



Quality Network for Forensic Mental Health Services

AGGREGATED REPORT

MSU CYCLE 12 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:

Reflection

Patient from Arts Project, Secure Care Services, Northumberland Tyne and Wear NHS
Foundation Trust

2019

Contents

Acknowledgements	2
Preface.....	3
Who We Are and What We Do	4
Introduction	7
Executive Summary	10
Key Findings	17
Physical Security	18
Procedural Security.....	20
Relational Security.....	24
Safeguarding	26
Patient Focus	28
Family and Friends.....	32
Environment and Facilities	36
Admission.....	40
Treatment and Recovery	42
Medication	46
Leave and Discharge.....	48
Physical Healthcare.....	52
Workforce.....	56
Governance	60
Discussion Summaries.....	62
Appendix 1 – Member Services’ Contact Information	i
Appendix 2 – Aggregated Data by Standard	vii
Appendix 3 – Event Programmes	xxi
Appendix 4 – Project Team Contact Details	xxxiv

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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 12th MSU aggregated report from the Quality Network for Forensic Mental Health Services (QNFMHS). This report covers 60 medium 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 QNFMHS, 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 QNFMHS. 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, 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

60 medium secure mental health services from across the UK and Ireland participated in cycle 12 of the Network (appendix 1). Within the below map, yellow flags denote medium 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 medium secure services is presented.



Participation

As part of peer-review visits, almost 500 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
- MSU Annual Forum, May 2018
- Prison Transfer and Remission, November 2018
- Managing a Healthy Weight, February 2019
- MSU Annual Forum, May 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 members 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 60 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 54% to 95%.

