80% of standards in this area, ranging from 33% to 100% compliance.

Policies and Procedures

96% of services have systems in place to ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that staff members find accessible and easy to use.

88% of services have systems in place to assess staff knowledge of policies critical to their role.

Good practice examples

Staff have a good awareness of policies and procedures. They also mentioned that policies are available in easy-read versions, and the security documents have been translated into different languages, which was in response to an incident occurring.

St Magnus Hospital

A policy champion is in place to assess staff knowledge on policies related to their role. There are question and answer sessions for each policy to review staff understanding of these policies.

Cygnnet Hospital Harrow

As a reminder to all staff, each key chain has a small booklet attached which contains important policy/process information on safeguarding and whistleblowing processes.

Battersea Bridge Hospital

Restrictive Practices

30% of services do not have a restrictive practice policy in place.

Good practice examples

Managers promote reducing blanket bans through staff meetings and facilitating regular refresher training. Patients showed good understanding of reducing restrictive practice, for example, the reasons as to why some patients were allowed certain items in possession and others were not.

Ridgeway

There is a reducing restrictive practices group in which patients can bring forward any items to be discussed. There is also a policy regarding restrictive practices, outlining the current blanket restrictions in place and how these can be minimised.

Humber Centre

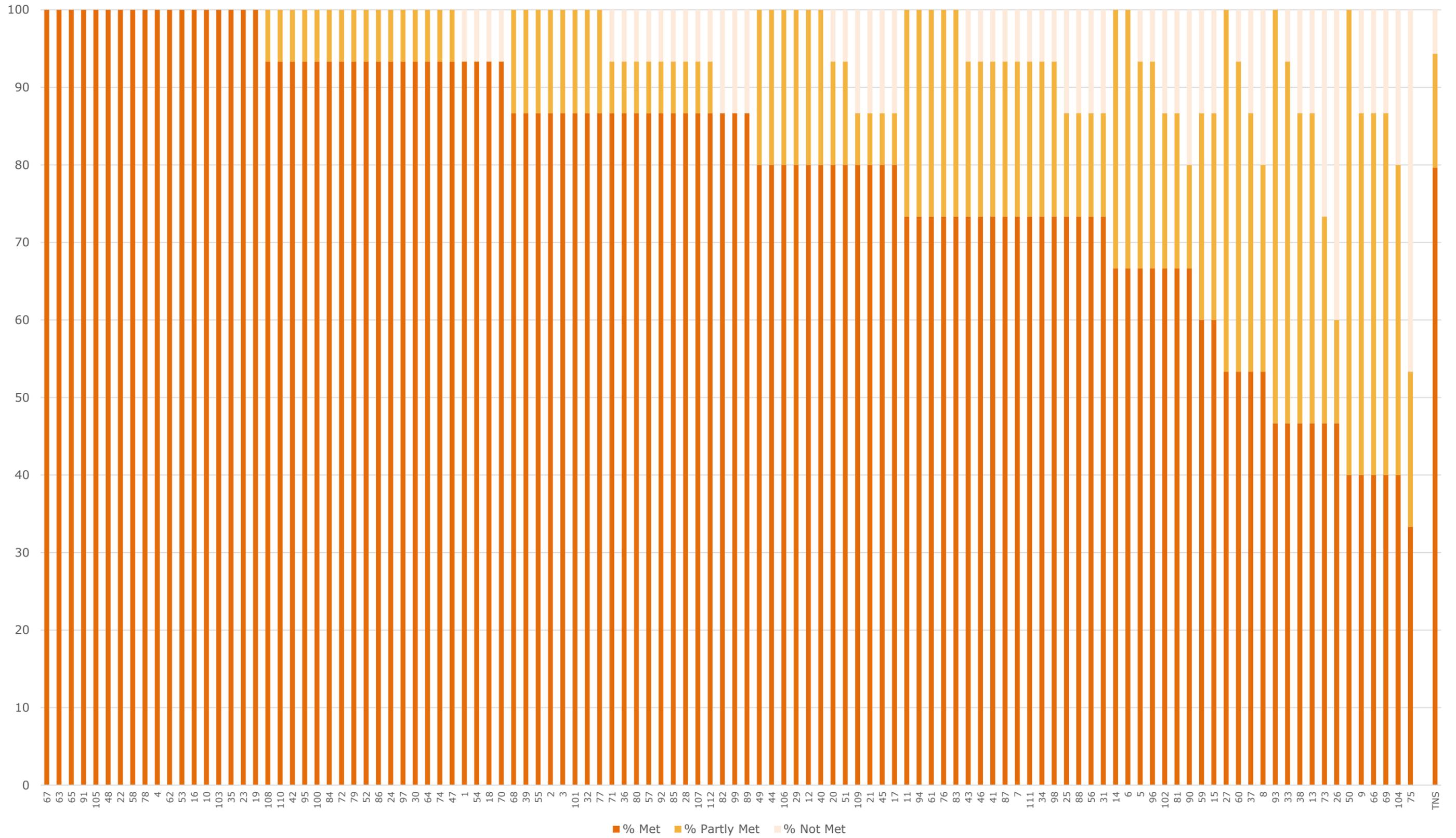


Figure 4: Percentage of criteria met, partly met and not met by service for Procedural Security.

Relational Security

On average, services fully met 84% of standards in this area, ranging from 0% to 100% compliance.

Training

86% of services have an induction and annual training programme in place for all staff that addresses issues of relational security and is supported by the use of See, Think, Act (2nd Edition).

Good practice examples

Senior management have co-produced a service specific e-learning module on relational security incorporating See, Think, Act, which all staff are required to complete as part of their induction. Frontline staff reported this being a great e-learning module.

Tatton Unit

The service has a strong relational security strategy. Training is provided to staff upon induction and incorporates the use of the See, Think, Act (2nd Edition). The explorer wheel is used as part of the decision-making process within clinical governance meetings. The service is intending to start using this during ward handovers.

Eaglestone View

Emphasis on relational security and the use of the See, Think, Act is embedded in all aspects of staff meetings and training.

Ellesmere House

Communication and Monitoring

There are clear and effective systems for communication and handover within and between staff teams in 90% of services.

However, 24% of services do not have a process in place to monitor how the service is performing against items relevant to relational security.

Good practice examples

Staff reported there has only been one prone restraint at the service in the past three years and that this is due to staff skill set. Staff are trained in the management of actual or potential aggression (MAPA) and the focus is on verbal de-escalation. Each patient has a 'My personal safety and support plan' which includes personalised de-escalation techniques for patients.

Clare Ward

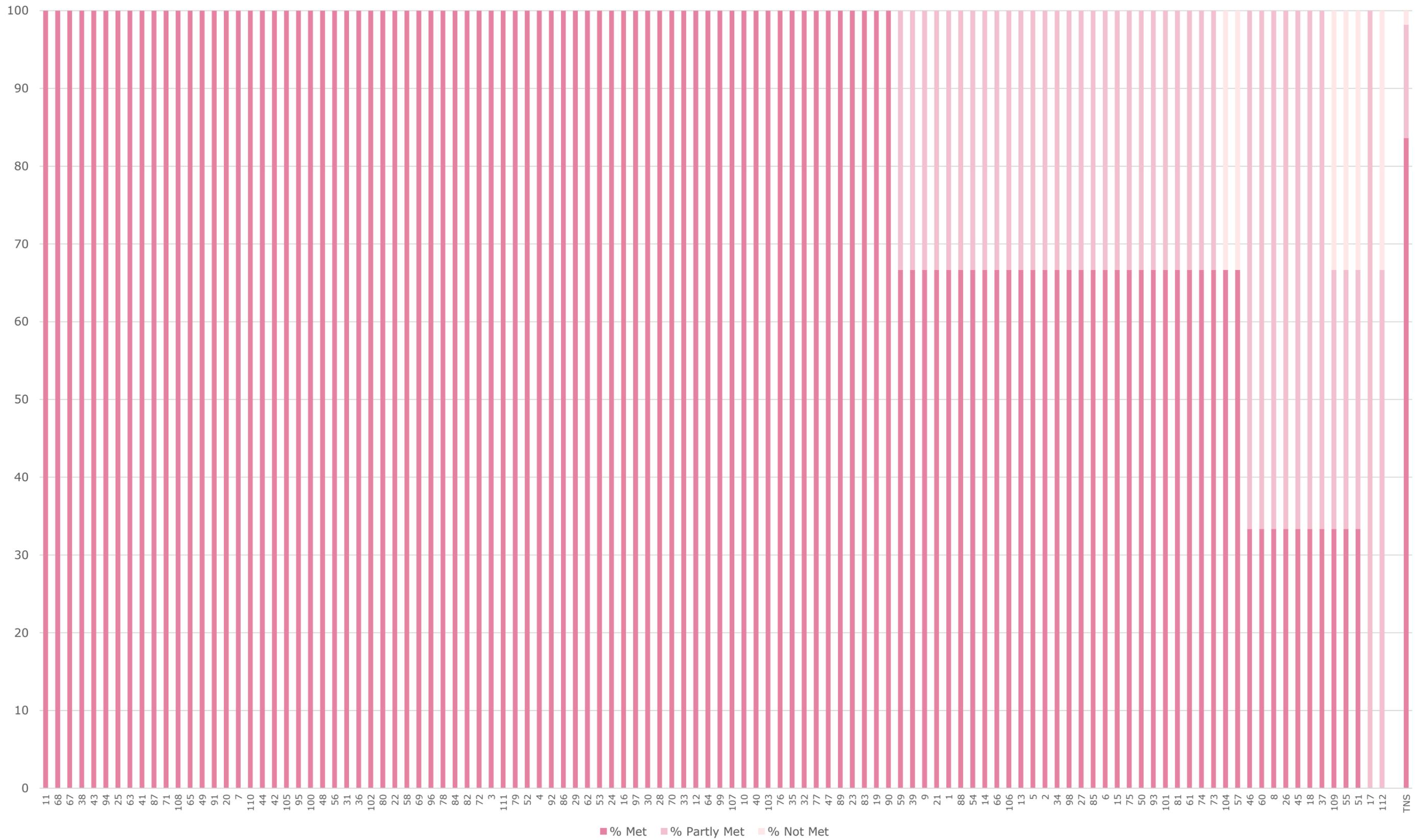


Figure 5: Percentage of criteria met, partly met and not met by service for Relational Security.

Safeguarding

On average, services fully met 90% of standards in this area, ranging from 25% to 100% compliance.

Procedures and Systems

99% of services have a system in place for the recording of children known to the patient and any known risks.

91% of services have as designated safeguarding lead, who is able to give advice and manage safeguarding issues.

Good practice examples

The service has a well-developed safeguarding protocol agenda. Staff are aware of who to approach regarding safeguarding concerns and making a referral. It was noted that the service's social worker liaises closely with patients' families to assess any safeguarding risks relating to children.

Avesbury House

There are three safeguarding leads at the service. The trust also runs regular group supervision, specifically for safeguarding, to allow staff to voice any concerns to an independent facilitator.

George Mackenzie House

The service has robust safeguarding arrangements in place. Frontline staff are confident about how to raise a referral and who to contact. There is a flowchart to follow which is displayed throughout the service.

Saddlebridge Recovery Centre and Alderley Unit

Staff have a thorough understanding of the safeguarding procedure at the service and are confident in raising or escalating any concerns they have with the designated safeguarding lead. There is a form for staff to complete and send to the lead, the team will also discuss concerns in meetings with the multi-disciplinary team.

Farmfield Hospital

There appears to be an effective procedure available for staff to make safeguarding referrals. This is available as a flowchart and staff are informed of how to make a referral in their induction. Staff are aware of who the designated safeguarding lead is and how they can access advice.

Wolfson House

Staff spoken with on the review day demonstrated a strong understanding of safeguarding procedures and policies in place. They are also provided a booklet on induction to refer to.

Mildmay Oaks

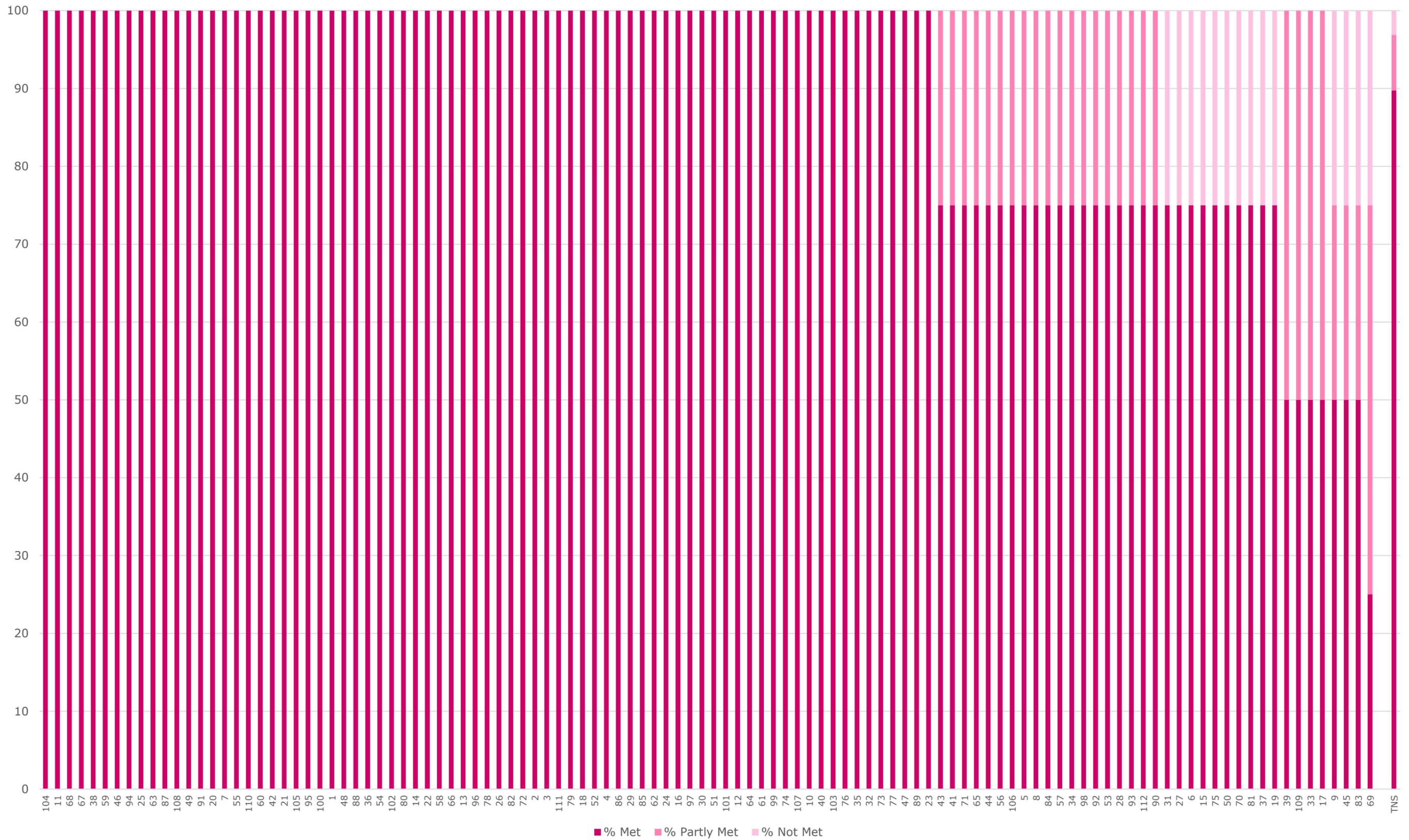


Figure 6: Percentage of criteria met, partly met and not met by service for Safeguarding.

Patient Focus

On average, services fully met 71% of standards in this area, ranging from 17% to 94% compliance.

Patient Care and Involvement

In 93% of services, there is a minimum of one community meeting per month that is attended by patients and staff members.

In 82% of services, patients and carers are given the opportunity to feed back about their experiences of using the service and their feedback is used to make improvements.

However, patients in 30% of services do not feel that they are treated with compassion, dignity and respect. Likewise, patients in 30% of services do not feel listened to and understood by staff members.

Good practice examples

There is a service user council forum where patients are able to discuss any environmental, procedural, relational and social issues on the ward.

Cygnet Hospital Beckton

Patients are clearly encouraged to share their thoughts on the challenges that the service experiences. A particular example includes where a patient representative had been consulted on the placement of staffing within the service. The service demonstrates that action has been taken through displaying 'You Said, We Did' boards on the ward.

Edward House

The service has a drama club which is very actively used and enjoyed by patients and staff. Four production shows were put on in the last year, which were a great event for family to be involved in and for everyone to come together. The patients also took pride in the set production, with backdrop banners being displayed in the stairwell entrance.

Cygnet Hospital Maidstone

Positive relationships between frontline staff and patients were observed on the review day. Patients reported staff are very welcoming and empathetic. They also feel as though staff listen to and understand them and are able to meet their needs. The communication and interactions between staff and patients is a reflection of the inclusivity of the unit.

The Montpellier Unit

Patient Information

In 99% of services, the patient's consent to the sharing of clinical information outside the team is recorded.

In 59% of services, clear information is made available in either paper or electronic format to patients, carers and practitioners on admission criteria, clinical pathways, how the service involve patients and carers and the contact details of the service.

49% of services offer information to patients regarding their rights, access to advocacy, how to access a second opinion, interpreting services, raising concerns and complaints and how to access their own health records.

Good practice examples

Pictorial information available to patients around the wards is vast and informative. Some of the pictorial information displayed was designed in collaboration with the patients.

Amber Lodge

The advocacy service is highly regarded by patients. All patients spoken to were aware of the advocate's name and were familiar with what the advocacy service does and how to access it. Patients reported that 'he gets the job done'.

Llanarth Court

The service has co-produced a new information booklet for families and carers following consultation with them via a focus group. This booklet covers information on psychosis and useful information for carers in relation to support and contact with the service.

Morris Ward

The service uses a program called 'Widget,' which allows them to convert any documents into an easy-read version.

St John's House

There are various information boards within the service, including information on occupational therapy and activities. There is also a "You Said, We Did" board to provide an update on patient, staff and carer feedback. This allows for the patient, staff and carer group to feel heard. A "Shout Out" board is also available for staff, which gives staff a chance to share examples of their colleagues' good work. This provides a positive way of helping staff feel appreciated and boost morale.

Southfield Low Secure Unit

A large amount of information is displayed on boards throughout the ward. These included information on occupational therapy activities, "question of the week" by the self-esteem steering group, psychological input information, photos of staff with an interesting fact about them and what they like/dislike, Mental Health Act information and information on safe sex, contraception and getting tested.

Twynham Ward

Food

In only 47% of services, patient felt that there are provided with meals which offer choice, address specific dietary requirements and are sufficient in quantity.

Good practice examples

The service is divided into self-contained flats, each with its own kitchen area. This gives patients the choice of being able to prepare their own food. Further to this, patients have a designated lockable cupboard in which to store food.

Avesbury House

A seclusion food menu has been introduced to enable patients to receive the same finger food as what is available on the ward. In the past, patients in seclusion would only be allowed sandwiches.

Cheswold Park Hospital

Patients reported being very happy with the meals that are provided. This included the meal options that are available for vegetarians and other dietary requirements, quality of the food produce and the portion sizes.

Hillis Lodge

Patients are given the opportunity to be independent as much as possible. The majority of patients will cook their own meals and will often cook meals for the rest of the ward.

Wood Lea Clinic

Patients said that they have a variety of choice for meal times, as there is a four-week rotating menu in place.

Kedleston Low Secure Unit

Food at the service is of a good quality. Patients reported that the food is amazing and offers a wide range of choice. The patients spoken to on the day stated that it is the best food they have received in a hospital.

Suttons Manor

Various meal choices are available and dietary requirements being met, such as vegetarian or halal. The menu available for patients in the dining area resembled the food menu of a restaurant with clear symbols for those with dietary requirements.

Twynham Ward



Figure 7: Percentage of criteria met, partly met and not met by service for Patient Focus.

Family and Friends

On average, services fully met 75% of standards in this area, ranging from 14% to 100% compliance.

Support

In 78% services, carers have access to a carer support network or group and in 77% of services, carers are signposted to a carers' assessment provided by an appropriate agency.

However, 29% of services do not offer family and friends individual time with staff members to discuss concerns, family history and their own needs.

Good practice examples

There is a family and friends group which runs quarterly and informal events, such as afternoon tea, allowing carers to meet and speak with staff. The service considers and supports a number of carers with financial support for travelling costs to the service to see their loved one, as some are located far away from the service.

Cheswold Park Hospital

The carer feedback was overwhelmingly positive regarding staff. The carer spoken to reported that she "couldn't speak highly enough of the service" and that staff are approachable and helpful. The carer further stated that she feels well supported.

New Hall Independent Hospital

The service has tried many means of engaging with carers, including hosting a number of events such as Lodge Fest, a Christmas Lunch and a number of BBQ's. This is also a good opportunity for patients from the medium secure unit to communicate with patients on the low secure unit and break down barriers.

Bretton Centre and Newhaven

Carers' were very positive about their experience with staff at the service, reporting that they are always approachable and welcoming. One carer reported that the care their loved one received was "the best that has ever been provided". This involved a particular reference to the consultant psychiatrist who made themselves readily available for a carer following concerns regarding their loved one's care and treatment.

Suttons Manor

The social work team offer financial assistance to carers and frequent house visits are facilitated. Carers are invited to CPA and discharge meetings. Behavioural Family Therapy is on offer and several patients and carers have benefitted from this.

St Andrew's Healthcare Birmingham

Communication

In 98% of services, family and friends are contacted for their agreement and in a timely manner before patients go on section 17 home leave.

However, 41% of services do not provide carers with a carers' information pack.

Good practice examples

Carer feedback about the service was positive stating that staff were very approachable and that in the past they had been encouraged to contact the service any time there were any questions or queries, and that "all staff are kind and compassionate". Staff members were reported as incredibly helpful and supportive and a lot of information has been provided.

Lee Mill Hospital

The Carer Lead checks in with carers to ensure they are kept informed of their loved one's progress and care. The service also provides a wide range of information to carers in the form of leaflets and brochures.

Allington and Tarentfort Centre

A social work mobile is in place, which carers can use to get in touch if they prefer to contact the service via text message with any queries or to access support. Staff have created a guide for carers on DBT and time is spent with families going through DBT skills to enable them to support patients and help them utilise the techniques they learn in therapy after discharge.

Waterloo Manor Hospital

The carer spoken to on the day reported she has received information in the post regarding the service when their loved one was admitted. The carer also reported feeling their loved one is being taken care of and feel the service keeps them informed of their loved one's progress.

Priory Hospital East Midlands

The social work team have been making improvements to their engagement with carers, including the development of a carers' information pack, the introduction of guided tours, contacting carers within a week of patient admission into the acute wards and a having a budget in place for carers' travel expenses.

Thornford Park Hospital

With the introduction of the new carer lead role, one carer in particular highly praised the service, reporting feeling the service knows their loved one well and responds to complaints in a timely manner. The carer also praised the flexibility of the service during visiting times and allowing visits to happen in the café, creating a more informal environment.

St Andrew's Healthcare Essex

Co-production

Good practice examples

Family members are involved in several aspects of the service and have access to regular support groups. They reported the service being a great environment for their loved one and being very much involved in care and treatment planning.

Amber Lodge

The team are proactive in initiating and maintaining carer engagement. The service holds a monthly carers' forum, where a core agenda is discussed and any other relevant items as indicated by carers. A member of the senior team will attend every carers forum to answer any questions carers may have. As well as the forum, carers are also regularly invited to attend ward rounds and MDT meetings.

Tasman Unit

Carers reported being involved in their loved one's care and having a good relationship with the social worker at the service. They reported being happy with the care their loved one is receiving. Carers receive the minutes of the meetings they are unable to attend via post and they are invited to CPA meetings.

Burston House

The recently appointed family liaison nurse has had an impressive impact on the service's communication and involvement with carers. Carers reported a huge improvement in their involvement since she was appointed, demonstrating a commitment by the service to enhance the experience of and relationship with carers.

Cedar House

The carer lead organises monthly groups for carers to encourage them to be more involved and to help improve communication between them and the service. Carers are also given the opportunity to phone the named nurse of their loved one and request an update on their well-being which has further improved communication.

Foxhall House

There are a number of opportunities for carers to get involved in work surrounding the service as well as within the trust, such as being part of the senior leadership team as a carer representative and being on interview panels. There are also a number of carer posts advertised which are paid roles.

Lowry Unit

Carers are given the opportunity to view acuity scores of their loved one's care, helping to keep them updated on their loved one's progress.

Francis Willis Unit

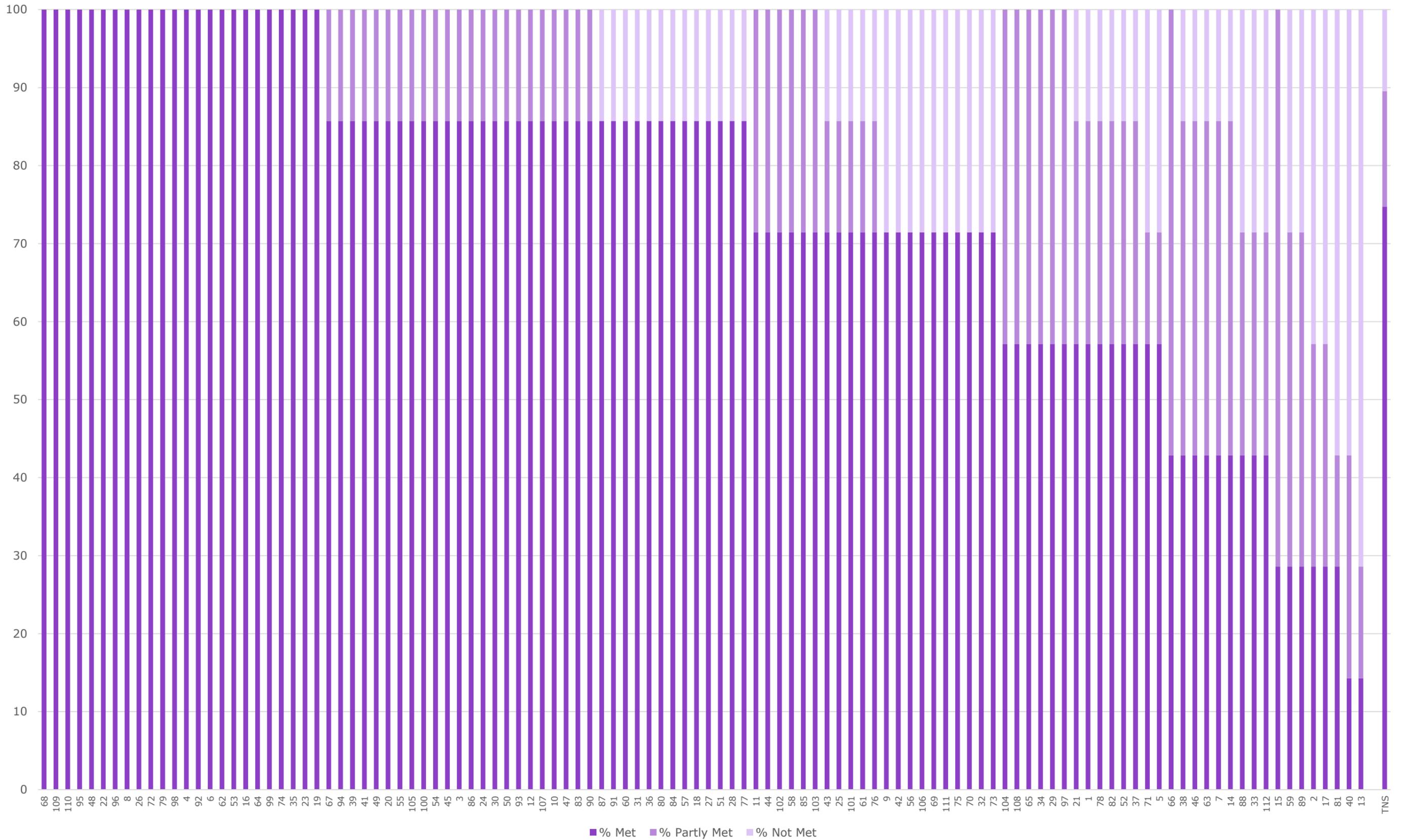


Figure 8: Percentage of criteria met, partly met and not met by service for Family and Friends

Environment and Facilities

On average, services fully met 81% of standards in this area, ranging from 43% to 100% compliance.

Ward Environment

73% of services are reported as being homely, light, clean and bright and patients are able to personalise their bedroom spaces in 97% of services.

The main entrance in 83% of services is welcoming, has comfortable seating, and provides a positive first impression.

However, 46% of seclusion facilities in services do not meet the requirements of the Mental Health Act Code of Practice and 41% of services do not have a dedicated de-escalation space.

Good practice examples

The wards were observed to be bright and open. Encouraging messages and uplifting quotes from books and movies were observed, a 'Get to know me' tree with hopeful messages and hand prints was on display and 'My discharge' messages could be read.

Cygnets Hospital Derby

The hospital grounds are in a beautiful location and the service is designed so that patients have views of the seafront and beach, which gives the ward a calming and therapeutic feel.

Cygnets Hospital Kewstoke

The main garden is well maintained and homely. There is plenty of space for patients, including a tennis court and picnic benches.

George Mackenzie House

Throughout the service, patients were asked to help decorate many aspects of the wards. The environment appears homely with wallpaper used to decorate and the quiet rooms on each unit were based on the patients' preferences.

Heatherwood Court

The wards are spacious, filled with natural daylight and are well decorated with positive quotes. Patient artwork is displayed on the walls and in cabinets.

St Nicholas Hospital

There are a number of effectively placed wall displays and artwork throughout the corridors and wards. This is the result of a working group, which includes patients who decide how the interior of the building will be furnished.

Three Bridges

Patient Facilities

In a majority of services, patients can access a range of current resources for entertainment. 83% of services have designated facilities for education, occupational and psychological therapy, tribunals, physical exercise, primary health provision, self-catering, dining, a shop/café and laundry facilities within the secure perimeter.

Patients in 97% of services are able to access safe outdoor space for recreational purposes at least daily.

Only 77% of services have a designated multi-faith room within the secure perimeter which provides patients with access to faith-specific materials and facilities that are associated with cultural or spiritual practices.

Good practice examples

There is a large and varied occupational therapy space with a well-equipped sensory room that includes a light bubble machine, bean bags and calming music, as well as an 'activities of daily living' kitchen. Patients are able to access the gym outside of conventional working hours with nursing staff.

Cygnnet Hospital Bierley

The shared communal area between the wards includes a gym, retreat room which appears cosy and relaxing, shop and café, education room, music room and art therapy room.

Hellingly

There is an excellent range of facilities available for patients on the grounds, which was commended by patients. This includes access to a swimming pool, well-equipped gym, a large sports hall with access to football and badminton, a horticultural centre and a patient operated café.

Llanarth Court Hospital

There is a wide range of facilities available on Morris Ward, such as communal cooking sessions, self-catering and pet therapy.

Morris Ward

The Kingswood Centre has a shop, café, music room, gym, and a carpentry workshop. A new light industries workshop has recently been built for patients interested in motor mechanics and bike maintenance. There is also a large garden that the patients look after, often with equipment they have repaired and maintain themselves.

North London Forensic Service

The Hub offers patients the opportunity to use facilities such as a library, a café, a shop, and an area for activities such as playing pool, air hockey, or use of a jukebox. Additionally, patients have access to numerous activity rooms, a group therapy room, a GP surgery, and the fitness suite which is a positive and encouraging environment with quotations on the wall.

Ridgeway

Visiting Facilities

In 97% of services, there are lockers provided for visitors away from patient areas to store prohibited or restricted items whilst they are in the service.

77% of services are able to safely facilitate child visits, with a visiting room that is equipped with a range of child-appropriate facilities such as toys, games and books.

However, 31% of services do not have a dedicated visitors' room within the secure perimeter.

Good practice examples

The reception area is welcoming and homely. A television screen plays videos to inform visitors about the service's work, including positive behavioural support, and there are a number of information boards and literature available for reading.

Cheswold Park Hospital

The reception area is open and welcoming and provides a good first impression of the service. There is a large amount of patient artwork on display which adds a great deal of colour and character. Information boards inform visitors of what is going on at the service.

Guild Lodge

The family visitors room is brightly decorated, stocked with age appropriate toys and books, has a kitchenette to make drinks and snacks, an en-suite toilet facility and access to an outside area which is within the secure perimeter. This provides a positive family environment for visits.

Hillis Lodge

As well as having a dedicated child visiting room outside the wards, there are two separate interview rooms in the entrance to each ward which can be used for visits. The rooms contain information for carers, including the name of the carer champion for that ward.

Rohallion Clinic

The child visitors room contains age appropriate toys, a television, a kitchenette, and an en-suite bathroom. The visiting room has a separate room for children to play in which has been made for patients and their loved ones to have private conversations in.

St Andrew's Northampton Men's Service

There is a visiting room in the entrance to each ward, plus a child visiting room with an en-suite toilet by reception.

Wellesley Hospital

The new family visiting room is of high quality, containing a changing station, comfortable seating and plenty of toys for young children.

Wickham Unit

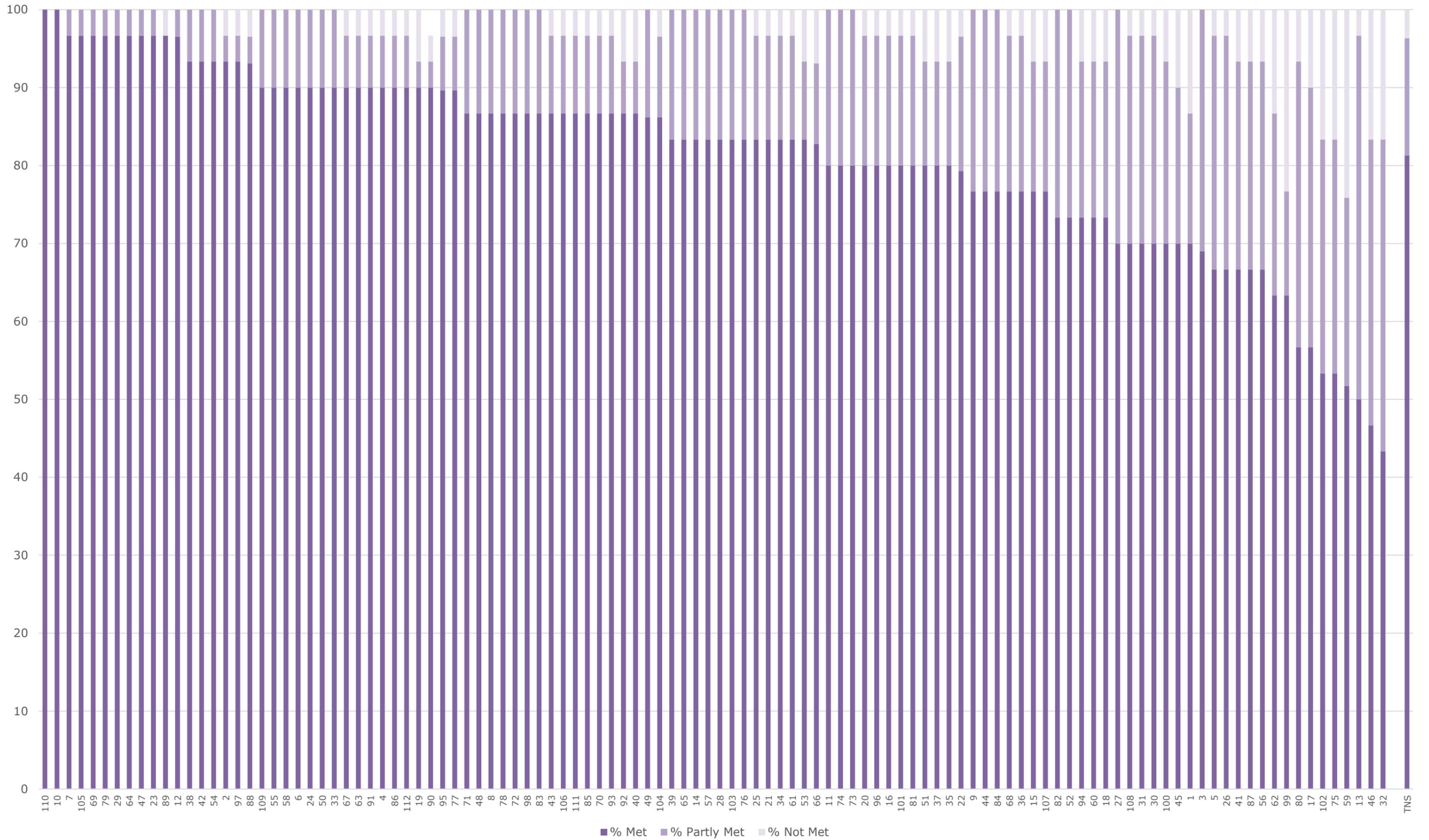


Figure 9: Percentage of criteria met, partly met and not met by services for Environment and Facilities.

Admission

On average, services fully met 91% of standards in this area, ranging from 33% to 100% compliance.

Admission Processes

All services conduct a multi-disciplinary pre-admission assessment of need, which ensures admissions to the service are appropriate and the needs of patients are clearly identified during this process.

In 95% of services, the multi-disciplinary team (MDT) make decisions about patient admissions or transfer and can refuse to accept patients if this will compromise the patient mix.

Good practice examples

Prior to a patient being admitted to the service, a multi-disciplinary team (MDT) discussion takes place and a collaborative assessment of the patient is completed. Prior to admission, exit strategies for the patient's discharge is agreed upon with commissioners, contributing to minimising delayed discharges and encouraging proactive care planning and progression through the service.

Mildmay Oaks

All patients receive a pre-admission assessment that considers risk factors, medical and physical health needs and safeguarding. The assessment includes: if the patient is known to other patients within the service; other personal needs and strengths; and goals for their time in the service. The key nurse will attend the assessment and all findings are written up in a formulation letter which is sent to the patient.

The Cleve Unit

Clinical Model

Only 77% of services have a clinical model in place to describe the purpose of the service and the clinical approach that is adopted.

Good practice example

There are clear and effective clinical models in place on the wards. These include attachment models and the recovery model. This assists with the security of the service, as well as the progression of patients through the service.

Wickham Unit

The positive behaviour support model places an emphasis on de-escalation techniques that have been identified by staff and patients to support them when challenging situations arise.

Farndon Hospital

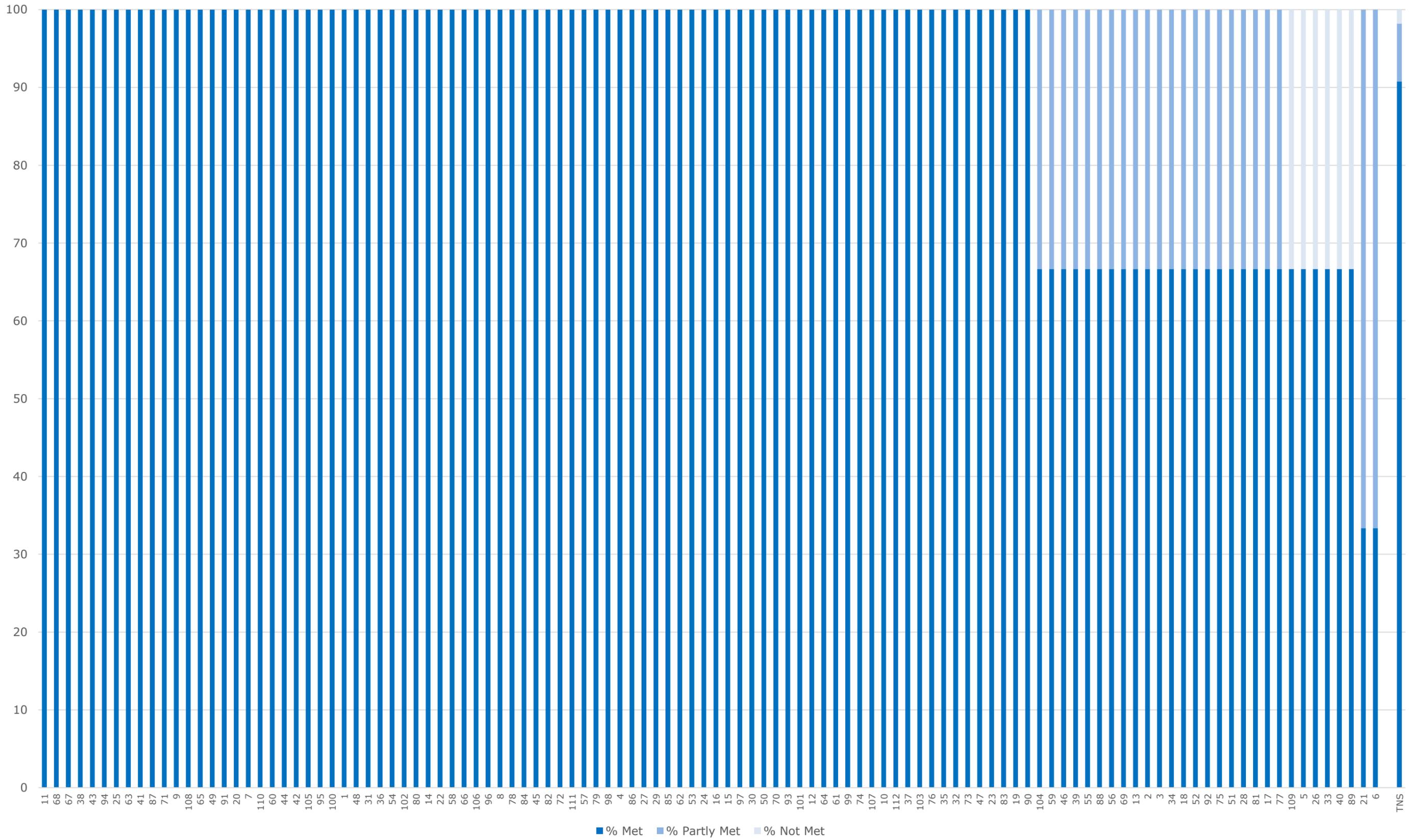


Figure 10: Percentage of criteria met, partly met and not met by services for Admission.