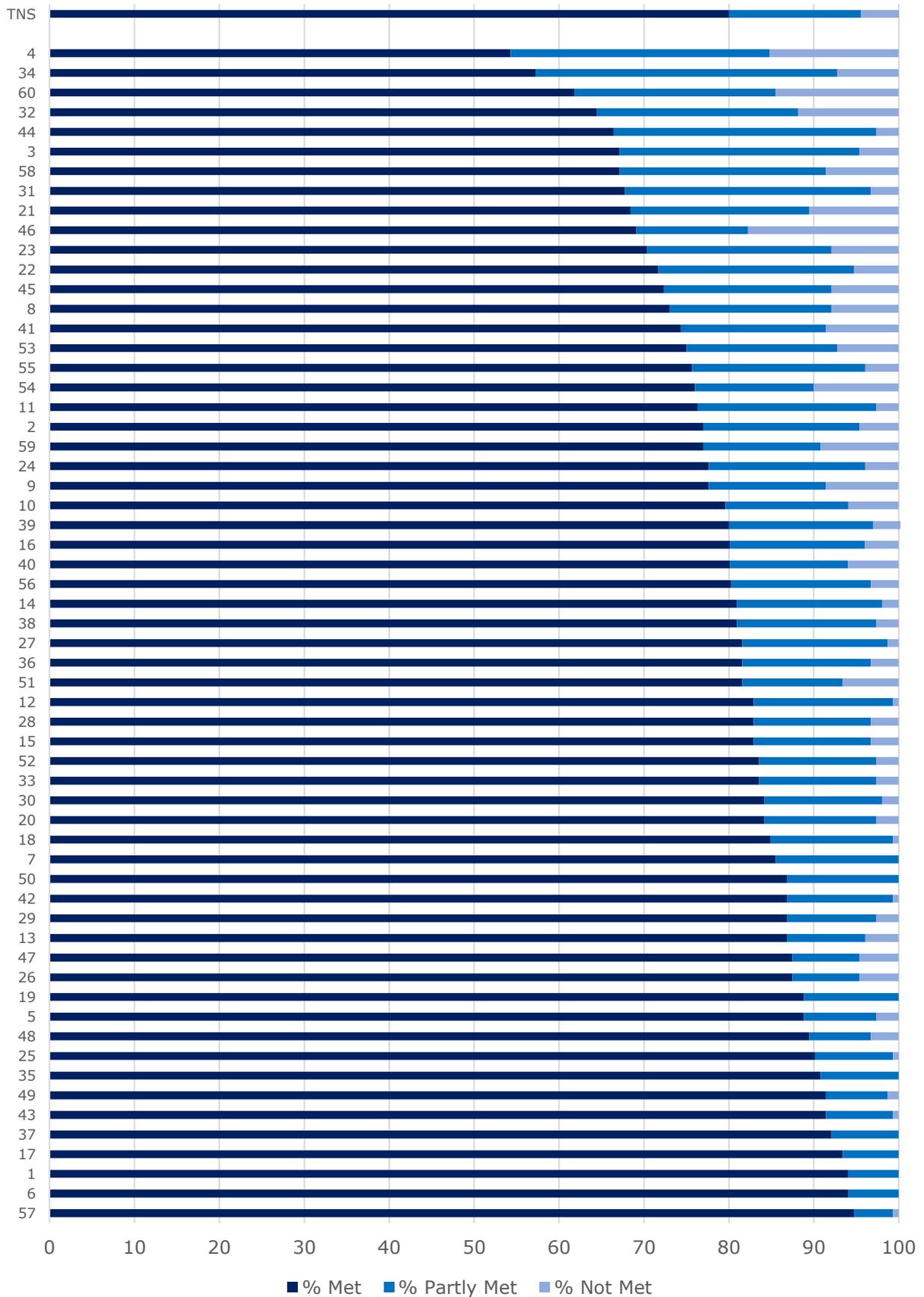


Figure 1: Percentage of criteria met, partly met and not met by services.

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 Physical Security. The areas in most need of improvement are Workforce and Patient Focus.