Treatment and Recovery

On average, services fully met 86% of standards in this area, ranging from 33% to 100% compliance.

Care Planning

Patients in most services have written care plans which reflect their individual needs.

Patients in a majority of services have a pathway of care planned, which is realistic and takes into account their aspirations and what patients are likely to need through their pathway to the community.

Multi-disciplinary teams in 94% of services review and update care plans according to clinical need or at least once a month. However, only 71% of these are developed in collaboration with patients and their carer.

Good practice examples

Patients are aware of their care pathways and what they needed to achieve in order to progress to their next level of care. They also spoke highly of the advocacy available and the work the social worker does to involve their family in care planning.

Ashford Unit

A new initiative has started to support patients to be involved in their care planning by the use of iPads.

Bracton Centre

The care planning process appears to be well organised and inclusive. Patients expressed being involved in the process along with their carers. Patients are familiar with 'My Shared Pathway' and patients understand their goals and pathway.

Burston House

Each patient has a milestone pathway which includes clear personalised outcomes in their own key recovery areas. Patients are helped to recognise which outcomes are critical to their pathway.

Chichester Centre

Care plans are developed and reviewed in collaboration with the patient; the speech and language therapist has assisted with this. Patients have a good level of understanding of their personalised care plan.

Gerry Simon Clinic

Patients and carers are involved in patients' care planning. Patients reported receiving a copy of this and knowing what to do to reach their next level of care.

Wells Road Centre

Therapies and Interventions

A majority of services offer patients evidence based pharmacological and psychological interventions.

Patients in 77% of services have clear personalised outcomes identified in key recovery areas and understand which outcomes are pathway critical.

Good practice examples

The service offers a wide range of psychological therapies to patients including offence treatment programmes, such as a thinking skills programme and offender relationships.

Brooklands Hospital

A 'brain in hand' pilot scheme has been implemented, in which patients have a mobile device and can alert staff to how they are feeling. This allows staff to respond immediately to patients who may otherwise not report their low mood and intervene accordingly, helping to reduce agitation and incidents.

Cedar House

The service has a structured programme of psychology and occupational therapy, such as dialectical behavioural therapy and cognitive behavioural therapy. Cooking groups are also available to develop life skills. Patients are aware of what is on offer and reported that these would help them to reach their recovery goals.

Cygnet Hospital Sheffield

The psychology provision was highly praised by patients, who reported the service allows them to be highly involved in their own care planning. Patients also reported, even though there is a lack of staffing, they feel staff are caring, dedicated, and work very hard to provide them with any support they may need.

St Andrew's Healthcare Northampton Women's Service

There are a range of real work opportunities for patients. There are voluntary opportunities in a charity shop in the local area. There are also on-site opportunities, with patients having to go through an application process to gain access to the occupational therapy horticulture facilities, including completing an application and an interview.

Kneesworth House Hospital

Psychology provide a number of evidence-based interventions. These are evaluated as to their effectiveness through psychometric questionnaires and focus groups.

Wheatfield Unit

The service has good community links with local supermarkets and cafés, providing patients with opportunities to integrate with the community. Many patients have had work roles at a local cafe and there is a work lead at the service who is working on securing more job roles for patients.

Priory Hospital Burgess Hill

Patient Activities

In 95% of services, staff provide information to patients where relevant, to access local organisations for peer support and social engagement.

Patients in 71% of services have a personalised plan of therapeutic and skill-developing activity that is directly correlated to their outcomes plan. This allows patients to see the connection between activities and the achievement of their recovery goals.

Good practice examples

Patients have access to local peer support groups and a group for patients with personality disorder. Skill development opportunities are available from the local college and an initiative which promotes engagement in art and film projects. Short courses are organised with Learn Direct.

Ash Ward

There are excellent educational and vocational opportunities for patients, such as a thriving recovery college, and patients have been involved in co-producing and delivering a number of courses.

Beech Ward

Cygnets Woking Recovery and Wellbeing College offers patients and carers a range of life skills courses, such as coping with stress, preparing for discharge, CV and interview preparation, domestic tasks, and applying for benefits.

Cygnets Hospital Woking

Ward representative roles are voluntary and paid roles are also available, such as car washing, catering, housekeeping and horticulture as part of the new garden project.

Kemple View

Evening activities are available, such as bingo, quiz nights and karaoke. Patients also have access to evening exercise activities, including yoga, Wii and exercise DVDs.

4 Bowlers Green

There is a wide array of activities offered at the service, which are provided seven days a week and during the evenings. Some of these consist of: gardening projects; access to a gym with range of exercise equipment and weights; an instructor who attends the service six days a week; and access to bicycles.

Memorial Hospital

Educational and real-working opportunities available to patients are commendable. The recovery college offers courses on IT, Maths, English, customer service, managing psychosis and patients have the opportunity to become a tutor.

Oxford Clinic

The recovery college offers patients courses such as 'Hearing Voices' and 'Spoken Word'. A recovery college manager supports patients to co-produce courses, with a recovery college working group to drive developments.

Wolfson House

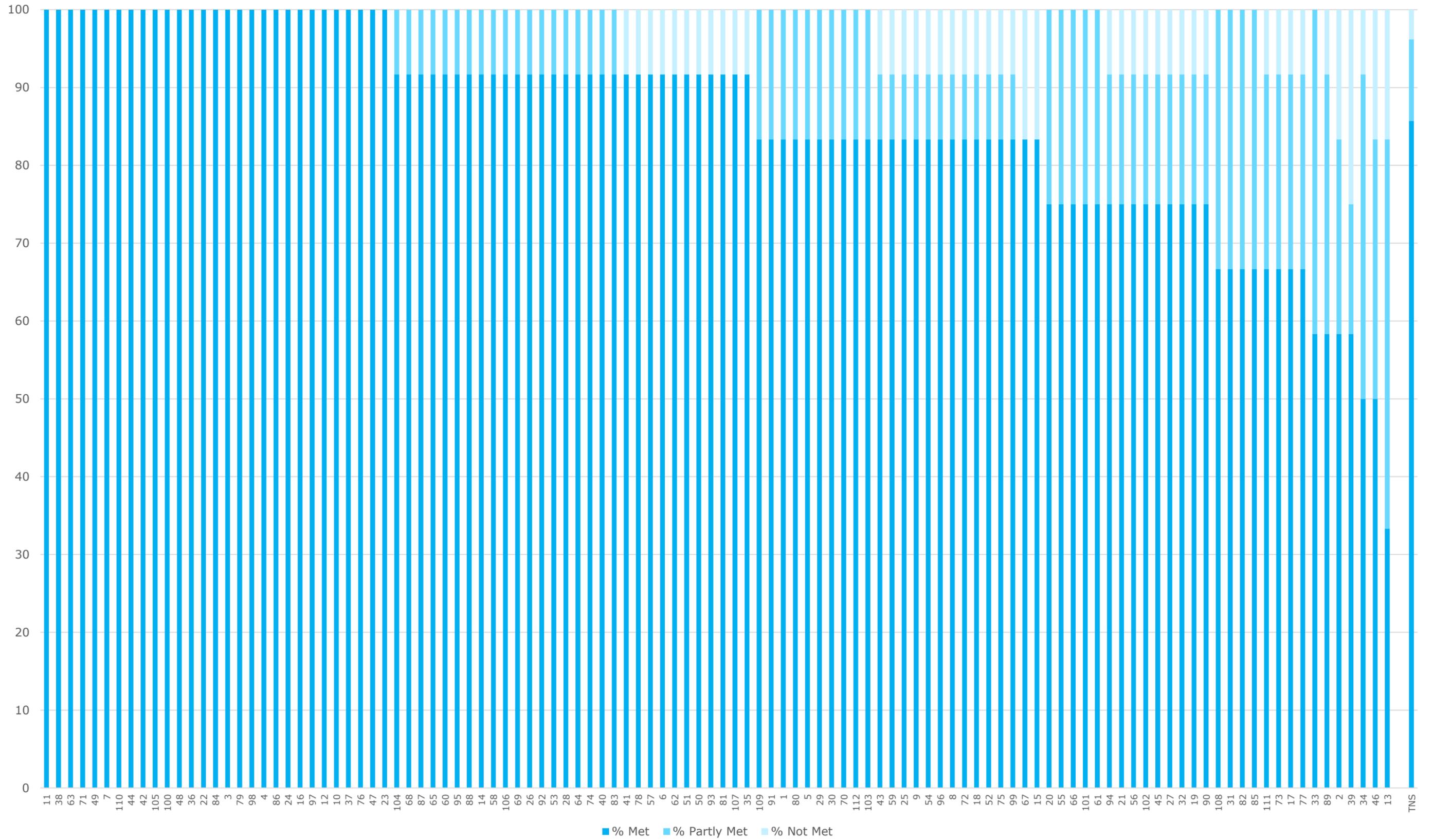


Figure 11: Percentage of criteria met, partly met and not met by services for Treatment and Recovery.

Medication

On average, services fully met 80% of standards in this area, ranging from 40% to 100% compliance.

Pharmacological Interventions

93% of services set treatment targets for patients when medication is prescribed, the risks and benefits are reviewed and a timescale for response is set.

43% of services are not reviewing high risk medication annually, at a service level.

Good practice examples

The pharmacy team provide information to the patients in different formats, including easy-read, and are happy to spend additional individual time with patients. The pharmacy team conducts regular audits and holds clinics for patients to discuss side effects.

Clifton House

Side effects are discussed with patients and their carers in ward rounds, and they are reviewed in CPA meetings. Posters are displayed around the service with information relating to different medications and the side effects.

North London Clinic

A local pharmacy service provides training to staff to help increase transparency through auditing medication and highlighting any issues.

Ty Catrin

Self-Medication

Patients and carers in 92% of services are helped to understand the functions, expected outcomes, limitations and side effects of their medication, and to self-manage as far as possible.

Good practice examples

The service were praised on how many patients are currently self-medicating. Four patients currently self-medicate; two of whom are responsible for their own medication and keep this in their bedrooms.

Bowman Ward

The service supports patients to self-manage their medication wherever possible, developing a plan for each patient which includes a series of steps and stages so that patients gradually learn to self-manage over time and with support from ward staff.

The Cleve Unit

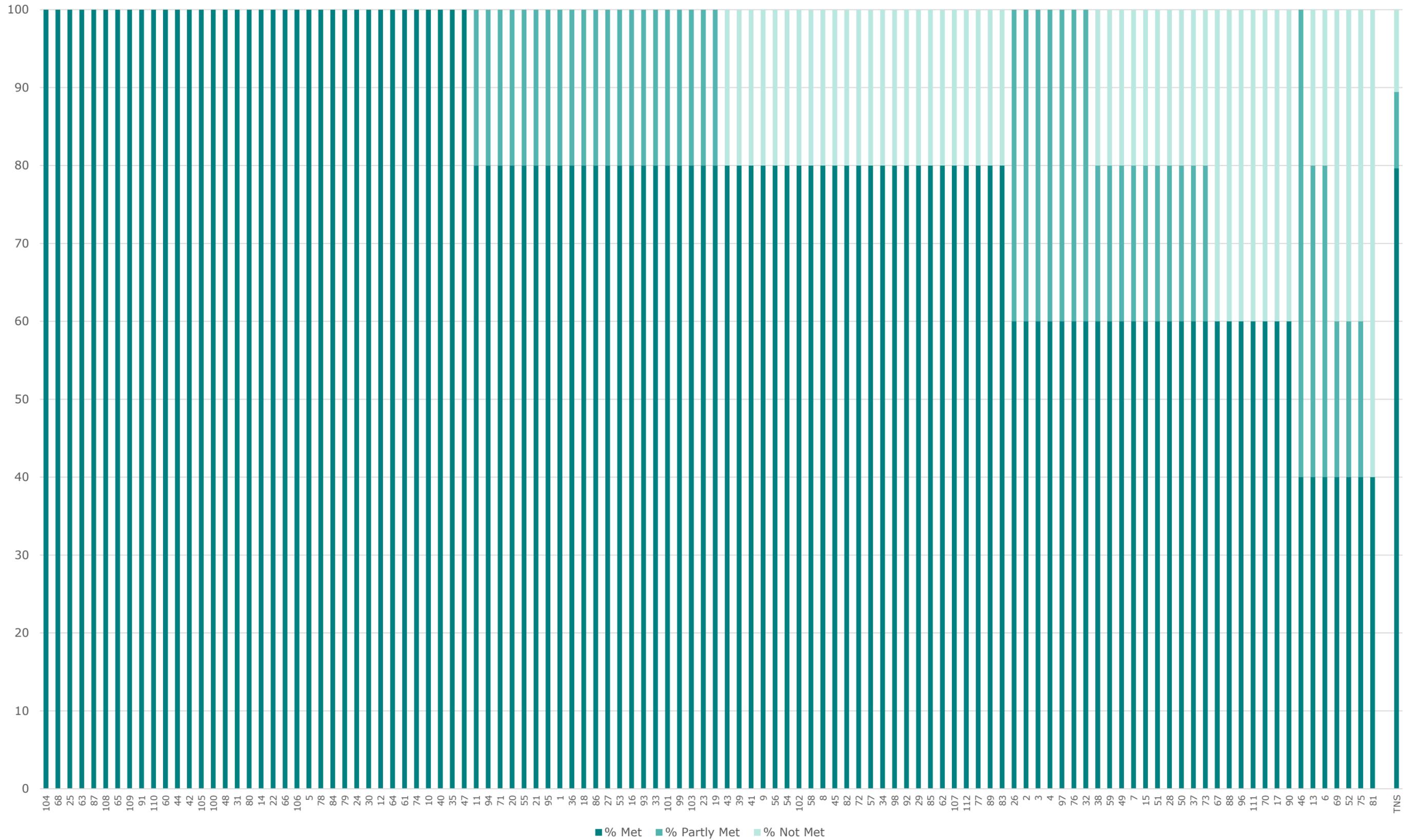


Figure 12: Percentage of criteria met, partly met and not met by services for Medication.

Leave and Discharge

On average, services fully met 94% of standards in this area, ranging from 60% to 100% compliance.

Discharge Planning

In 90% of services, patients and their carers are invited to a discharge meeting and they are involved in decisions about discharge plans.

In a majority of services, the team work proactively with the home area care coordinator and next point of care, to develop robust discharge and transfer arrangements and to minimise delay. This includes other inpatient services, forensic outreach teams, community mental health teams or prison.

Good practice examples

An innovative discharge planning document has been developed, which includes a self-reporting section at the start of the discharge planning document and patients evidently feed into this practice.

All Saints Hospital

There is a large forensic community team attached to the service which helps with the continuity of care for patients. Once patients are discharged, they are followed up every week by the same responsible clinician for at least six months.

Lowry Unit

A pre-discharge ward contains self-contained flats and patients are responsible for the upkeep of their flats, cooking, shopping and laundry. This is a positive way for patients to prepare for leaving the service and managing their new accommodation.

Brockfield House

Patients are aware of what they need to do to be discharged. One of the carers spoken to felt that the service as a whole ensured that their loved one was ready to move on and nothing felt rushed in the process.

Morris Ward

There is a transition team to support patients with accessing their next point of care. Continuity of care is maintained as the team conduct follow ups after the patient has been discharged.

Moorlands View

The establishment of a dedicated Service Outreach Transition (SOT) team has resulted in a more streamlined process for discharge. The team is optimistic and confident in their work and continuing to establish and strengthen relationships with community providers.

Northgate Hospital

Support

In 96% of services, the team supports patients to access organisations which offer support in housing, finance and benefits and debt management.

95% of services identify and address the immediate needs and concerns of the patient in relation to transitions to other services or to the community.

Good practice examples

There is a clear pathway of care and progression for patients from the low secure service to progress onto the locked rehab ward, and from there they can progress onto the open unit. The pathway is effective as staff work across all three wards and they have an awareness of patients' needs across the service.

Cygnets Hospital Harrow

The transitions group demonstrates a positive approach for getting patients discharged into the community. The service has developed connections with non-secure placements in the region and implemented a discharge co-ordinator role.

Forest Lodge

The service is piloting a recovery transition worker. A healthcare assistant adopted the role to ensure patients who are being discharged into the community have continued support for at least three months with someone they are already familiar with. Patients can also ask for longer support if they require it.

George Mackenzie House

The service has staff 'champions', who are responsible for expertise in specific areas, such as housing and benefits. Patients can seek advice and guidance about the relevant issue with these staff members, and the ease of access to this information reflected positively on signposting and referrals.

Hellesdon Hospital

The Independent Living Area (ILA) was a great facility to enable patients to transition to a less restrictive environment as part of the discharge process. Patients on the ILA are able to cater for themselves.

Prospect Place

There is a robust treatment pathway for patients, with step-down flats which are immediately available to patients working towards leaving secure care. This promotes independence and provides patients with a recovery goal.

Shaftesbury Clinic

Staff are proactive in finding a patient's home area care co-ordinator at the earliest opportunity, ideally at the point of admission, and will work with them throughout their journey to ensure they receive wraparound care.

Wellesley Hospital

Leave Arrangements

95% of services develop a leave plan jointly with the patient which includes the aim and purpose of section 17 leave, conditions of leave, a risk assessment and risk management plan and contact details of the service.

Good practice examples

The service has introduced a 'Safe Places' scheme in the local community, where shops and businesses are able to volunteer their assistance for patients on unescorted leave who may be distressed and require some help contacting the team.

Maplewood

There is a specific induction for staff on escorting patients whilst on leave. This is particularly positive as it means all staff are aware of the therapeutic side of this activity and how both the patients and staff should behave whilst on leave, for example ensuring the patient has road safety awareness and staff are not using this time to take an extra break. It also ensures staff have a strong awareness of how to manage a situation if a patient absconds.

St Magnus Hospital

There are good links with community services, giving the patients with unescorted leave opportunities to gain voluntary experience at local charity shops and food banks. From this, the patients can get referencing and employment experience, preparing for when they are discharged.

Taith Newydd

The service has innovative links with the community. Patients are able to volunteer with dog walking, gardening and in charity shops when on section 17 leave. The service develops these links based on patient preferences and requests.

Ty Catrin

Ty Cwm Rhondda has good links with local organisations to support patients in developing life skills prior to discharge into the community. Voluntary opportunities are available in local charity stores for patients with unescorted leave. A furniture upcycling service provides patients with purposeful activity and skill development.

Ty Cwm Rhondda

Patients are granted regular leave, and the service is currently doing a piece of work on how to ensure that leave is utilised in a meaningful and therapeutic way.

Woodlands House

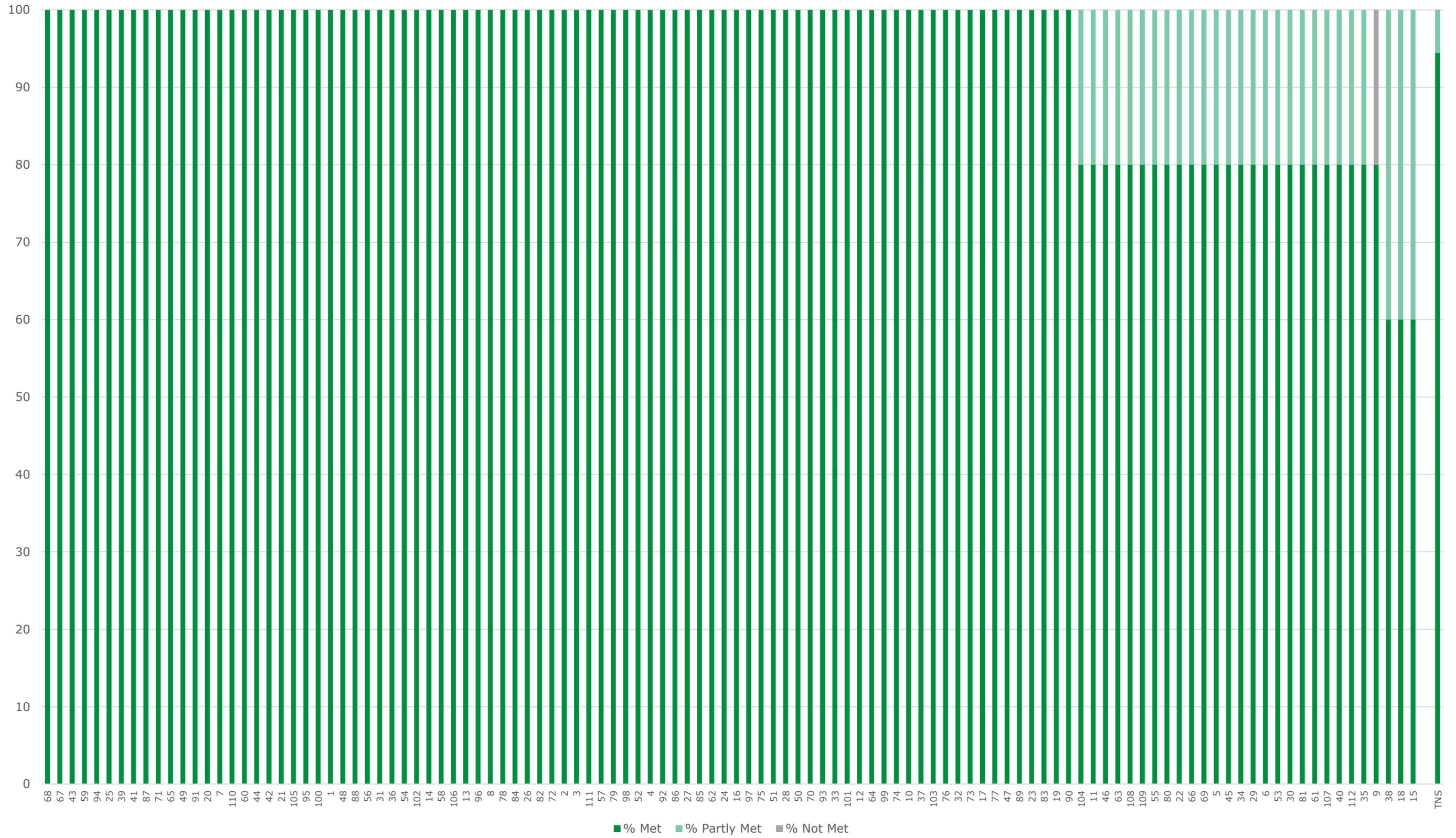


Figure 13: Percentage of criteria met, partly met and not met by services for Leave and Discharge.

Physical Healthcare

On average, services fully met 82% of standards in this area, ranging from 38% to 100% compliance.

Physical Assessment and Examination

In 95% of services, patients have their physical healthcare needs assessed on admission and reviewed every six months or more frequently if required.

Patients in a majority of services have access to screening programmes, as available to the general population, with the aim of ensuring early diagnosis and prevention of further ill health.

Good practice examples

A range of physical health initiatives are in place, such as a Men's Health Week, which involves tackling issues and promoting awareness of general screening processes for testicular cancer. The Clozaril Clinic at this service involves taking blood samples and weekly physical health monitoring.

Ellesmere House

The service benefits from having a general hospital on site, however there is also an in-house GP service. All patients have access to a range of screening programmes. Breast screening is done at external centres to ensure that eligible patients are sent for mammography. In addition to this, the service has recently opened a new dental suite.

The Orchard Unit

The team provides comprehensive physical healthcare support for patients, with all patients being regularly monitored. All staff have been trained on how to use the Modified Early Warning System (MEWS) tool for physical health. This allows staff to identify deterioration in a patient at the earliest opportunity and refers them to seek appropriate medical support. Additionally, staff have been trained in using the Disability Distress Assessment Tool (DisDAT) specifically to aid two patients who are limited in communication due to their conditions.

West Drive

Patients have regular physical health check reviews and access to a dietician. Staff are supportive of patients' wellbeing and support them to achieve healthy lifestyles. There is a food forum where patients can meet with caterers to discuss improvements to meals.

Eaglestone View

Joint Working Protocols

73% of services do not have joint working protocols or care pathways in place to support patients in accessing primary health care, accident and emergency, social services, local and specialist mental health services or secondary physical healthcare.

Good practice examples

There are strong links with the community GP service to provide comprehensive physical assessments. Each patient is provided an annual physical health screen from a GP with a good understanding of patients with personality disorder (PD) and who specialises in forensic settings. There is a service level agreement in place for this.

Cygnnet Hospital Clifton

There is a physical health centre which provides a GP clinic, dentist, podiatrist, ECG technician and dietician. The GP runs two clinic sessions each for the low secure unit, and there are two practice nurses and two assistant practitioners working onsite. The service has started a 'motivate group' to encourage healthy living for patients. This is run by the consultants, psychologists, OTs and GPs working collaboratively and includes groups such as cooking and physical exercise.

Lowry Unit

Each patient has a physical health care plan and a health promotion care plan. The health promotion care plans are formed in collaboration with the patients and other agencies and cover: health awareness; weight management; smoking; diet and nutrition; exercise; and any patient specific items.

Heatherwood Court

The service has recently employed a GP and established a joint working agreement.

Rohallion Clinic

The service has developed the use of a 'GP Passport' as an innovative way to ensure patient notes are more easily integrated into one electronic system. The patient takes their GP passport to all appointments so the professional seen can update it, and return it to Ty Catrin, where it is uploaded to their electronic system. This came as a result of the service having difficulties accessing GP medical notes for their patients.

Ty Catrin

There is a good focus placed on physical health monitoring for patients. Posters outline healthy eating advice and physical exercise provisions. There are also groups, such as a walking group, that patients can partake in for physical exercise.

Taith Newydd

Healthy Living

In 88% of services, the team provide targeted lifestyle advice and provide health promotion activities to patients.

Patients in 98% of services have care plans which consider their physical health outcomes and interventions in health awareness, weight management, smoking, diet and nutrition, and exercise.

Good practice examples

The service is committed to providing physical health awareness to patients and promoting healthy living. The site is smoke-free and patients felt that they were supported in reducing their nicotine intake prior to the ban. Healthy eating is actively encouraged through self-catering and healthy on-site meals are freshly prepared by a chef. There is also a dietician that advises the patients on healthy eating.

Arbury Court

The fitness instructor is largely responsible for the development of the 'FITTER Programme' initiative. Every patient is allocated 150 minutes of activity per week, with access to an extensive gym suite and physical exercise equipment. Patients are able to use FitBits and there are innovative ways of creating challenges to encourage patients to engage in physical exercise, such as the Walk to Paris, which is treated as an achievement and milestone for patients.

Rathbone Low Secure Unit

A programme of physical health is in place and patients are offered targeted advice and activities. They are well supported to monitor their diet, access opportunities to exercise and they are offered smoking cessation advice. There is a gym onsite and a weekly cycling group takes place. The onsite GP provision is excellent and provides a dedicated space with a waiting area for the patients to access daily.

River House

Patients are encouraged to eat healthily through the provision of healthy meal options. There is plenty of opportunity for patients to participate in physical exercise activities including access to a fully equipped gym and playing in a service wide football tournament.

St Andrew's Nottinghamshire

The service organised a 12-week course, 'Mission Fit', in which patients were involved in healthy eating, physical exercise and healthy living. This was positively commented on by patients who were proud of the achievements they had made. There are different levels they can complete, with a t-shirt given for each level achieved. One patient reported being able to access the gym between one and two times per day as all staff are trained in supporting patients to use the gym.

Ty Cwm Rhondda

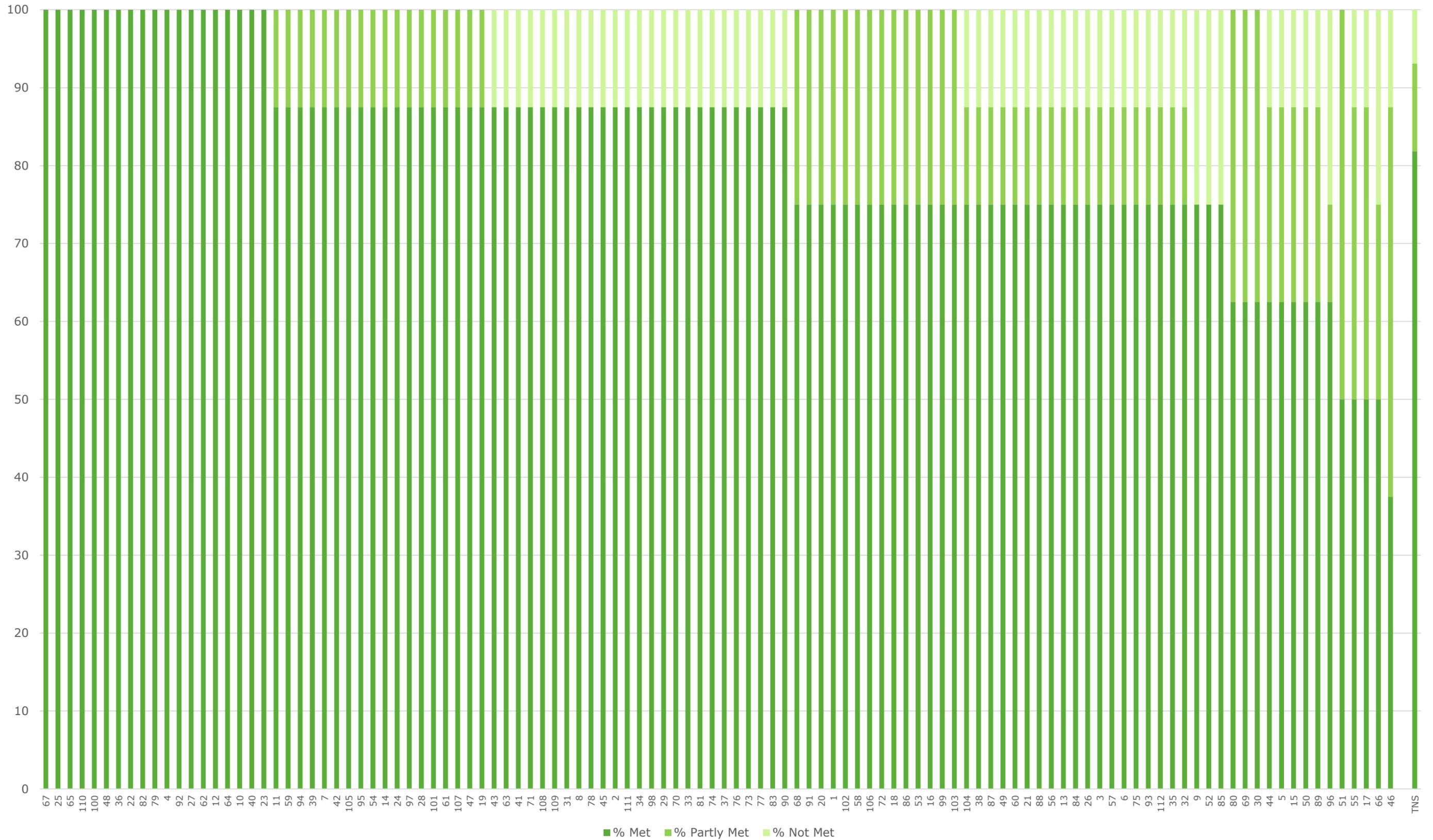


Figure 14: Percentage of criteria met, partly met and not met by services for Physical Healthcare.

On average, services fully met 66% of standards in this area, ranging from 29% to 100% compliance.

Supervision and Support

In 91% of services, staff receive an annual appraisal and personal development planning (or equivalent).

59% of staff reported receiving monthly managerial supervision and 68% of staff reported receiving monthly clinical supervision. Monthly reflective practice sessions are available in 60% of services.

68% of staff felt the service they work at actively supports their health and wellbeing.

Good practice examples

The service has a designated wellbeing champion who has undergone specific training on identifying signs of stress and trauma among staff.

Foxhall House

Staff have access to mindfulness and relaxation sessions and an audit is currently being rolled out to identify and address staff burnout.

Cygnet Hospital Blackheath

The psychology team provide reflective practice twice a week to ensure staff from both day and night shifts have access to it on a weekly basis.

Llanarth Court

There are relaxation days for staff where they can receive massages and beauty therapy.

The Spinney

The service has a register of supervisors containing the skills and experience of those within the service who are qualified to facilitate staff supervision. Staff can select a particular supervisor based on these qualities.

Cygnet Hospital Bury

A clinical supervision passport has been implemented, which effectively monitors and logs monthly supervision sessions. Reflective practice sessions take place at least once a week and weekly debriefs are also facilitated for all staff members.

Francis Willis Unit

There is a counselling service that staff can access, as well as reflective practice sessions taking place twice a week, with additional sessions being offered following any incidents. Staff can also request additional supervision if required.

Hollins Park Hospital

Staff Team and Skills Mix

There is a mechanism in place for responding to low staffing levels in around half of services.

60% of services have not conducted a review of staff members and skill mix of the team within the past 12 months to identify gaps in the team and develop a balanced workforce, to meet the needs to the service.

In 81% of services there is a medical on-call arrangement in place which enables the service to respond within 30 minutes to psychiatric emergencies and fulfil the requirements of the Mental Health Act Code of Practice.

Good practice examples

The service recently recruited a Family and Carer Lead, who has an occupational therapy background. Additionally, a Healthy Lifestyle Advisor and a Smoking Cessation Advisor are in post.

Ash Ward

As well as the MDT, there are other professionals available on site, including pharmacists, a GP, primary health nurse, a physio, and activity coordinators.

Langdon Hospital

Staff have timed 'huddles' throughout the day, which are mini-handovers that allow staff to update each other regularly.

Robin Pinto Unit

There is a highly robust quality improvement team in place at the service which involves engaging with a team of multi-disciplinary staff. The team attend regular meetings to discuss initiatives to further improve quality of care at the service.

Newsam Centre

The Speech and Language Therapist (SaLT) has implemented a range of initiatives to aid communication with patients and better meet their needs.

Oaktree Manor

Training

Only 34% of services evidenced that their staff receive training consistent with their role.

81% of services are not involving patients and carers in the delivery of face-to-face training.

83% of staff are receiving an induction on an agreed list of core competencies, including bank and agency staff.

Good practice examples

The team can access additional training that is funded by the Trust. For example, a staff member is completing a postgraduate course, and another is due to begin training to become a personal trainer.

Wood Lea Clinic

Staff are able to book training within their Trust and also have access to outside training and external conferences. For example, some staff are receiving training on motivational interviewing and psychopharmacology.

Twynham Ward

Training on brain injury was praised by a member of staff who stated they found it extremely helpful. The service also ensures new staff complete basic Level 1 training in British Sign Language and have the opportunity to continue it.

St Mary's Hospital

Staff feel supported in training and development, and the service has provided training for all staff in dialectical behaviour therapy (DBT).

Brockfield House

The senior management team recognise staff strengths and are proactive in promoting their personal development. Health care assistants have been supported to become nursing associates and Band 5 nurses have been offered the opportunity to attend a leadership course to gain a qualification and move up into a Band 6 role.

Foxhall House

Staff receive a thorough induction when they join the service. This includes a two-week training period, followed by a supernumerary period where the new starter shadows an experienced member of staff on a full range of shifts, including nights.

Hazelwood House

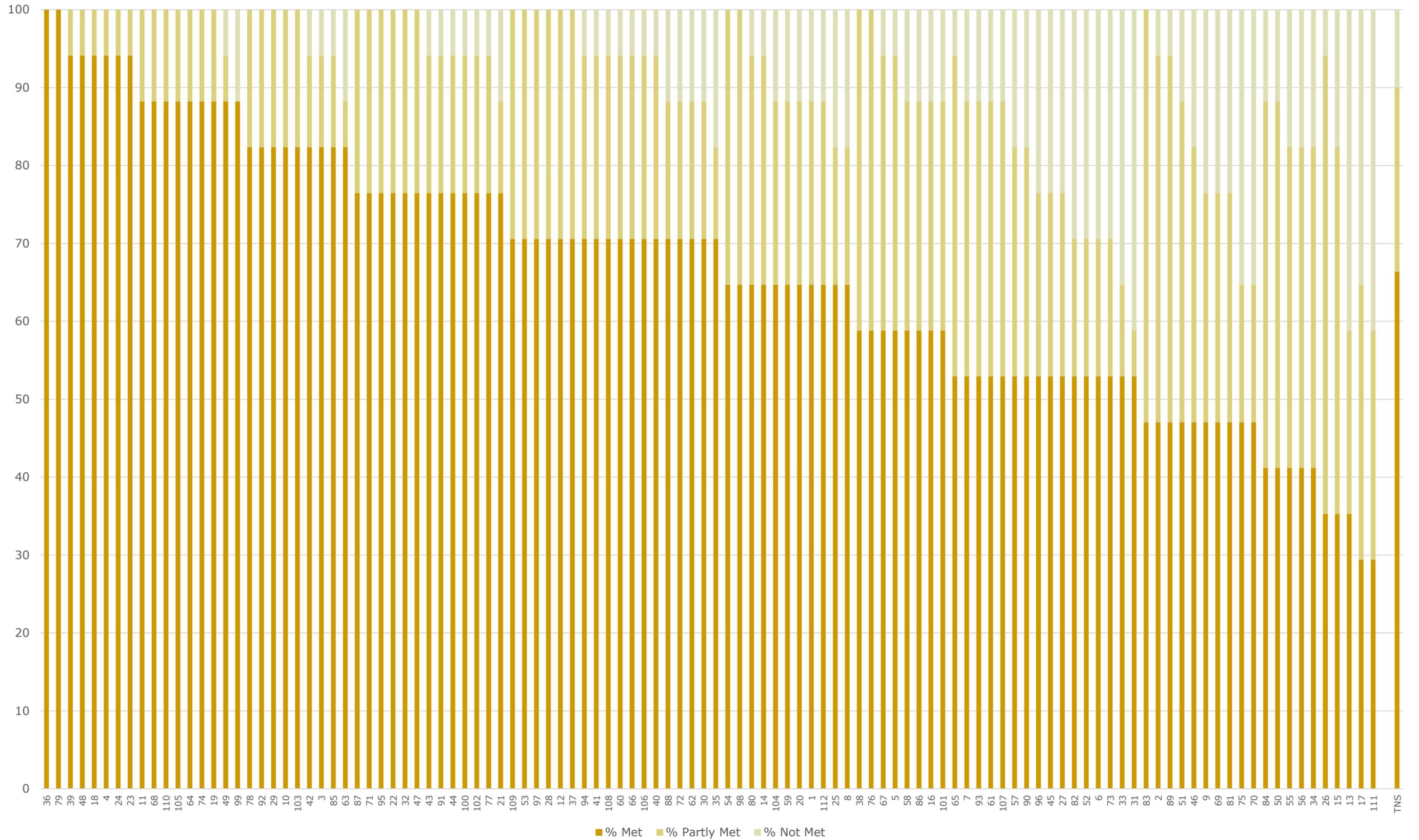


Figure 15: Percentage of Criteria Met, Partly Met and Not Met by Service for Workforce.

Governance

On average, services fully met 83% of standards in this area, ranging from 36% to 100% compliance.

Incidents and Lessons Learned

In almost all services, findings from investigations, measures and reports are routinely shared between the team and the board, and vice versa, so that lessons can be learned.

77% of services offer staff members, patients and carers post-incident support following a serious or distressing incident.

Good practice examples

The service creates learning flyers which cover a range of lessons learned following incidents. These are cascaded to all frontline staff.

Allington and Tarentfort Centre

Service Improvement

Complaints are reviewed on a quarterly basis to identify themes, trends and learning in 81% of services.

Good practice examples

The service holds a twice daily meeting where staff from all levels discuss issues affecting the wards, including staffing levels, safeguarding referrals, incidents, concerns and patient observation levels.

Cygnets Hospital Stevenage

Audits

74% of services conduct an audit of environmental risk annually and agree on a risk management strategy.

Good practice examples

The service is part of a Trust wide audit known as I (information) Fox, which audits all areas at the service and provides a colour score of what needs improving.