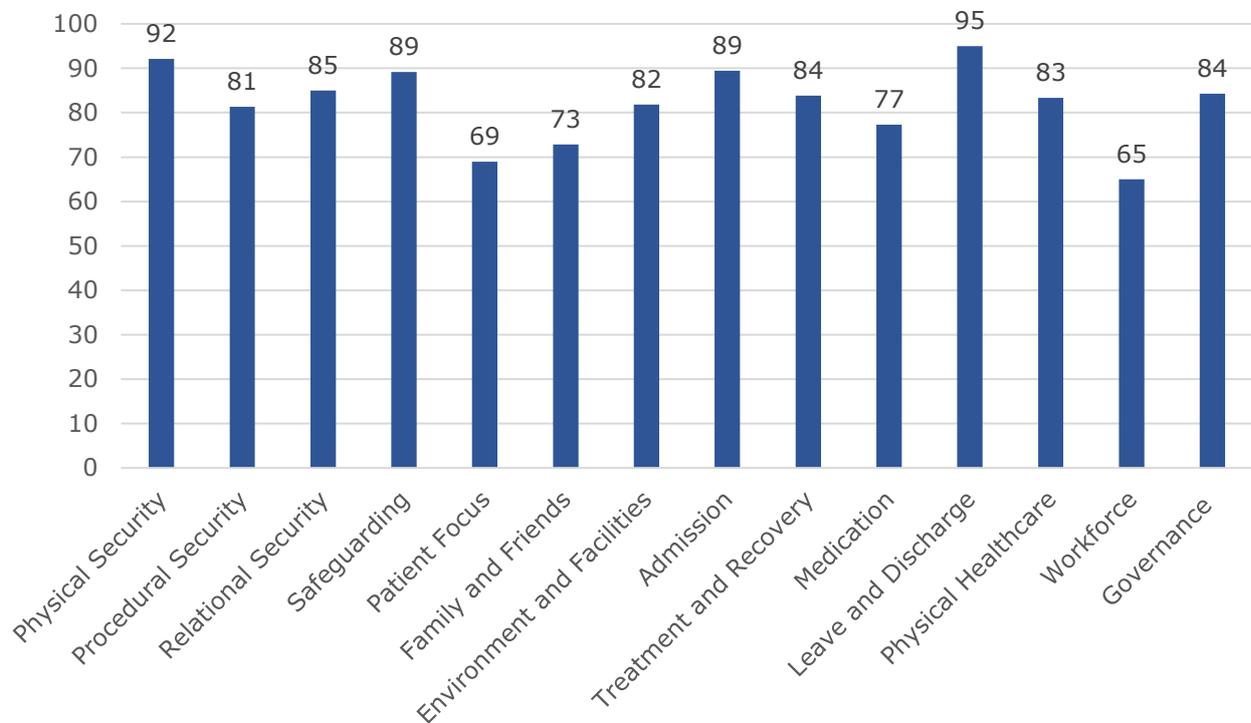


Figure 2: Average percentage of met criteria per section.

Physical Security

On average, services fully met 92% of standards in this area.

- The majority of services have a robust key management system.
- Most services have a designated security lead within the service.

Procedural Security

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

- One third of services do not have procedures in place to minimise the use of restrictive practices.
- Not all services have established formal procedures on anti-bullying, the prevention of suicide and self-harm, and effective liaison with local police on incidents of criminal activity/harassment/violence.
- Just over 30% of services do not develop their policies and procedures with patients, carers and staff members.

Relational Security

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

- Most services include training on relational security as part of their induction programme.

- Almost 90% of services demonstrated effective handover and communication systems.

Safeguarding

On average, services fully met 89% of standards in this area.

- The majority of services have procedures in place to report and respond to safeguarding concerns.
- Nearly 20% of services do not have an identified safeguarding lead.

Patient Focus

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

- In 47% of services, patients reported not being treated with compassion, dignity and respect.
- Only 60% 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. Similarly, only 60% of services provide patients with a welcome pack on admission.
- In just under half of services, patients reported not being satisfied with the food provision, with concerns around choice, quantity, and dietary and cultural requirements.
- Most patients know the advocate working within their services and how to contact them.

Family and Friends

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

- Nearly 80% of services reported providing advice to carers on how to access a statutory carers' assessment.
- One third of carers do not have access to a carer support network or group.
- Only half of services have a protocol for communicating with carers when their loved one does not consent to their involvement.
- 60% of carers are not provided with a carers' information pack.

Environment and Facilities

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

- Most services have video-conferencing facilities for patients to use.
- Most services enable patients to make their own hot and cold drinks and snacks.
- Nearly all patients reported being able to personalise their bedroom spaces.
- 88% of services have a dedicated visitors room within the secure perimeter.

Admission

On average, services fully met 89% of standards in this area.

- Patients in nearly all services receive a pre-admission assessment of need.
- Three-quarters of services have a clear clinical model that details the clinical approach relating to key therapeutic outcome areas.

Treatment and Recovery

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

- Patients spoken with in all services reported that they have a clear care plan that reflects their individual needs.
- In 27% of services, patients reported not being included in developing their care plan.
- In almost 40% of services, patients reported not having clear personalised outcomes in key recovery areas.
- One-quarter of patients did not recognise having a personalised plan of therapeutic and skill developing activity.

Medication

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

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

Leave and Discharge

On average, services fully met 95% 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 83% of standards in this area.

- Most patients have their healthcare needs assessed on admission and reviewed every six months thereafter.
- Around one quarter of patients reported that they are not offered a staff member of the same gender as them for physical examinations.
- Almost 90% of services evidence providing patients with targeted lifestyle advice and health promotion activities.

Workforce

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

- Monthly clinical supervision was reportedly received in only 45% of services and monthly managerial supervision was reportedly received in 55% of services.
- 38% 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 40% of services did not feel that their health and wellbeing is supported.
- Most staff members reported feeling able to raise concerns about standards of care.
- Staff in only two-thirds of services receive training on risk assessment and risk management.

- Only one-fifth of services involve patients and carers in delivering face-to-face training.

Governance

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

- Most services have systems in place to enable staff to quickly and effectively report incidents with managers, and staff members are encouraged to do this.
- An annual meeting to discuss service developments occurs in nearly all services.

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 of 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

- 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.

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

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 12 2017-19

Physical Security

On average, services fully met 92% of standards in this area, ranging from 64% to 100% compliance.

Key Management Systems

98% of services have a key management system in place that accounts for all secure keys.

Most services have a process to ensure keys are not issued without an induction being completed and only upon presentation of valid ID.

Good practice examples

The physical security arrangements are robust and well organised. There is an electronic key management system in place which works effectively and obviates the need for a member of staff to be on duty to manage keys.

John Howard Centre

Secure Environment

All services have controlled systems in place to manage access through all doors.

97% of services have a designated security lead within the service.

Good practice examples

Security is well-managed at the service and the communication regarding security amongst the team is positive, with a security handover taking place on a daily basis.

Calverton Hill

The directorate drug dog and handler demonstrate good practice in the prevention of drugs and illicit substances from entering the wards. This has led to a significant reduction in the number of drugs entering the wards over the past five years.

Hatherton Centre

There is a robust security team in place at the service, and security liaison staff attend ward rounds and multi-disciplinary team (MDT) meetings. There is a direct police liaison on site who is readily available to discuss incidents of criminal activity at the service if required.

Scott Clinic

The security lead tests the team's security training and knowledge by regularly producing security quizzes.