Memorial Hospital

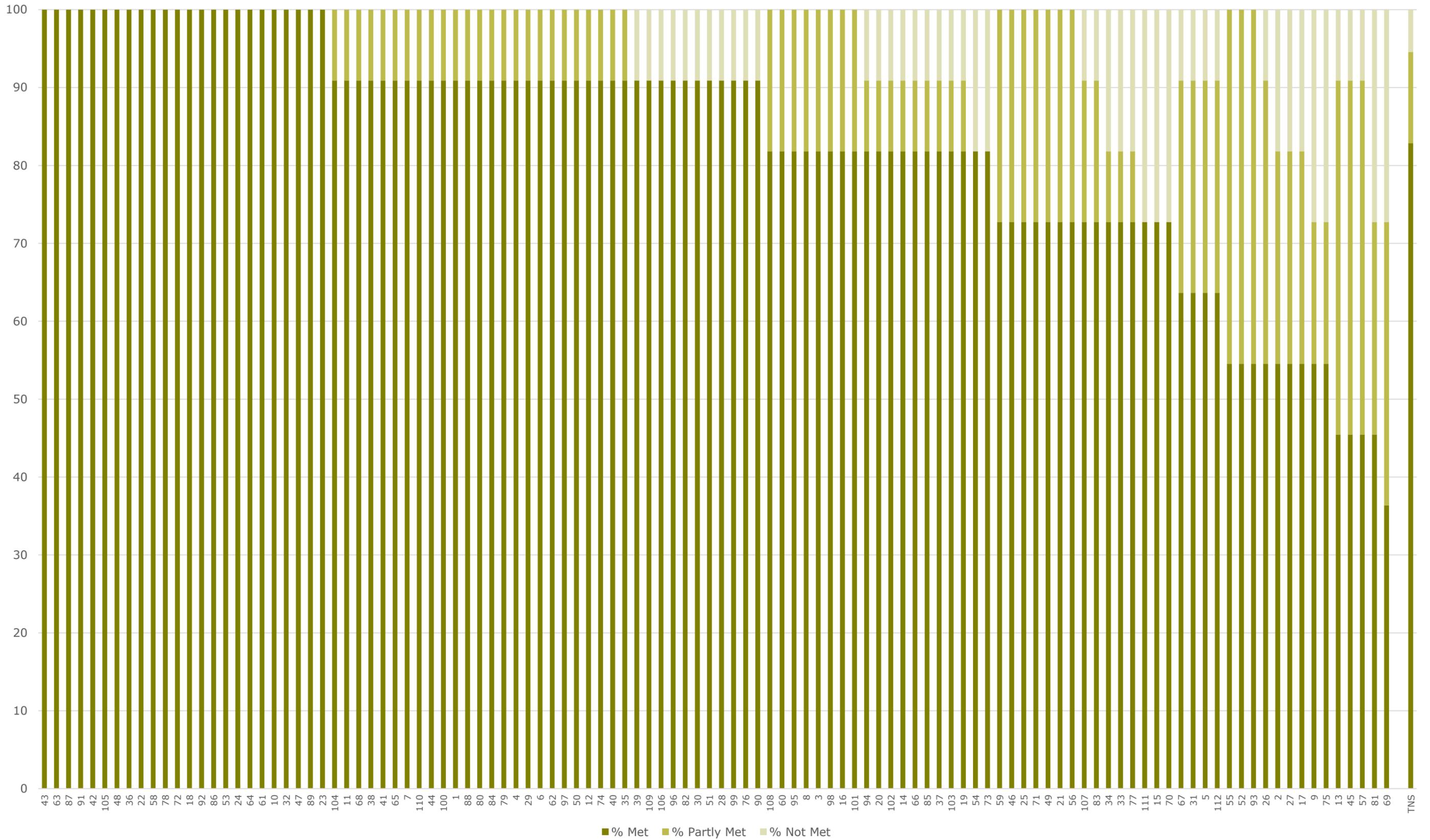


Figure 16: Percentage of criteria met, partly met and not met by service for Governance.

Discussion Summaries

In July 2018, we launched our online discussion forum on a platform called Knowledge Hub. Staff, patients and carers from member services and stakeholder organisations have been actively engaging in conversations on topics of interest. This section explores the themes from the most active discussion threads that have taken place.

Moving to a smoke-free campus

This query was flagged by a member service that was scheduled to move to a smoke-free campus in the coming two years. It had been identified that other services have successfully achieved this and this query opened the floor for others to share examples of good practicing in implementing this smoke-free policy.

Respondents shared the following information:

- A low secure unit rolled out the smoke-free policy successfully, followed by the rolling out of a new initiative where patients can receive three free vapes from the service.
- Another service has been non-smoking for two years, which has included whilst patients are on escorted leave. However, exceptions have been made to allow patients to smoke whilst on escorted leave which led to all patients who smoke now having leave and using this time to smoke. The service tactically supports patients smoking in the secure grounds by not addressing this with them or reviewing their use of leave. The service hopes to refresh their approach soon and return to a mutually agreed boundary about the use of leave. It is also likely for this service that they will be making e-burn cigarettes available to all patients.
- One respondent stated that their service has been smoke-free since 2015 across the whole Trust and forensic services. It is recognised that there are challenges with this, but staff have worked hard to ensure this is successful overall. The service allows single-use e-cigarettes.
- An additional response discussed that their service has been smoke-free on the wards for some time and nicotine replacement therapies like patches and puffers have been offered. The service recently extended this so that patients do not smoke whilst on escorted leave. This rule was implemented with the introduction of e-cigarettes. Each ward decided where the e-cigarettes would be used such as the bedrooms and garden only. Then, each ward was able to decide the rules about the use of e-cigarettes which was appreciated and welcomed.

The high number of responses around this topic highlights that services adopting the smoke-free policy is variable across secure services. Greater clarity around implementing this and the use of e-cigarettes and vapes in secure services would be beneficial.

Storing patient property

An issue was highlighted surrounding several difficulties a service was having with the storage of patient property. A number of patients were entering the service with more property than was capable of being stored in their bedrooms.

Respondents shared the following information:

- One respondent was experiencing this issue in addition to security concerns and legislative drivers such as fire, food hygiene, health and safety, ability to safely manage violence and aggression and medical emergencies.
- Another service completed a piece of work collaboratively with patients to explore why a limit was needed on the amount of property that can be stored, whilst still supporting patients to review their property and make arrangements with family and friends to store excess property where possible. Some patients opted to pay for their own off-site storage facilities. Additionally, at the point of pre-admission, the service advises patients and the transferring service that storage is limited, to minimise excessive volumes coming into the hospital.
- It was highlighted that Local Authorities have the duty under Section 47 of the National Assistance Act (1948) to store patient / residents' property whilst they are in hospital according to Protection of Property Rules.
- A service identifies patients' property prior to being admitted and where possible, limits property to a maximum of two boxes which is not always stored in patient bedrooms. There are off-site storage facilities for this service, which can sometimes lead to issues in ensuring a double-signed inventory is completed to prevent items being lost.
- Within patient bedrooms, there are no standard procedures for how much patients can store in their bedrooms, this is risk assessed by the multi-disciplinary team. There is a 'swap' items initiative in place so that rooms do not become over crowded.
- A response from a patient's perspective illustrates the importance of patients' rights under Article 8 of the HRA (1998), and how patients in secure services already have a lot taken from them in terms of their autonomy, dignity and liberty. This then impacts patients' perceptions of coercion and receptivity to treatment and can compromise their potential for recovery. Patients need to have a sense of control over their property in order to feel safe and it is crucial that services do not enact restrictions regarding property that does harm.

It is apparent from this discussion thread and the responses that follow, that managing patient property and identifying appropriate storage in secure services is an on-going issue. Overcoming this issue includes working collaboratively with patients and putting steps in place before patients are admitted to services.

Managing a healthy weight in secure services

This thread was initiated by a service with the view to start quality improvement projects around managing a healthy weight in secure inpatient services. The service posting this query currently roll out the following initiatives: facilitated gymnasium, walking group, self-catering and dietician and care-planning individually.

Respondents shared the following information:

- One service that is working on managing a healthy weight in secure services is strongly geared towards co-production in achieving this. The recovery college at the service and patient and staff forums have been used to help formulate and drive action plans.
- Goals of achieving this include demonstrating active engagement and involvement in the work of NHS England's Adult Secure Clinical Reference Task and Finish Group on healthy weight that includes its outputs and time frames for delivery.

- Initiatives that are being rolled out to support managing a healthy weight include:
 - Walking groups
 - S17 leave geared towards physical activities such as walking, biking, climbing and trampolining
 - Gymnasium and physical activities within individual patient's timetables
 - Physical challenges i.e. pedometer challenge or rowing challenge with staff and patients
 - Introduction of healthy snack alternatives in the unit shop
 - Recovery college courses on healthy eating and individual cooking sessions
 - Self-catering on the rehabilitation ward
 - Dietetic involvement with individual patients and individual care planning around healthy eating
 - Exercise bikes in ward living rooms
- A patient perspective on this thread illustrated that even when initiatives and interventions were in place, they were not consistently implemented due to either staff shortages, work load, turnover or lack of staff awareness for supporting healthy approaches to care and treatment.

It is apparent through this discussion thread that managing a healthy weight in secure services is a common issue which many services are working hard to address. Several excellent initiatives are being rolled out to address this and the involvement of patients in co-producing these ideas is beneficial. However, it must be recognised that once implemented, practices must be maintained regularly and consistently.

Addressing blanket rules

This discussion thread was started by a service looking to identify best practice in addressing blanket rules and how they are evidencing governance around this.

Respondents shared the following information:

- A service runs a monthly reducing restrictions group (RRG) to which patients and carers are invited to contribute. This group looks at both restrictive interventions and restrictive practices, which are recorded with written minutes. The procedural security index highlights which service procedures are blanket restrictions. All new or reviewed procedures have statements about whether it does or does not constitute a blanket restriction.
- It was raised that there is still an importance to recognise why blanket restrictions are in place, whilst still understanding what they are, that they are necessary, reasonable and proportionate, and that they are regularly reviewed.
- Another issue regarding blanket restrictions is surrounding visiting procedures. One service's procedure is that all visits are initially supervised, but the nature and degree of supervision can be individually varied and subject to risk assessment. This would also include visits occurring outside of the secure perimeter and without escort.
- One response highlighted the patient's perspective in this matter, which outlined that the application of any restriction on any individual patient should be regularly revised to take into account the sometimes dynamic nature of risk. Rhetoric such as 'this is a medium or low secure unit and therefore we always impose this restriction on all patients' still exists and needs to be challenged.

This topic for discussion highlights great contention around the use of blanket rules followed by the attempts services have made to reduce restrictive practices. The use of patient and carer input into developing these policies around restrictions are highly advantageous, whilst recognising the importance of maintaining safety. It is also vital to take into consideration individual risk assessments and avoiding the use of restrictions on all patients.

Appendix 1 – Member Services’ Contact Information

Service Name	Key Contact Details	Patient Population
All Saints Hospital	Ron Morris Hospital Director ronald.morris@elysiumhealthcare.co.uk 01616 224 220	Men, LD & Deaf
Allington and Tarentfort Centre	Simon Cook Service Manager simon.cook5@nhs.net 01322 622 222	Men & LD
Amber Lodge	Andrea Vincent Service Manager andrea.vincent@nhs.net 01302 796 436	Men & LD
Arbury Court	Abi Scott Lead Administrator abi.scott@elysiumhealthcare.co.uk 01925 400 600	Women
Ash Ward	Colin Reynolds Ward Manager colin.reynolds@sompar.nhs.uk 01278 454 131	Men
Ashford Unit	Chris Davy Clinical Ward Manager Christopher.Davy@southernhealth.nhs.uk 0 2382 310 917	Men
Avesbury House	Alexandra Thurlby Hospital Director alexandrathurlby@priorygroup.com 02088 845 837	Men
Battersea Bridge House	Reuben Evans Hospital Director reubenevans@inmind.co.uk 02079 247 991	Men
Beech Ward	Conor O'Boyle Team Manager conor.o'boyle@nhs.net 01923 850 501	Men
Bowman Ward	Darren Nye Ward Manager darrennye@nhs.net 01208 251 307	Men
Bracton Centre	Fiona Starkey-Norman Service Manager f.starkey-norman@nhs.net 01322 394 349	Men & Women
Brockfield House	Ian Carr Associate Director of Specialist Services ian.carr1@nhs.net 01268 568 171	Men & Women

Brooklands Hospital	Lesley Wilson Matron lesley.wilson@covwarkpt.nhs.uk 01213 294 990	Men & LD
Burston House Hospital	Sam Popple Hospital Director SamPopple@pioritygroup.com 01379 649 900	Men & LD
Caswell Clinic and Taith Newydd	Sian Dolling Service Manager sian.dolling@wales.nhs.uk 01656 753 431	Men & Women
Cedar House	Emma Harrison Hospital Director emma.harrison@huntercombe.com 01227 833 700	Men, Women & LD
Chadwick Lodge and Eaglestone View	Charlotte May Lead Nurse and Deputy Hospital Director charlotte.may@elysiumhealthcare.co.uk 01908 593 000	Men & Women
Cheswold Park Hospital	Vanessa Blanshard Admissions and Contracts Officer vblanshard@cheswoldparkhospital.co.uk 01302 762 875	Men & LD
Chichester Centre	Tim Wellington Deputy Service Director Tim.Wellington@sussexpartnership.nhs.uk 01243 791 808	Men & Women
Clee Unit	Melanie Watson Head of Operations melanie.watson@mpft.nhs.uk 01785 257 888	Men
Clifton House	Kayleigh Abbott Advanced Nurse Practitioner k.abbott1@nhs.net 01904 294 132	Men & Women
Cygnnet Blackheath	Rebecca Pye Hospital Manager rebeccapye@cygnethealth.co.uk 02086 942 111	Men
Cygnnet Hospital Beckton	Charles Uwaifo Service Manager CharlesUwaifo@cygnethealth.co.uk 02075 112 299	Women
Cygnnet Hospital Bierley	Samantha Barrow Clinical Manager samanthabarrow@cygnethealth.co.uk 01274 686 767	Men & Women
Cygnnet Hospital Bury	Faniel Zendera Snr PDN fanuelzendera@cygnethealth.co.uk 01617 627 200	Men, Women & Deaf
Cygnnet Hospital Clifton	Charles Stima Hospital Manager charlesstima@cygnethealth.co.uk 01159 457 070	Men

Cygnet Hospital Derby	Mark Varney Hospital Manager Markvarney@cygnethealth.co.uk 01332 365 434	Men & Women
Cygnet Hospital Harrow	Alexander Lawrence Hospital Manager alexanderlawrence@cygnethealth.co.uk 02089 667 000	Men
Cygnet Hospital Kewstoke	Thokozane Chiloane Ward Manager ThokozaneChiloane@cygnethealth.co.uk 01934 428 989	Women
Cygnet Hospital Maidstone	Laura Baker Clinical Manager laurabaker@cygnethealth.co.uk 01622 580 330	Men
Cygnet Hospital Sheffield	David Williams Hospital Manager davidwilliams1@cygnethealth.co.uk 01142 793 342	Women
Cygnet Hospital Stevenage	Ron Gutu Hospital Manager RonGutu@cygnethealth.co.uk 01438 342 942	Men & Women
Cygnet Hospital Woking	Nanday Obace Clinical Managernandayobace@cygnethealth.co.uk 01483 795 100	Men & Women
Edenfield Centre and Lowry Unit	Stephen Clarke Service Manager janice.greenwood@gmmh.nhs.uk 01613 581 410	Men & Women
Edward House	Mike Odell Integrated Clinical Lead michael.odell@nhs.net 01245 315 850	Men
Eric Shepherd Unit and 4 Bowlers Green	Charity Chitauro Matron charity.chitauro@nhs.net 01923 682 062	Men & LD
Farmfield	Malcolm Campbell Hospital Director malcolm.campbell@elysiumhealthcare.co.uk 01293 787 500	Men
Farndon Hospital	Dr Santhana Gunasekaran Consultant Forensic Psychiatrist santhana.gunasekaran@elysiumhealthcare.co.uk 01636 704 420	Men
Forest Lodge	Ajay Pawar Consultant ajay.pawar@shsc.nhs.uk 01142 716 085	Men
Foxhall House	Lindsay Sadler Ward Manager lindsay.sadler@nsft.nhs.uk 01473 322 200	Men

Francis Willis Unit	Amy Semper Ward Manager amy.semper@lpft.nhs.uk 01522 573 623	Men
Fromeside and Wickham Unit	Lynn Bradford Performance and Business Manager lynnbradford@nhs.net 01173 784 315	Men, Women & LD
George Mackenzie House	Katherine Atkins Clark Ward Manager katherine.atkins@cpft.nhs.uk 01223 219 566	Men & Women
Gerry Simon Clinic	Carol Spalding Inpatient Service Manager LD Division carolspalding@nhs.net 07817 571 179	Men & LD
Guild Lodge	Mark Swan Service Manager mark.swan@lancashirecare.nhs.uk 01772 401 695	Men
Hatherton Centre and Ellesmere House	Melanie Watson Head of Operations melanie.watson@mpft.nhs.uk 01785 257 888	Men, Women & LD
Hazelwood House	Nikki Swift Director of Clinical Services nicolaswift@priorygroup.com 01246 856 565	Men & LD
Heatherwood Court	Rebecca Conlon Clinical Lead Manager Rebecca.Conlon@lshealthcare.co.uk 01443 490 380	Men & Women
Hellingly	Nick Clark General Manager nick.clark@sussexpartnership.nhs.uk 01323 444 185	Men
Hollins Park Hospital	Sue Lee Mordern Matron sue.lee@nwbh.nhs.uk 01925 664 000	Men, Women & LD
John Howard Centre and Wolfson House	Dr. Clare Bingham Head of Psychology clare.bingham1@nhs.net 02085 102 545	Men, Women, LD & OPD
Kedleston Unit	Rebecca Mace Senior Nurse rebecca.mace@nhs.net 01332 623 700	Men
Kemple View	Mags Gallagher Hospital Director magsgallagher@priorygroup.com 01254 243 026	Men
Kneesworth House Hospital	Gary Stobbs Hospital Director garystobbs@priorygroup.com 01763 255 700	Men, Women & LD

Langdon Hospital	Julie Donaghue Directorate Business Manager j.donaghue@nhs.net 01626 884 475	Men
Lee Mill	Emily Rowe Manager emilyrowe1@nhs.net 01752 314 805	Men
Llanarth Court Hospital	Dr Damian Gamble Medical Director damiangamble@porygroup.com 01873 840 555	Men, Women & LD
Maplewood	Kim Seed Divisional Capacity and Flow Manager kimberley.seed2@merseycare.nhs.uk 01254 821 346	Men, Women & LD
Memorial Hospital	Ismail Muana Modern Matron ismaila.muana@nhs.net 01322 294 300	Men
Mildmay Oaks Hospital	Yolanda Spicer-Martinez Director of Clinical Services YolandaSpicer-Martinez2@porygroup.com 01252 845 826	Male & LD
The Montpellier Unit	Sarah Campbell Unit Manager sarah.campbell11@nhs.net 01452 894 580	Men
Moorlands View	Amanda Barker Clinical Manager amanda.barker@bdct.nhs.uk 07701 280 155	Men
Morris Ward	0300 555 1200	Men
Newsam Centre	Kirstin Gillatt Acting Matron Kirstin.Gillatt@nhs.net 01138 556 411	Men & Women
Newton Lodge, Bretton Centre and Newhaven	Catherine Eaves General Manager catherine.eaves@swyt.nhs.uk 01924 316 108	Men & Women
North London Clinic	Duncan Barton Hospital Director duncanbarton@porygroup.com 02089 561 234	Men
North London Forensic Service	Sarah Tozer Service Manager s.tozer@nhs.net 02087 025 918	Men, Women & LD
Northgate Hospital	Dennis Davison Associate Director Secure Care Dennis.Davison@ntw.nhs.uk 01670 394 051	Men, Women & LD

Oaktree Manor	Beatrice Nyamande Hospital Director beatricenyamande@priorygroup.com 01255 871017	Men & Women
Oxford Clinic	Trish Davies Service Manager trish.davies@oxfordhealth.nhs.uk 01865 902 601	Men & Women
Priory Hospital Burgess Hill	Mark Taylor Hospital Director marktaylor@priorygroup.com 01444 231 000	Women & LD
Priory Hospital East Midlands	Christine Walker Hospital Director christinewalker@priorygroup.com 01623 727 900	Women
Priory Hospital Lincolnshire	Palmer M Chinosengwa Hospital Director palmerchinosengwa@priorygroup.com 01427 666 080	Men
Prospect Place	Mike Liffen Unit Manager michael.liffen@nhs.net 01706 676 131	Men
Rathbone	Carl Howard Modern Matron carl.howard@merseycare.nhs.uk 01514 730 303	Men
Reaside Clinic and Hillis Lodge	Matthew Thomas Clinical Nurse Manager matthew.thomas6@nhs.net 01213 013 067	Men & Women
Ridgeway Secure Services	Neil Woodward Security Manager neilwoodward@nhs.net 01642 837 482	Men, Women & LD
River House	Emma Porter Deputy Director Forensic Offender Health emma.porter@slam.nhs.uk 07712 390 428	Men, Women
Robin Pinto Unit	Killian Matiwa Ward Manager killian.matiwa@nhs.net 01582 657 540	Men
Rohallion Clinic	Barbara Wilson Regional Service Manager barbarawilson3@nhs.net 01738 562 474	Men
Saddlebridge Recovery Centre and Alderley Unit	Dave Jones Head of Clinical Service david.jones47@nhs.net 07825 522 058	Men & LD
Shaftesbury Clinic	Richard Stiles Forensic Manager richard.stiles@swlstg.nhs.uk 02035 136 065	Men

Shannon Clinic and Clare Ward	Noel McDonald Operations Manager noel.mcdonald@belfasttrust.hscni.net 02895 046 100	Men & Women
Southfield	Sue Hayward Modern Matron Susan.Hayward@southernhealth.nhs.uk 02380 874 555	Men & Women
St Andrew's Healthcare Nottinghamshire	Jo Baker Clinical Lead Joanne.Baker@standrew.co.uk 01623 665 324	Men & LD
St Andrew's Healthcare Birmingham	Imelda Leon Operational Lead ileon@standrew.co.uk 01214 322 173	Men & Women
St Andrew's Healthcare Essex	Patrick Okoli Operational Lead POkoli@standrew.co.uk 01268 723 940	Men & Women
St Andrew's Healthcare Northampton Men's Service	Cheryl Harrington Quality Business Partner Charrington@standrew.co.uk 01604 616 139	Men & LD
St Andrew's Healthcare Northampton Women's Service	Alastair Clegg Acting Director of Operations ABClegg@standrew.co.uk 01604 608 704	Women & LD
St John's House Hospital	Fungai Nhiwatiwa Hospital Director fungainhiwatiwa@priorygroup.com 01379 649 989	Women & LD
St Magnus Hospital	David Munns Clinical Governance Manager dmunns@stmagnus.co.uk 07769 167 739	Men
St Mary's Hospital	Nick Shaughnessy Hospital Director nick.shaughnessy@elysiumhealthcare.co.uk 01925 423 300	Men & Deaf
St Nicholas Hospital	Helen Goudie Clinical Manager helen.goudie@ntw.nhs.uk 01912 467 270	Men
Suttons Manor Hospital	Lewys Savill Hospital Director lewysavill@priorygroup.com 01708 687 398	Men
Tasman Unit	Denise Cox Operational Manager denise.cox1@nhs.net 02089 554 515	Men
Tatton Unit	Michelle Davis Unit Manager michelledavis3@nhs.net 01617 163 795	Men