Broadland Clinic

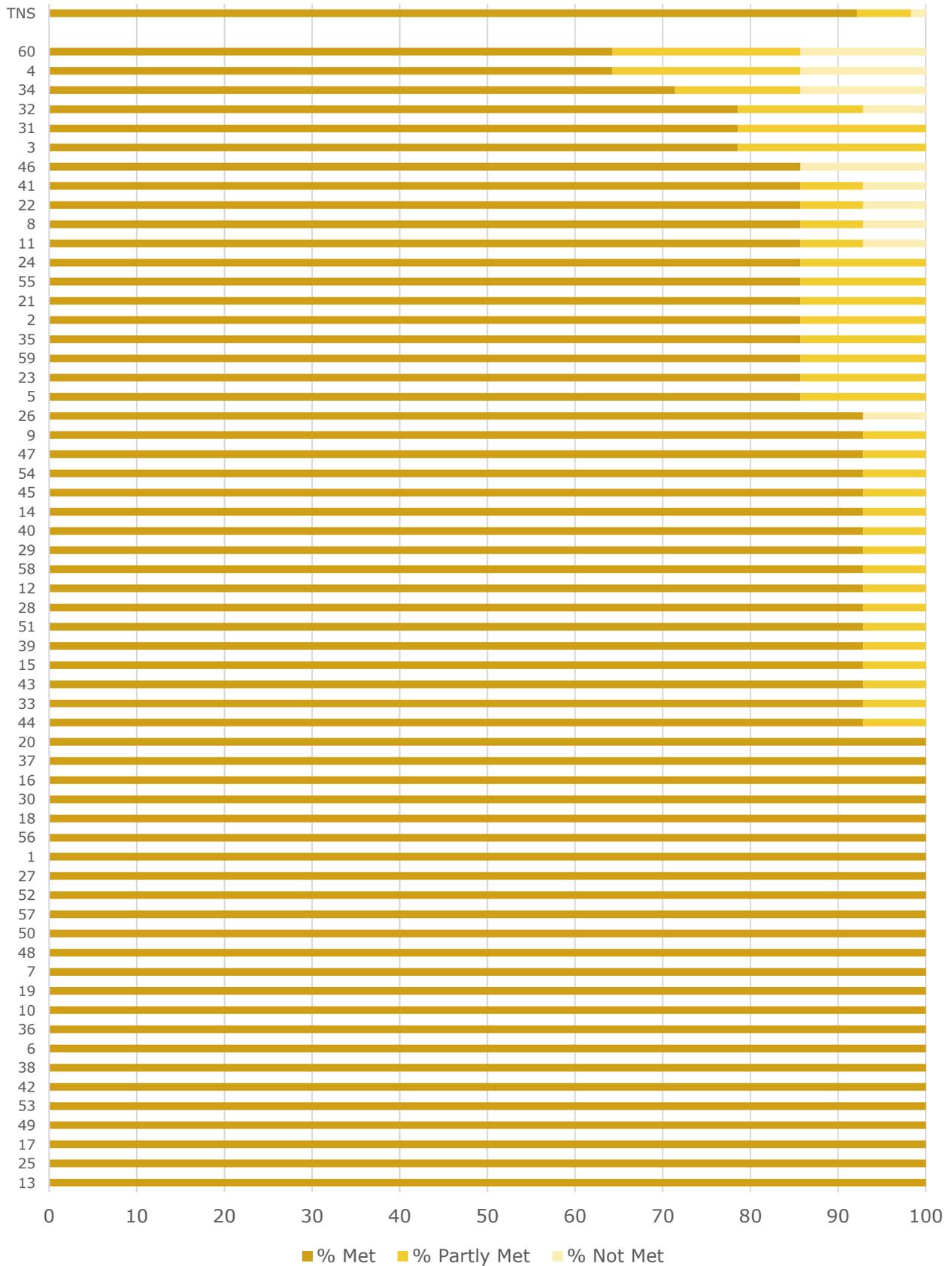


Figure 3: Percentage of criteria met, partly met and not met for each service relating to Physical Security.

Procedural Security

On average, services fully met 81% of standards in this area, ranging from 40% to 100% compliance.

Restrictive Practices

32% of services do not have reducing restrictive practice procedures in place.

Good practice examples

There is an effective and consistent strategy of reducing restrictive practice throughout the service. There appears to be very few blanket restrictions and decisions are made according to individualised risk assessments. This is an ethos that is shared and instilled at all levels in the service. Managers promote this through meetings with staff and facilitating regular refresher training.

Ridgeway

The service has continued to reduce restrictive practice. There is a current trial of patients having access to basic mobile phones on the ward, patients are individually risk assessed for different internet access, there is also a trial of ceramic mugs on the ward. When patients come back from leave, there is a random generator used to decide whether the patient will be searched.

Kneesworth House Hospital

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

Humber Centre

The service has worked collaboratively to reduce restrictive practice throughout the hospital. They no longer have the RAG (red, amber, green) system in place, which was based on the behaviours the patients presented with, following feedback from both staff and patients.

Llanarth Court Hospital

The service has a strong focus on least restrictive practices; a structured approach to risk assessment and risk management is in place, with positive risk taking at the centre of their practice. For instance, there is 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.

Cygnet Hospital Stevenage

Policies and Procedures

Only 62% of services have an effective liaison with local police on incidents of criminal activity/harassment/violence.

67% of services develop their policies and procedures with patients, staff and carers and 95% of services format, disseminate and store policies, procedures and guidelines in ways that staff find accessible and easy to use.

70% of services have prevention of suicide and self-harm policies in place and 32% of services do not have anti-bullying policies.

Most services have patient observation policies in place.

Good practice examples

Patients are fully informed of policies and procedures that govern the service and their care and treatment. They can be accessed within the hospital's shared activity spaces by the shop and are displayed in a helpful way.

Arnold Lodge

Staff are informed about changes made to policies and procedures and are aware of how to find them. Updates are provided via business meetings, emails and through the staff intranet. This ensures effective communication and means that staff can work within the specified procedures for the service.

Fromside

To ensure staff are aware of policies in place at the service, there is a 'policy of the month', this is discussed with frontline staff and is often linked with lessons learned from either service level or organisation wide.

Kneesworth House Hospital

There is greater focus on governance and ensuring that policy changes take place as required. The service has up to date procedural security documents covering a number of essential areas, including visiting procedures for children and unwanted visitors as well as policies relating to suicide and self-harm prevention, patient observation, searching patients and their personal property, anti-bullying and patient use of mobile devices within the service.