The Humber Centre for Forensic Psychiatry	Dave King Security Lead dave.king@nhs.net 01482 336 200	Men
The Orchard Unit	Arthur Chiwandire Senior Nurse Arthur.Chiwandire@westlondon.nhs.uk 02083 548 603	Women
The Spinney	Rena Henderson Lead of OT and Education rena.henderson@elysiumhealthcare.co.uk 01942 885 637	Men
Thornford Park Hospital	Jo Sherman Hospital Director jo.sherman@elysiumhealthcare.co.uk 01635 273 827	Men
Three Bridges	Sach Beeraje Senior Nurse Sachendra.Beeraje@westlondon.nhs.uk 02083 548 462	Men
Twynham Ward	Naomi Jenkins Ward Manager naomijenkins@nhs.net 01202 492 412	Men
Ty Catrin	Therisa Galazka Hospital Director TherisaGalazka@porygroup.com 02920 556 300	Men & Women
Ty Cwm Rhondda Hospital	Rhiannon Ham Hospital Director rhiannonham@porygroup.com 01443 424 940	Men
Waterloo Manor Independent Hospital	Nicola Johnson Hospital Director nicolajohnson@inmind.co.uk 01132 876 660	Female
Wellesley Hospital	Gerry Graham Hospital Director Gerry.Graham@elysiumhealthcare.co.uk 01823 668 150	Men & Women
Wells Road Centre	Andy Latham General Manager andy.latham@nottshc.nhs.uk 01159 691 300	Men, Women & LD
West Drive	Kim Seed Divisional Capacity and Flow Manager kimberley.seed2@merseycare.nhs.uk 01254 821 346	Men, Women & LD
Wheatfield Unit	Charles Chikandwa Ward Matron charles.chikandwa@nhft.nhs.uk 01604 685 461	Men
Whitlingham Ward (Hellesdon)	Richard Tomlinson Ward Manager richard.tomlinson@nsft.nhs.uk 01603 421 937	Women

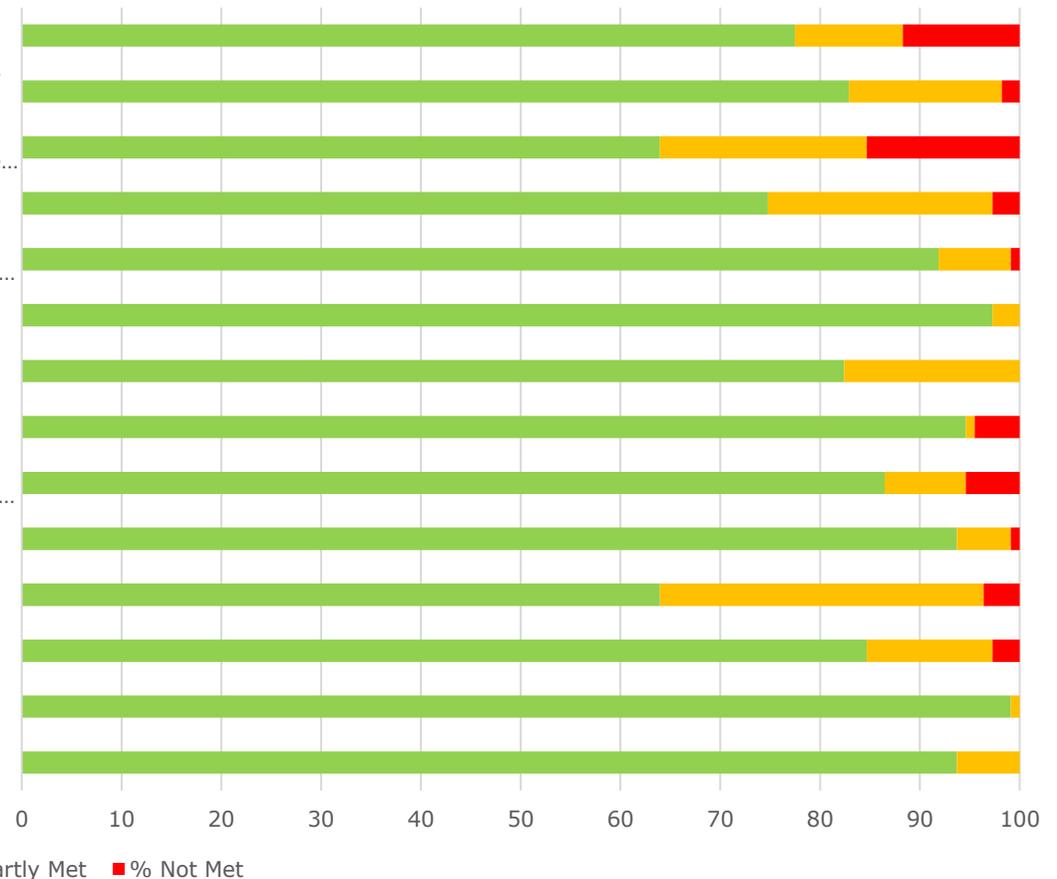
Wood Lea Clinic	John Mupoto Deputy Ward Manager john.mupoto1@nhs.net 01234 310 754	Men & LD
Woodlands House	Dan Bowie Service Manager daniel.bowie@oxfordhealth.nhs.uk 01865 902 826	Men & Women

Appendix 2 – 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.

Physical Security

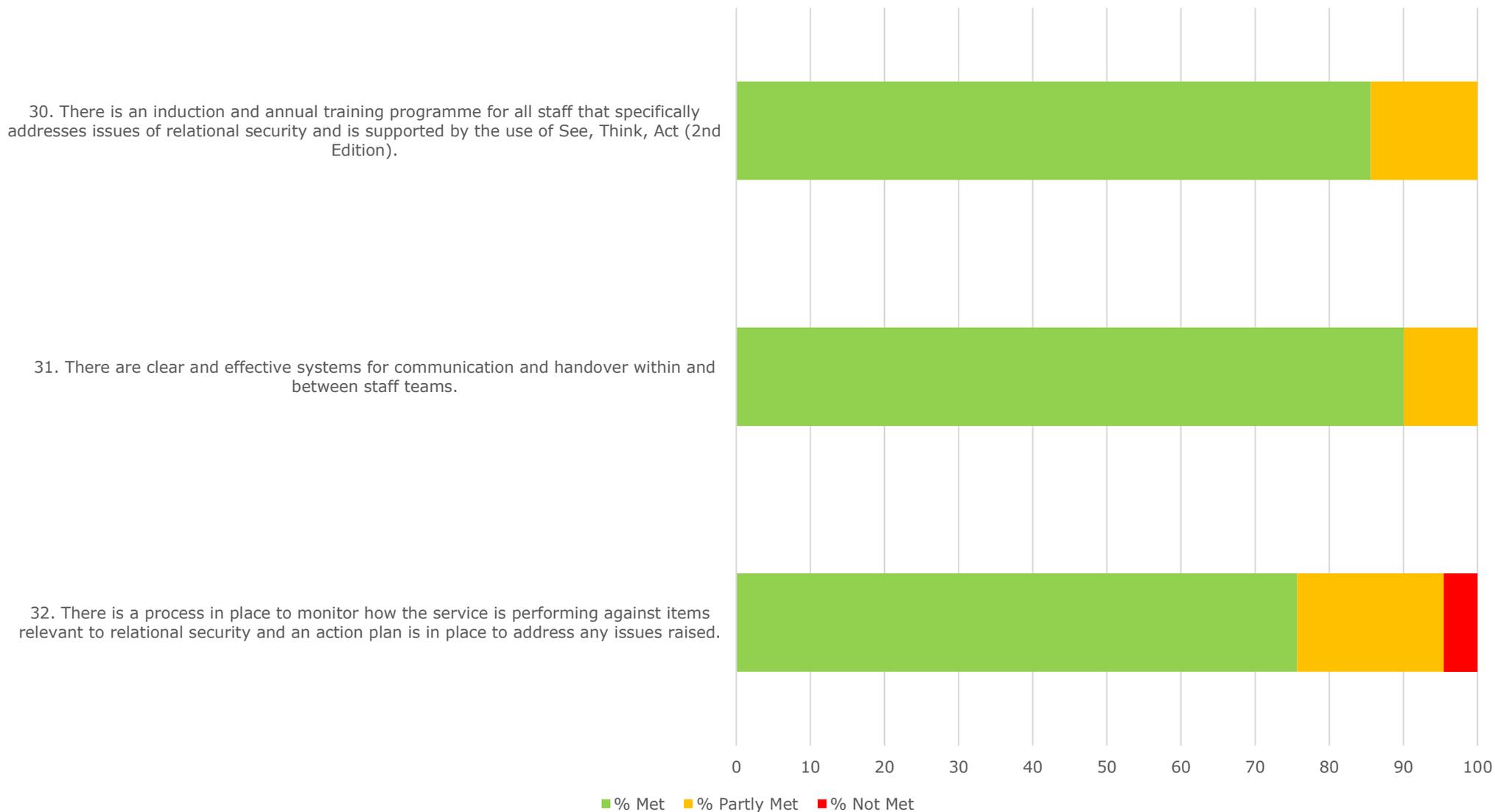
1. A physical security document (PSD) describes the physical security in place at the service.
2. The secure perimeter is in line with the planning specification for the level of security offered, is protected against climbing, and is easily observable.
3. There is a daily recorded inspection of the perimeter and programme of maintenance specifically for the perimeter, with evidence of immediate action taken when problems are...
4. In outside areas within the secure perimeter, permanent furniture, fixtures and equipment are fixed and are prevented from use as a climb aid.
5. Windows that form part of the external secure perimeter are set within the building masonry, do not open more than 125mm and are designed to prevent the passage of...
6. There are controlled systems in place to manage access and egress through all doors and gates that form part of the secure perimeter.
7. Where CCTV is in use, there should be passive recording of the perimeter, reception frontage and access from the secure area to reception.
8. Access to the secure service for visitors, staff and patients is via an airlock.
9. The reception/control room; is within or forms part of the secure external perimeter; is manned 24 hours per day 7 days week or can be made fully operational in the case of an...
10. There is a key management system in place which accounts for all secure keys/passes, including spare/replacement keys which are held under the control of a senior manager.
11. Secure pass keys are; on a sealed ring; secured to staff at all times within the secure perimeter; prevented from being removed from the secure perimeter.
12. There is a process to ensure that; keys are not issued until a security induction has been completed; keys are only issued upon the presentation of valid ID; a list of approved key...
13. Prohibited, restricted and patient accessible items are risk assessed, controlled and monitored.
14. There is a designated security lead with responsibility for security within the service.