North London Clinic

Carers are included in the development of policies and procedures, through the FOSIT group, and are regularly invited to events and meetings.

Trevor Gibbens Unit

Visiting and Leave Procedures

95% of services have procedures in place to manage situations where patients are absent without leave.

23% of services do not have visiting procedures in place, including information on child visits and unwanted visitors.

A majority of services have policies and procedures in place to manage prohibited and restricted items from entering the service.

Good practice examples

Those visiting the service for the first time have their details recorded and are given a visitor's photo ID. Visitors are required to confirm that they do not have prohibited items in their possession. These procedures continue whilst a large number of people are passing in and out of the service.

St Andrew's Northampton Women's Service

The service has created a 'Leave Ladder' document for patients which details the purpose of leave and the different stages of section 17 leave. Within this document, the physical considerations of leave, a section on 'plans to keep me safe', and templates for an after leave debrief are included. This document is patient-focused and goal oriented, whilst keeping a good level of detail for patients to easily understand the processes and stages.

Edenfield Centre

A randomiser button at reception to randomly choose patients for searches on returning to the ward and returning from section 17 leave was observed, as opposed to searching every patient when they leave the ward for section 17 leave and when they return. This demonstrated an effective way of reducing blanket rules and procedures for patients at the service.

Calverton Hill

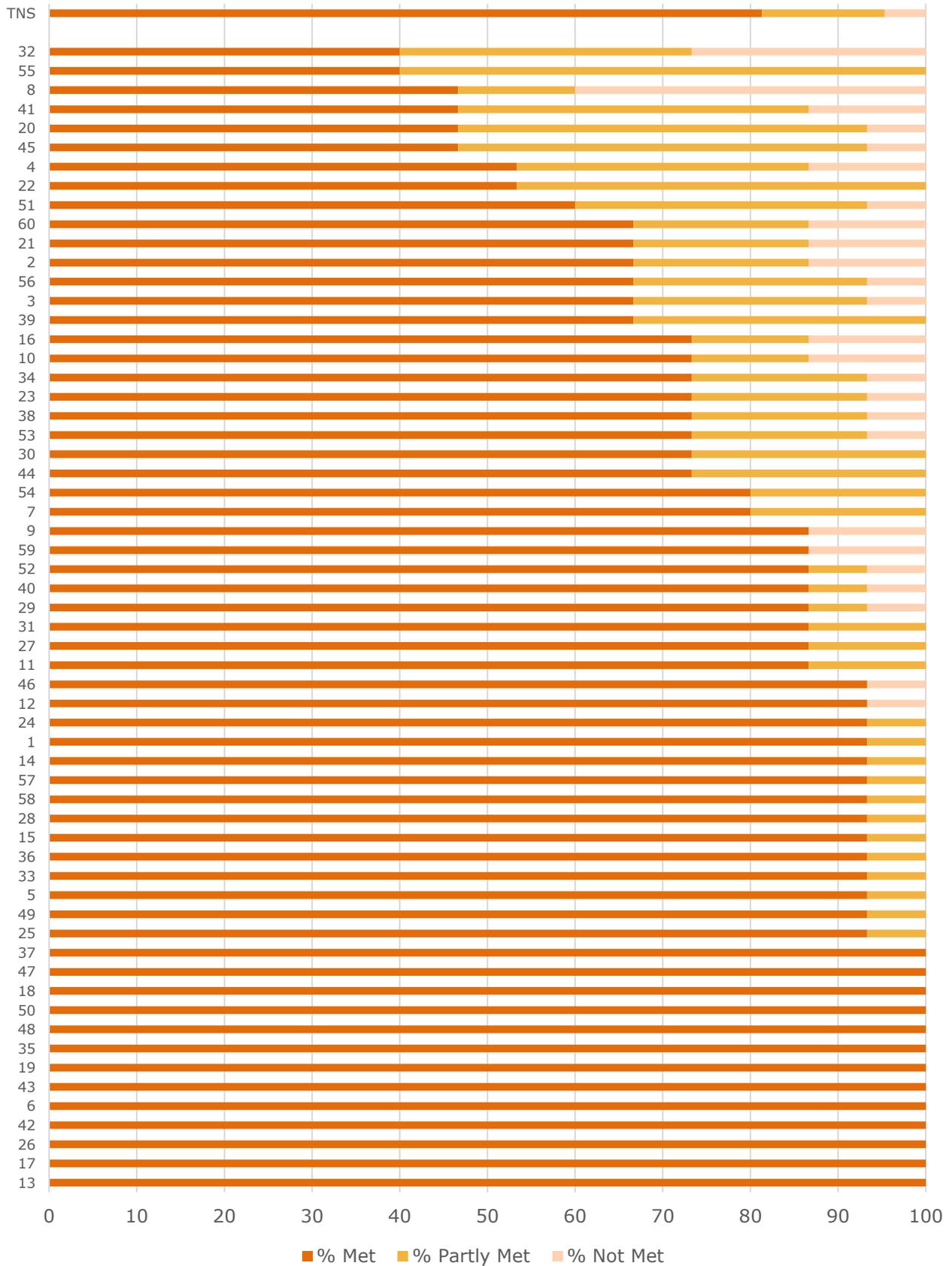


Figure 4: Percentage of criteria met, partly met and not met for each service relating to Procedural Security.

Relational Security

On average, services fully met 85% of standards in this area, ranging from 0% to 100% compliance.

Training

87% of services provide an induction and annual training in the use of See, Think, Act (2nd Edition).

Good practice examples

Relational security is robust throughout the service, as staff are aware of patients' individual risk and all staff spoken with receive annual training on relational security.

Llanarth Court Hospital

Relational security training is provided consistently to staff, including training on the use of See, Think, Act.

Bracton Centre

Communication and Monitoring

87% of services have clear and effective systems for communication and handover within and between staff teams.

18% of services do not have processes to monitor performance against items relevant to relational security.

Good practice examples

There are two daily meetings to plan activities; this has enabled the team to build on their relational security and therapeutic relationships with their patients. Patients are supported and encouraged to chair these meetings independently or with staff members.

Brooklands Hospital

Staff work cohesively together, and it is evident that relational security is robust throughout the service. This is a standing item on the agenda of staff meetings to address and monitor how they are working against items relevant to relational security.

Hatherton Centre

Staff reported receiving regular training which incorporates the use of See, Think, Act (2nd Edition). The relational explorer tool is utilised when making decisions about the service and individual patients.