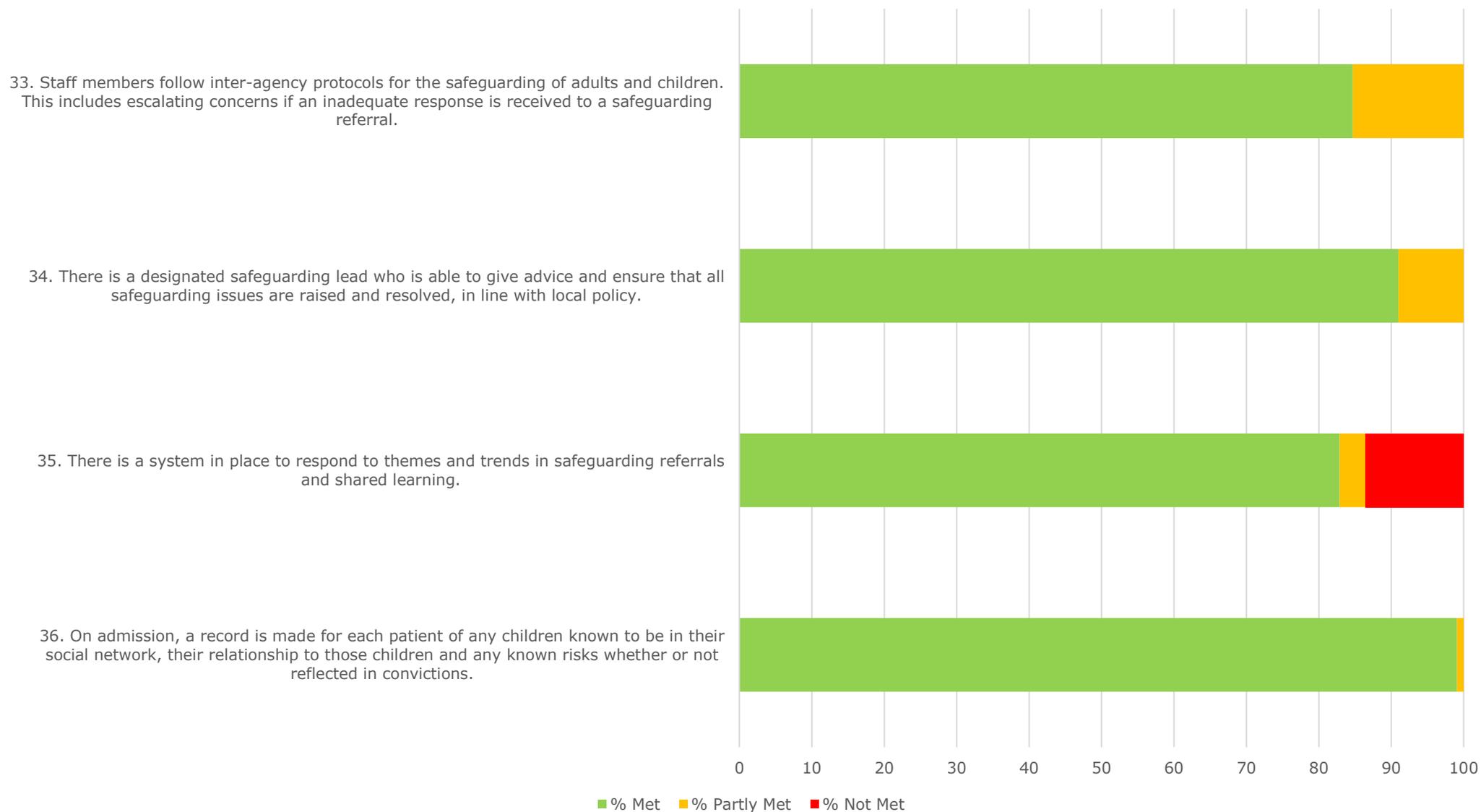
Procedural Security



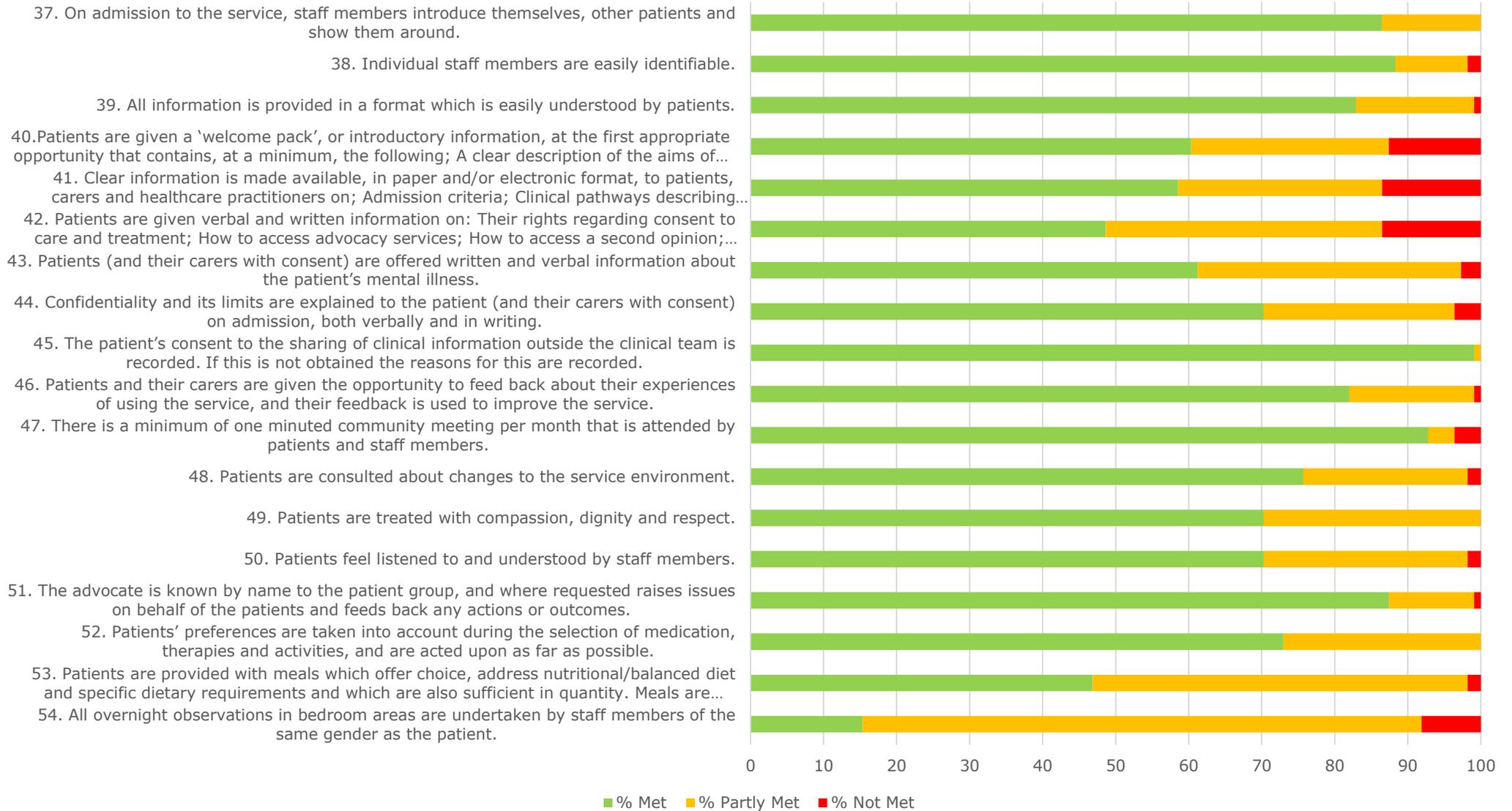
Relational Security



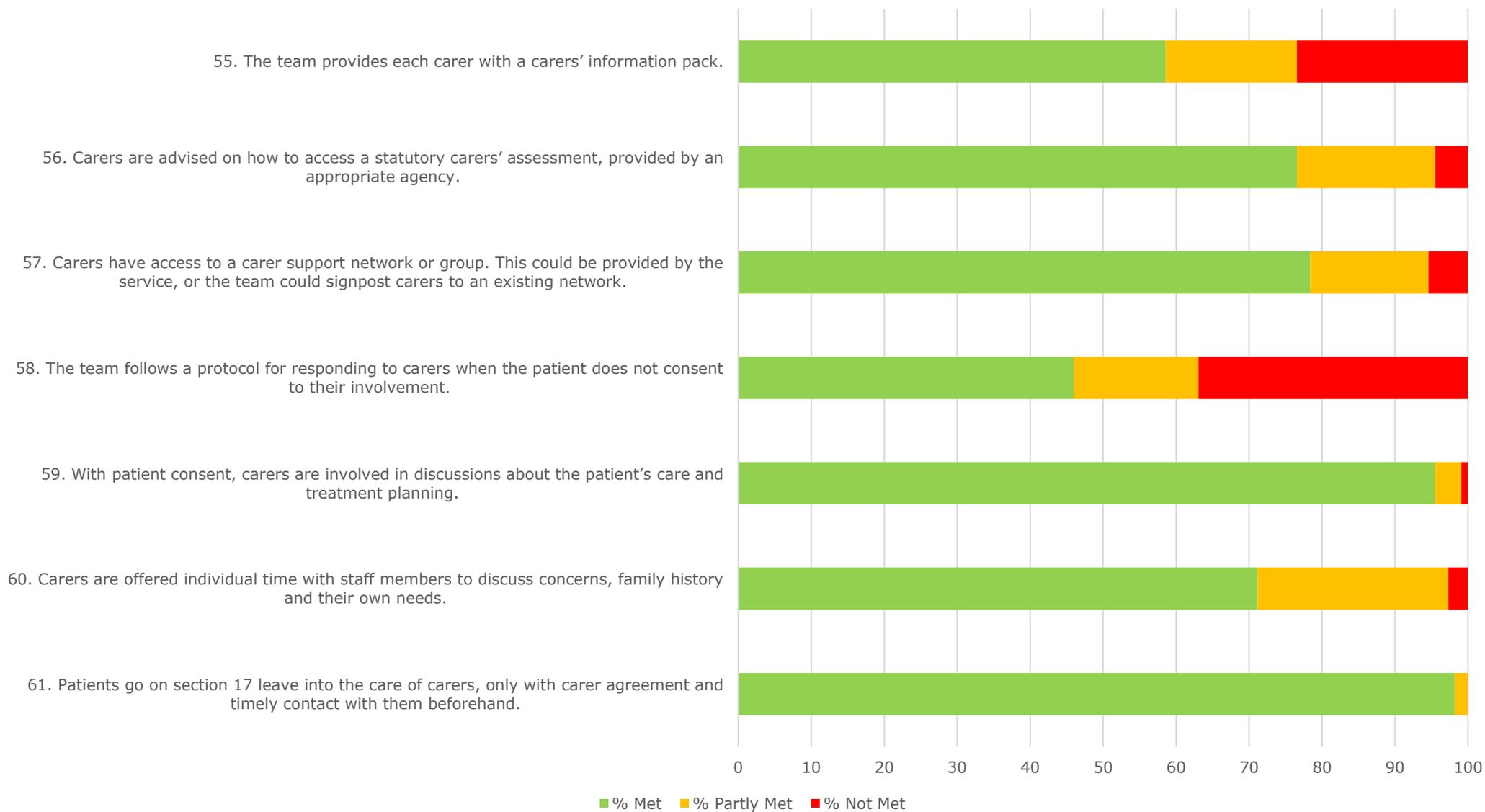
Safeguarding



Patient Focus



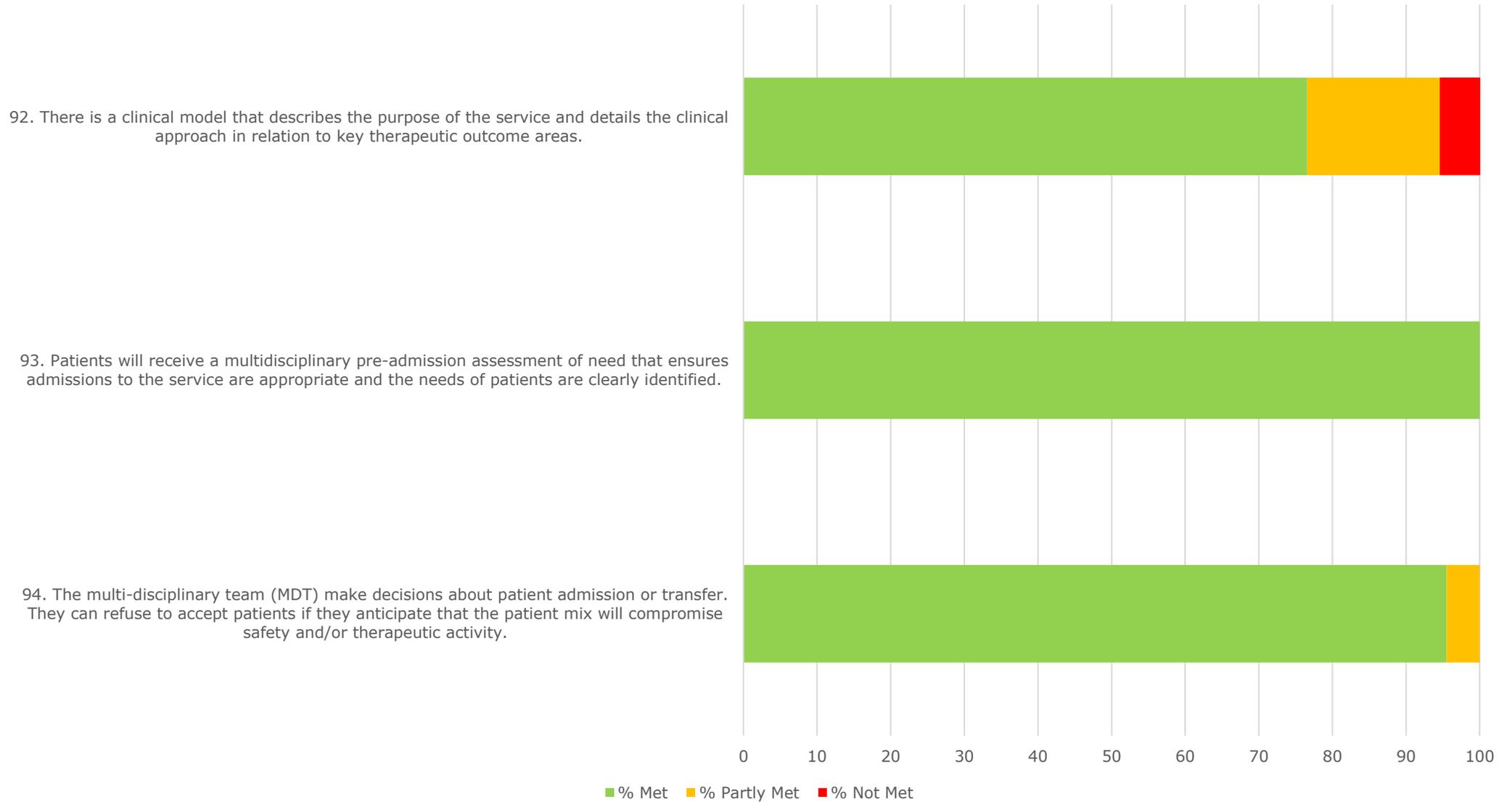
Family and Friends



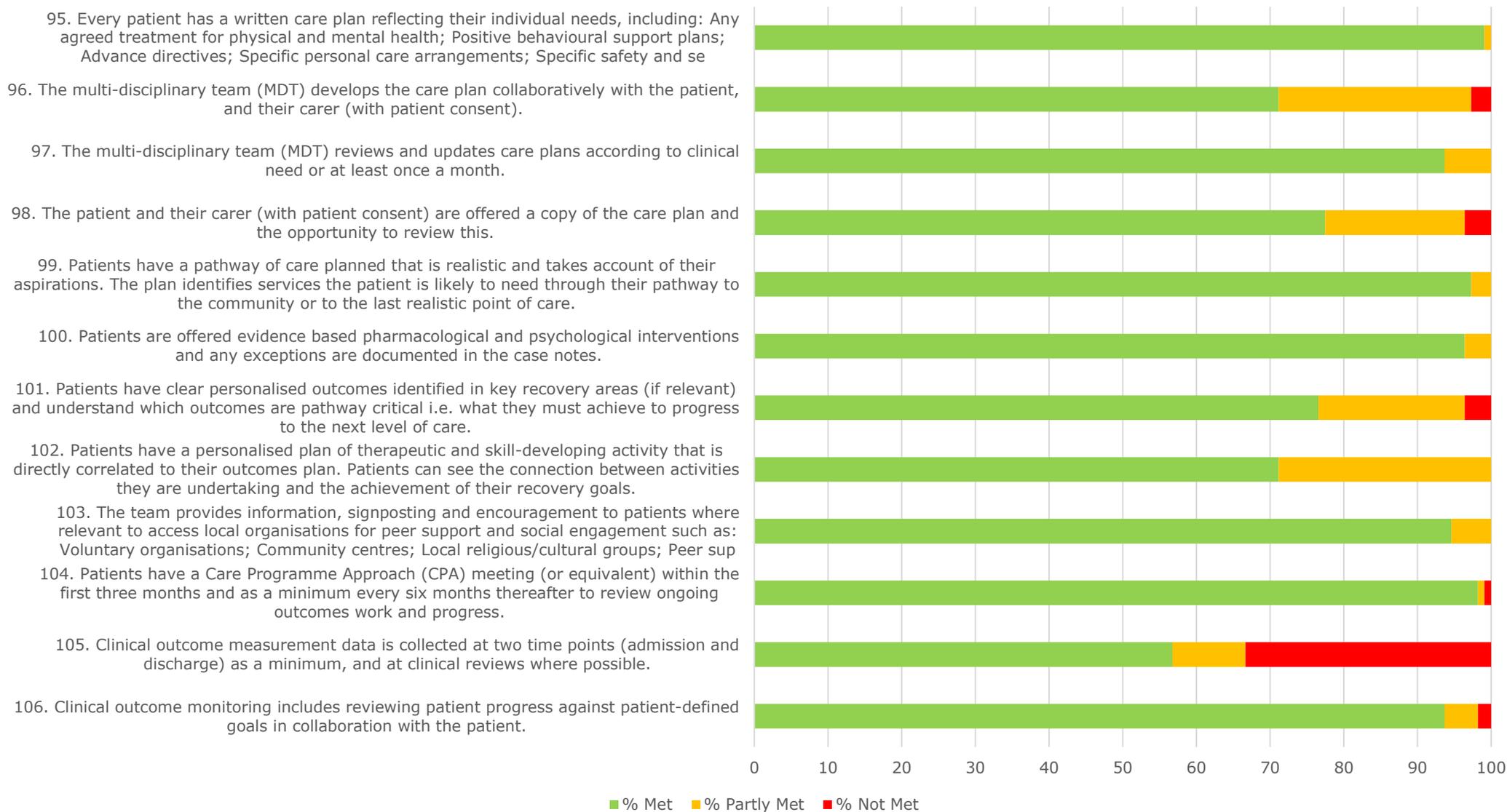
Environment and Facilities



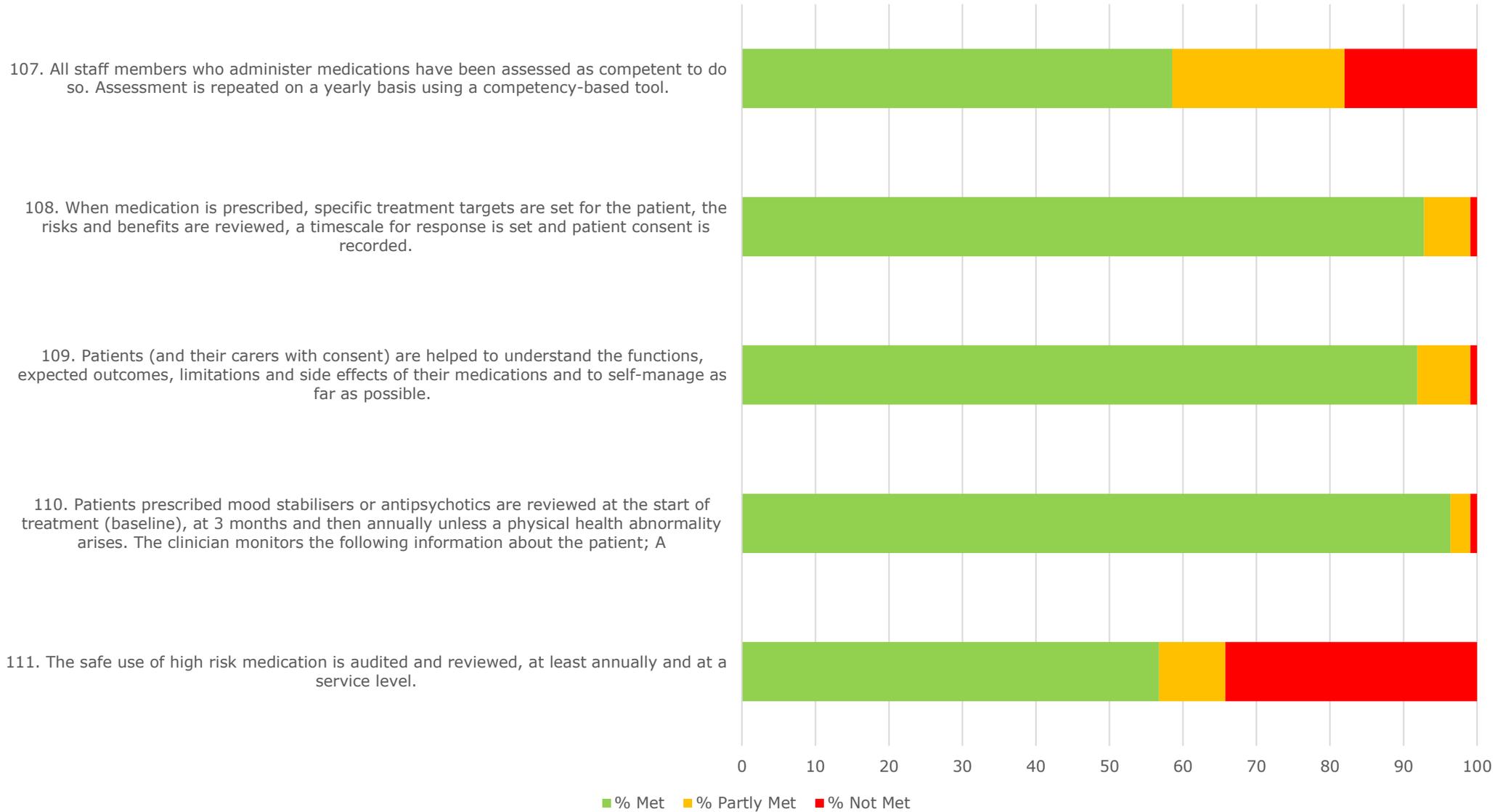
Admission



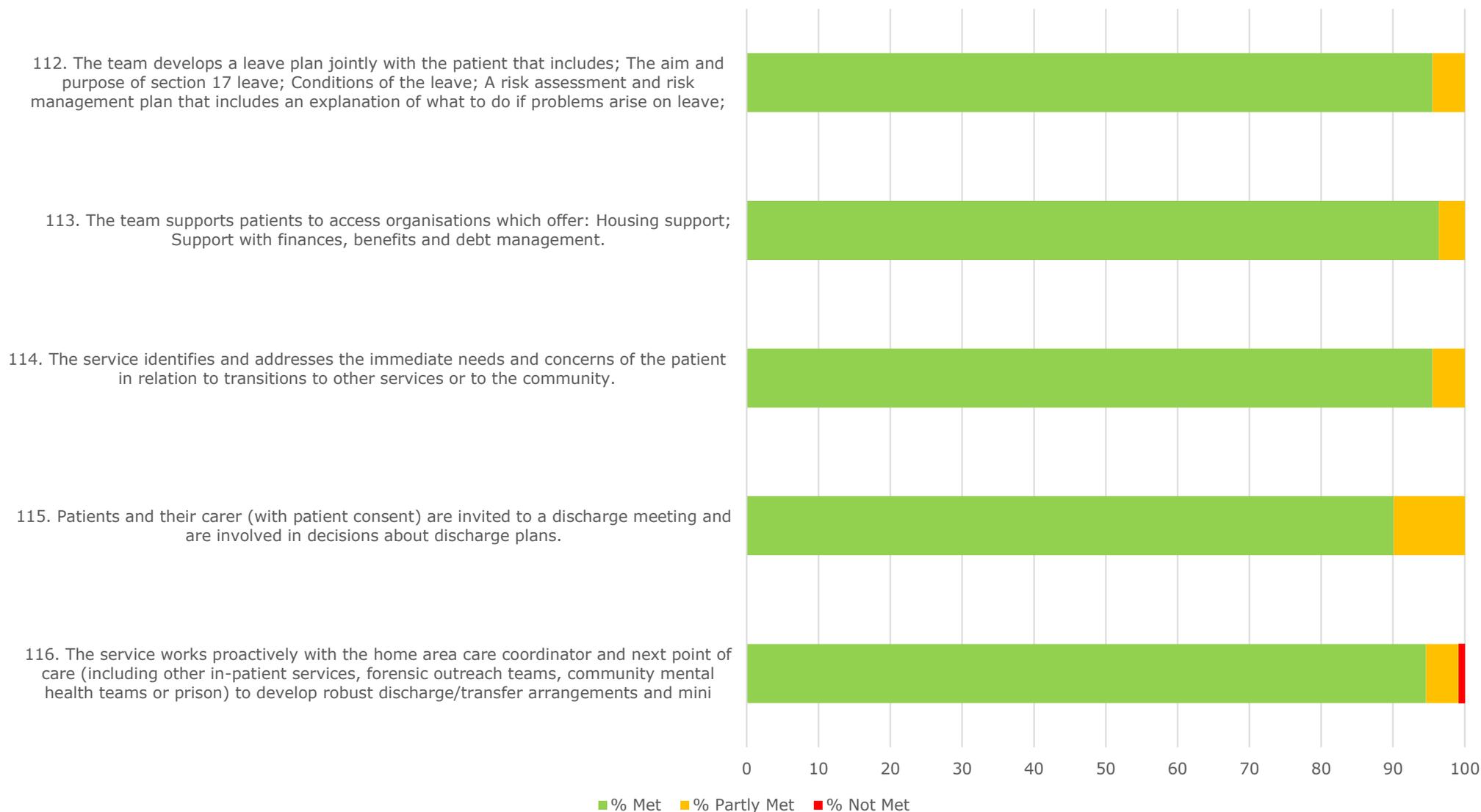
Treatment and Recovery



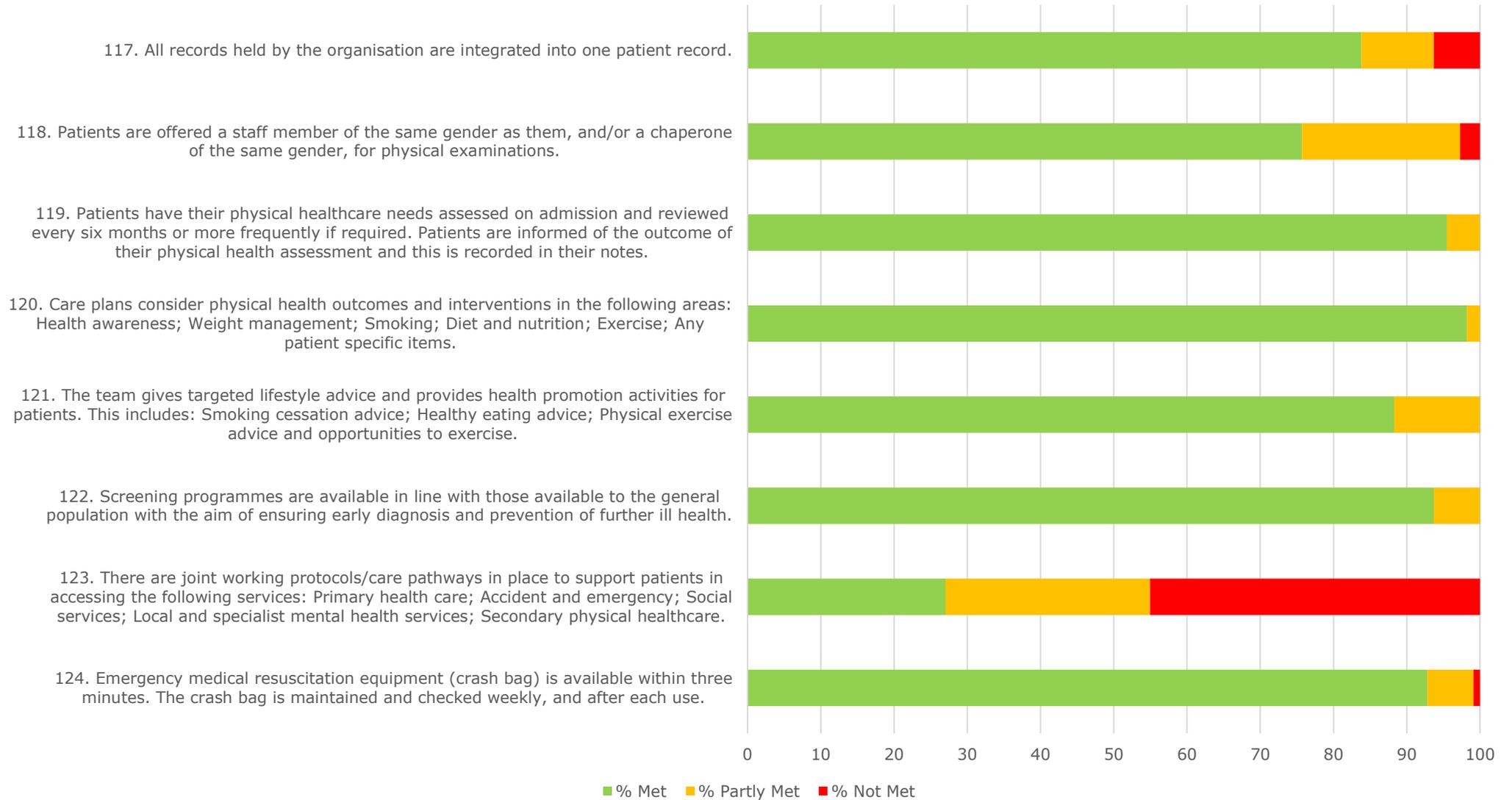
Medication



Leave and Discharge



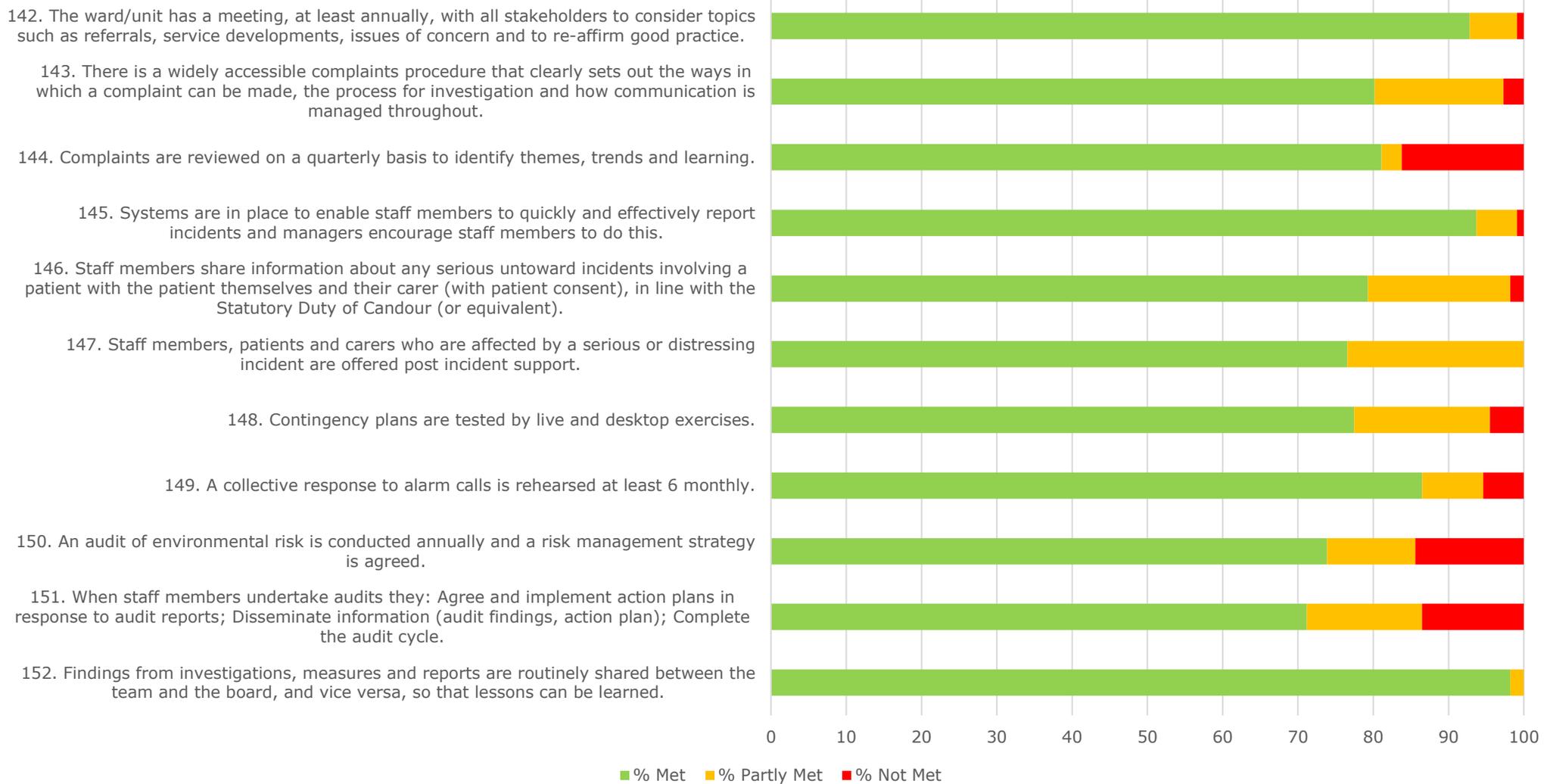
Physical Healthcare



Workforce



Governance



Appendix 3 – Event Programmes

Appendix 3.1 – Communicating with Family and Friends, 31 August 2017. Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.

10:00 Registration and refreshments

10:30 Welcome and introduction

Matthew Oultram, Quality Network for Forensic Mental Health Services

10:45 Carers Toolkit – involving carers in secure mental health services

Mick Mckeown, Reader in Democratic Mental Health, University of Central Lancashire

11:15 Just Do It – get involved

Sheena Foster, Family and Friends Representative, Quality Network for Forensic Mental Health Services

11:45 South East Regional Carer’s Involvement Group – An evolving journey to improve carer engagement and experience across the region

Charlotte Allen, Quality and Governance Assistant, Lynne Clayton, Carer Representative, Kathryn Fullbrook, Forensic Social Worker, Katharine Pearson, Lead Inpatient Social Worker

12:15 Lunch

13:15 Project Teulu: Implementing Family Liaison Meetings in Low Secure Forensic Service

Andrea Davies, Clinical Psychologist & Systemic Psychotherapist, Stephen Godden, Acting Clinical Lead

13:45 Discussion

14:15 Themed work groups:

1: Delivering the Triangle of Care, Secure Carer Participation and Engagement in Practice

Amanda McBride, Senior Forensic Social Worker & Carers Lead Secure Division and Paula Jackson, Family Member of a Patient

2: The role of the Secure Services Carers Support Worker in enhancing communication with Family and Friends

Wayne Burrows, Matron, Julie Carey, Deputy Matron

3. Family and Friends at Langdon Hospital: our journey, and the next steps

Emily Poole, Patient Carer Liaison

4. Supporting family and friends to become active participants in care provision at an inpatient mental health service

Jennifer Beal, Head of Occupational Therapy, Emily Kobelis, Deputy Head of Occupational Therapy, Mr & Mrs Hendle, Family Members of Service User

15:00 Break

15:15 Feedback from work groups

16:00 Close

**Appendix 3.2 – Revisiting See Think Act, 27 November 2017.
Royal College of Psychiatrists, 21 Prescot St, London, E1 8BB.**

10:00 Registration and refreshments

10:30 Welcome and introduction

Elizabeth Allen, FrontFoot and author of See Think Act

10:45 Step into my shoes for a moment

Susannah Pashley, Patient Reviewer, QNFMHS

11:15 Relational Security – Where we are now

*Wayne Harvey, Forensic Security Manager, South Staffordshire and Shropshire
Healthcare NHS Foundation Trust*

11:35 Bringing back 'See Think Act'

*Dan Austin, Clinical Security Co-ordinator, Sussex Partnership NHS Foundation
Trust*

11:50 Refreshments

**12:00 The clinical utility of the Relational Security Explorer: views of forensic
mental health professionals**

Verity Chester, Research and Projects Associate, Priory Group

12:30 How we adapted See Think Act for community housing services

Patrick O'Dwyer, Karen Browne and Nathan Rhodes, Look Ahead

13:00 Lunch

14:00 What we learned when we were delivering training

Elizabeth Allen, FrontFoot and author of See Think Act

14:45 Group discussion

A: Team

B: Other Patients

C: Inside World

D: Outside World

15:30 Feedback from group discussions to wider group

15:45 Final plenary

16:00 Close

Appendix 3.3 – Secure Mental Health Carers Toolkit Launch, 27 March 2018.

Royal College of Psychiatrists, 21 Prescott St, London, E1 8BB.

10:00 Registration

10:30 Welcome

Olivia Butterworth, Head of Public Participation, NHS England

10:40 Showing of first carers film

10:45 NHS England commitment to carers

Dame Philippa Russell, Chair Emeritus, Standing Commission on Carers, Vice-President of Carers UK, Member of NHS England's Commitments to Carers Oversight Group; Jen Kenward, Experience of Care Lead, Community, Primary and Integrated Care

11:00 The importance of carers as partners

Jacqueline Dyer, MBE, Carer and Previously Vice Chair of Mental Health Taskforce

11:15 Celebrating collaboration with carers

Dr Quazi Haque, Executive Medical Director of Elysium Healthcare and Chair of RCPsych, Forensic Quality Network; Louise Davies, Deputy Head of Mental Health – Specialised Commissioning (Adult Secure) NHS England; John and Gertie Hendle, Carers and Members of Women's Secure Strategy Task and Finish Group

11:30 Coffee

12:00 Quality Network for Forensic Mental Health Services: Supporting the implementation of the carers toolkit

Dr Quazi Haque, Executive Medical Director of Elysium Healthcare and Chair of RCPsych, Forensic Quality Network; Megan Georgiou, Programme Manager, RCPsych, Forensic Quality Network

13:00 Lunch

14:00 Showing of second carers film

14:10 The value and purpose of the toolkit

Sheena Foster – Carer Member of the Toolkit Steering Group; Sue Stewart – Carer Member of the Toolkit Steering Group; Mick McKeown – University of Central Lancashire

14:30 Round table discussions

15:30 Carers – a valuable asset to services

15:45 Next steps and close

Olivia Butterworth, Head of Public Participation, NHS England

Appendix 3.4 – Patient Engagement and Involvement in Secure Services, 4 April 2018.

Horizon, Third floor, 2 Brewery Wharf, Kendall Street, Leeds LS10 1JR.

10:00 Registration and refreshments

10:30 Welcome and introduction

Michael Humes and QNFMHS Patient Reviewers, CCQI

10:50 Walk a mile in my shoes

Chris Young, author of 'Walk a Mile: Tales of a Wandering Loon'

11:10 The reality of living with mental illness

Suzi Taylor, author of 'I Blame the Hormones'

11:30 You're hired! Choosing the ultimate MDT member

Su Pashley and Michael Humes, Patient Reviewers, and Megan Georgiou, Programme Manager

12:15 Life as a patient reviewer

Sue Denison and Mark Haslam, Patient Reviewers, CCQI

12:30 Lunch

13:15 Music

13:35 Workshops: Session One

A: Involvement and Engagement in Ridgeway

The Recovery & Outcomes Support Team and Patients from Ridgeway, Tees, Esk & Wear Valley NHS Foundation Trust

B: Running For My Life: My mental health recovery journey

Rachel Cullen, author of 'Running for my Life'

C: Creative Mindfulness: Finding Mindfulness in Art

Staff and Patients from St. Mary's Hospital, St. George's Healthcare Group

14:00 Workshops: Session Two

A: My Recovery Journey: Finding My Voice

Sarah Markham, Patient Reviewer, QNFMHS

B: Boxercise: Fighting Stigma in a Secure Setting

Staff and Patients from John Howard Centre, East London NHS Foundation Trust

C: Working Together – Reducing Restrictive Practice

Staff and Patients from Cygnet Hospital Bierley, Cygnet Healthcare

14:20 Refreshments

14:30 Workshops: Session Three

A: In Order to Move Forward, We Need to Make Sense of the Past

Wayne Saville, Expert by Experience

B: Tamarind Service User Awards

Staff and Patients from Tamarind Centre, Birmingham & Solihull NHS Mental Health Foundation Trust

C: Mission Fit

Staff and Patient from The Spinney, Elysium Healthcare

14:55 Taking control of your own recovery

Su Pashley, Patient Reviewer, CCQI

15:15 Take home message

Michael Humes and QNFMHS Patient Reviewers, CCQI

15:30 Close

**Appendix 3.5 – LSU Annual Forum, 12 June 2018.
Royal College of Psychiatrists, 21 Prescott St, London, E1 8BB.**

10:00 Registration and refreshments

10:30 Welcome and introduction

Michael Humes, Patient Reviewer, QNFMHS

10:35 Managing the diversity challenge

Mat Kinton, National MHA Policy Advisor, Care Quality Commission

11:00 The value and purpose of the Carers' Toolkit

Sheena Foster, Family and Friends Representative, CCQI and Rosie Ayub, NHS England

11:25 Refreshments and poster presentations

11:40 An update from the Quality Network

Megan Georgiou and Matthew Oultram, QNFMHS

12:05 Workshop session 1

Leaving secure care

A: A successful discharge

Mark Haslam and Michael Humes, Patient Reviewers, QNFMHS

B: Independent review of the Mental Health Act

Dr Sarah Markham, Patient Reviewer, QNFMHS

Family and friends

A: Improving the involvement of family/carers and friends of patients on a low secure unit

Jane Arnold, Ward Manager and Dr Ken Murphy, Senior Clinical Psychologist, River House, South Maudsley NHS Trust

B: A parent's responsibility has no expiry date- In sickness and in health, 'til death us do part'

Sarah Shirley, Friends and Family Representative, QNFMHS

Staff support and wellbeing

A: Staff support and well-being and a model of a healthy organisation *Hilary Dunne, Director of Clinical Services, Tammazine Adcock, Regional Lead Psychologist and Maria Patron, Ward Manager, Priory Hospital East Midlands, Priory Group*

B: Improving staff health and well-being in a low secure setting

Lisa Potter, Associate Director of Clinical Services, Kemple View, Priory Group

13:00 Lunch and poster presentations

14:00 Moving on: transforming low and medium secure care

Justine Faulkner, Programme Lead, Mental Health Secure Care Programme, NHS England

14:25 Mind the Gap: Specialist Community Forensic Teams

Dr Paul MacAllister, Consultant Forensic Psychiatrist/Medical Psychotherapist, Devon Partnership NHS Trust

14:50 Refreshments and poster presentations

15:05 Workshop session 2

Effective treatment and support

A: Working with men who sexually offend against children – The importance of peer support

Dr James Winkworth, Clinical Psychologist and Lucy Pedrick, Ward Sister, Wood Lea Clinic, Essex Partnership University NHS Trust

B: Implementing DBT skills training on a male low secure ward

Dr Louise Roberts, Lead Clinical Psychologist and Viktoria Nagy, Assistant Psychologist, Robin Pinto Unit, Essex Partnership University Trust

Health and wellbeing

A: Creative mindfulness: Finding mindfulness in art

Abi Akinyemi, Integrative Psychotherapist, St Mary's, St George's Healthcare Group

B: Men's health group

Gavin Jones, Engagement, Activity and Physical Health Practitioner, Montpellier Unit, 2gether NHS Trust

Diversity in secure services

A: Women's well-being

Anna Gillespie, Clinical Lead Occupational Therapist, Hope Donnelly, Therapeutic Working Day Coordinator and Nancy Marsh, Forensic Recovery College Worker, Bracton Centre, Oxleas NHS Foundation Trust

B: Addressing diversity and equality in forensic services

Cassie Baugh, Project Worker and Kate Townsend, Deputy Programme Manager, CCQI

16:00 Final plenary

16:05 Close

Appendix 3.6 – 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: Transfer planning and escorting

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: A patient's perspective

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

Appendix 3.7 - Managing a healthy weight, 27 February 2019.
Royal College of Psychiatrists, 21 Prescott Street, London, E1 8BB.

10:00 Registration and refreshments

10:15 Welcome and introduction

*Dr Mehdi Veisi, Clinical Director, Barnet, Enfield and Haringey, and QNFMHS
Advisory Group Member*

10:20 Managing a healthy weight

*Louise Davies, Deputy Head of Mental Health - Specialised Commissioning (Adult
Secure), and Steve Sylvester, Head of Mental Health, Specialised Commissioning
NHS England*

10:30 Prevention and treatment of obesity in secure hospitals - The journey so far

*Dr Rajesh Moholkar, Consultant Forensic Psychiatrist, Reaside Clinic, Birmingham
and Senior Clinical Advisor to Public Health England*

11:00 A patient's perspective

Hannah Moore, Patient Representative, CCQI

**11:20 Managing a healthy weight – What people said at the Recovery and
Outcomes groups**

Ian Callaghan, Recovery and Secure Care Manager, Rethink

11:35 Workshops: Food and nutrition

A: Developing a food and nutrition working group

***Ingrid Small, Specialist Mental Health Dietitian, Greater Manchester Mental
Health Foundation Trust,***

*Elizabeth Atherton, Higher Scientific Officer, Obesity and Healthy Weight Team,
Public Health England*

**B: Weight management in medium security: setting up and running a
Weight Watchers group in an MSU for male adult patients**

*Dr Lisa Gardiner, Consultant Forensic Psychiatrist and Carly Rogers, Occupational
Therapist, Ravenswood House, Southern Health NHS Foundation Trust*

12:05 Refreshments

12:15 Obesity within high security

Dr Melanie Higgins, Consultant Forensic Psychiatrist, Mersey Care NHS Trust

12:45 Workshops: Rehabilitation and recovery

**A: Take Control, promoting ownership & instigating change, without
restrictions through Occupational Therapy**

*Melanie Hopkirk, Specialist Occupational Therapist, Ray Godwin, Specialist Technical
Instructor, and Kelly Peare, Occupational Therapy Clinical Lead, Ridgeway, Tees, Esk
& Wear Valley NHS Foundation Trust*

B: Claret in Mind – partnership working with Burnley FC

*Daniel Cockle, Physical Health and Wellbeing Coach, Kemple View, Priory Group, and
Sam Wilcock, Health and Wellbeing Officer, Burnley FC in the Community*

13:15 Lunch

14:00 Improving physical health - Key success factors

Dr Irene Cormac, Honorary Consultant Forensic Psychiatrist, Rampton Hospital, Nottinghamshire Healthcare NHS Foundation Trust

14:30 Workshops: Treatment interventions

A: Treatment interventions for obesity

Dr Rajesh Moholkar, Consultant Forensic Psychiatrist, Reaside Clinic, Birmingham, and Dr Mehdi Veisi, Consultant Forensic Psychiatrist, Barnet, Enfield and Haringey

B: The impact of wearable technology on physical health and self-efficacy in patients detained in medium secure service: Ideas for a research project

Helen Ayres, Matron and Darren Davies, Fitness Instructor, Oxford Clinic, Oxford Health NHS Foundation Trust

15:00 Refreshments

15:10 The role of the exercise professionals and physical activity in secure settings

Steven Clark, Exercise Professionals for Mental Health

15:40 Workshops: Physical activity

A: Ways to achieve a healthier weight through the use of physical activity interventions

Steven Clark, Lead Clinical Exercise Therapist, and Sofie Grabinski Clinical Exercise Therapist, South West London & St. George's Mental Health NHS Trust

B: Mission Fit

Jason Bonney, Lead Physical Health and Wellbeing Coach, and Chelsey Hallam, Health and Wellbeing Coach, The Spinney, Elysium

16:10 Final plenary

16:15 Close

**Appendix 3.8 Low Secure Annual Forum 2019, 20 June 2019.
Royal College of Psychiatrists, 21 Prescott Street, London, E1 8BB.**

10:00 Registration and refreshments

10:20 Welcome and introduction

Dr Quazi Haque, Chair, QNFMHS Advisory Group, Hannah Moore, Patient Reviewer and Louise Maclellan, Family and Friends Representative, QNFMHS

10:30 CQC's thematic review of restraint, segregation and prolonged seclusion

Dr Robert Bates, National Professional Advisor in Forensic, Care Quality Commission

11:00 (Not so) legal highs - what you need to know about Novel Psychoactive Substances

Dr Derek Tracy, Consultant Psychiatrist and Clinical Director, Oxleas NHS Foundation Trust and Dr Abu Shafi, ST4 Psychiatry, East London NHS Foundation Trust

11:45 Refreshments

11:55 Preliminary findings from cycle 6

Megan Georgiou, Programme Manager, and Matthew Oultram, Deputy Programme Manager, QNFMHS

12:15 Workshop session 1

Co-production

Involvement and co-production at Fromeside

Luisa Suarez, Service User Involvement Coordinator, and Louise Maclellan, Carer Representative, Fromeside and Wickham Unit, Avon and Wiltshire Mental Health Partnership NHS Trust

Novel Psychoactive Substances

NPS Substances 2019 – Where we are now

Wayne Harvey, Forensic Security Manager, Narcotics Search Dog Handler, Hatherton Centre, Midlands Partnership NHS Foundation Trust

Reducing restrictive practice

We have a Barry: Changing the culture of a low secure unit in a medium secure specification.

Caroline Ardron (Consultant Forensic Psychiatrist), Chris Pullinger (Ward Manger), Chris Linnett (Charge Nurse), Barry Vidler (Support Worker), Kat Syrigou (Assistant Psychologist), Denise Barker (Occupational Therapist), James (Service User)

13:10 Lunch and poster presentations

14:00 Launch of the new standards for forensic mental health services

Dr Quazi Haque, Chair, QNFMHS Advisory Group

14:20 The Digital Evolution: Using technology to improve patient safety

Dr Tim Riding, Associate Director and Dr Cecil Kullu, Consultant Psychiatrist, Mersey Care NHS Foundation Trust

14:50 Refreshments

15:05 Workshop session 2

Co-production

A: Secure Carers Toolkit – Where are we now?

Sheena Foster, Family and Friends Representative, Quality Network for Forensic Mental Health Services

B: Co-production and Involvement: Collaborative Risk Assessment & Safety Planning

Dr Sarah Markham, Patient Reviewer, Quality Network for Forensic Mental Health Services

Reducing restrictive practice

An evaluation of reducing restrictive practice at Cygnet Bury

Sibongile Attley, Clinical Manager, Cygnet Bury

Delivering quality services

From inadequate to outstanding

Jack Launer, Business Development Manager, Reuben Evans, Hospital Director and Registered Manager, Battersea Bridge Hospital, and Nicola Johnson, Hospital Director and Registered Manager, Waterloo Manor Hospital

16:00 Final plenary

16:05 Close

Appendix 4 – Project Team Contact Details

Team contact information

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Address

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