Farmfield Hospital

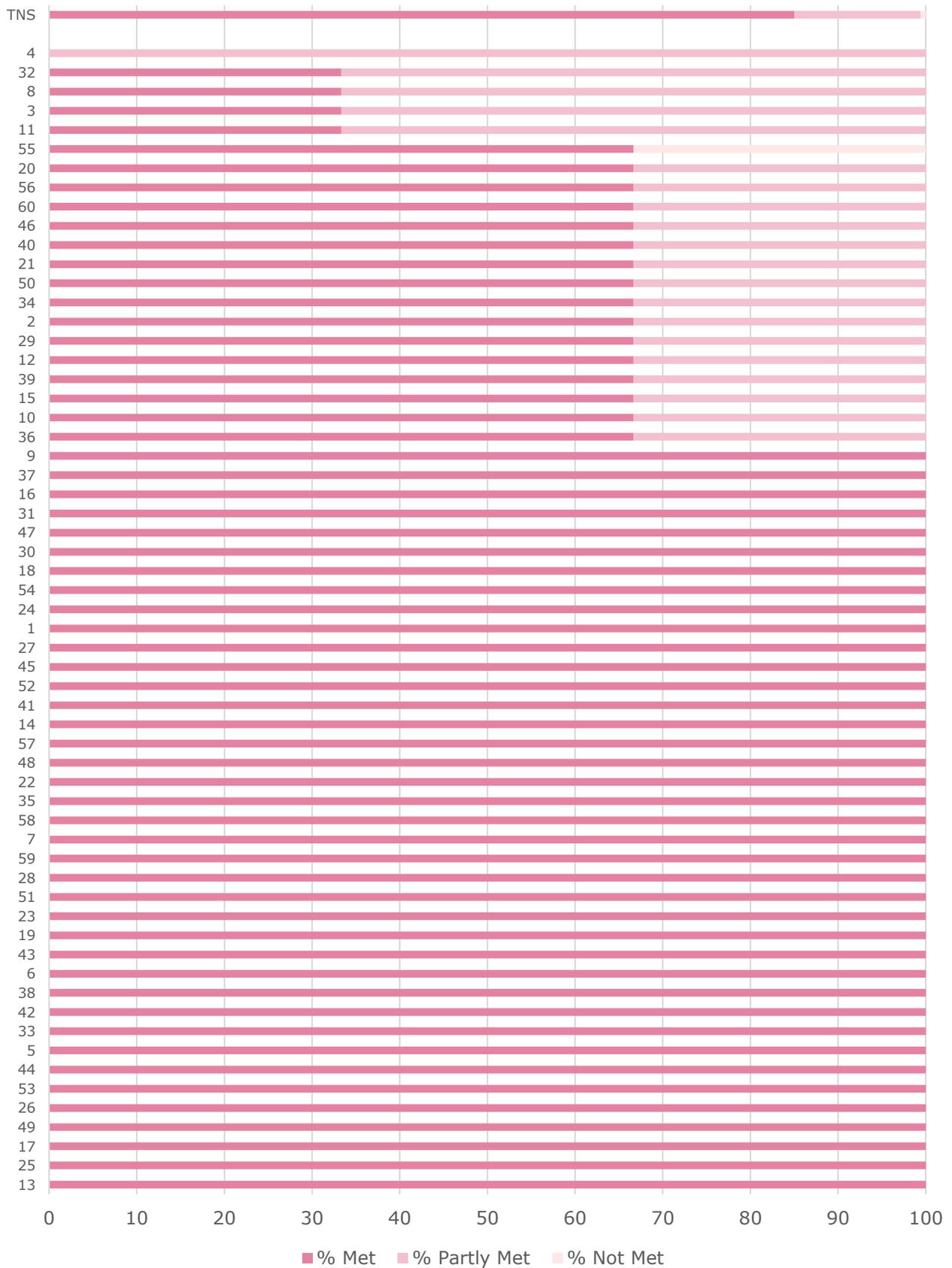


Figure 5: Percentage of criteria met, partly met and not met for each service relating to Relational Security.

Safeguarding

On average, services fully met 89% of standards in this area, ranging from 25% to 100% compliance.

Procedures and Systems

92% of services have safeguarding adults and children procedures, including how to escalate concerns.

85% of services have systems in place to respond to themes and trends in safeguarding referrals. Only 18% of services do not have a safeguarding lead.

Good practice examples

There is a dedicated safeguarding and training lead, who is responsible for the availability of training. The training was highly praised by frontline staff.

Bracton Centre

Staff across all disciplines are aware of inter-agency safeguarding protocols for adults and children, and a designated safeguarding lead at the service ensures training is provided to new staff. Consequently, all staff are aware of how to escalate concerns relating to safeguarding.

Thornford Park Hospital

Staff have a thorough understanding of the safeguarding procedures 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

Staff spoken with on the review day showed a comprehensive understanding of the safeguarding processes at the service. They feel the process works well and that any issues raised are managed appropriately and effectively. A safeguarding team is available to provide advice and ensure concerns are picked up, in line with the local policy, and staff reported they find the team helpful.

Northside House (formerly Norvic Clinic)

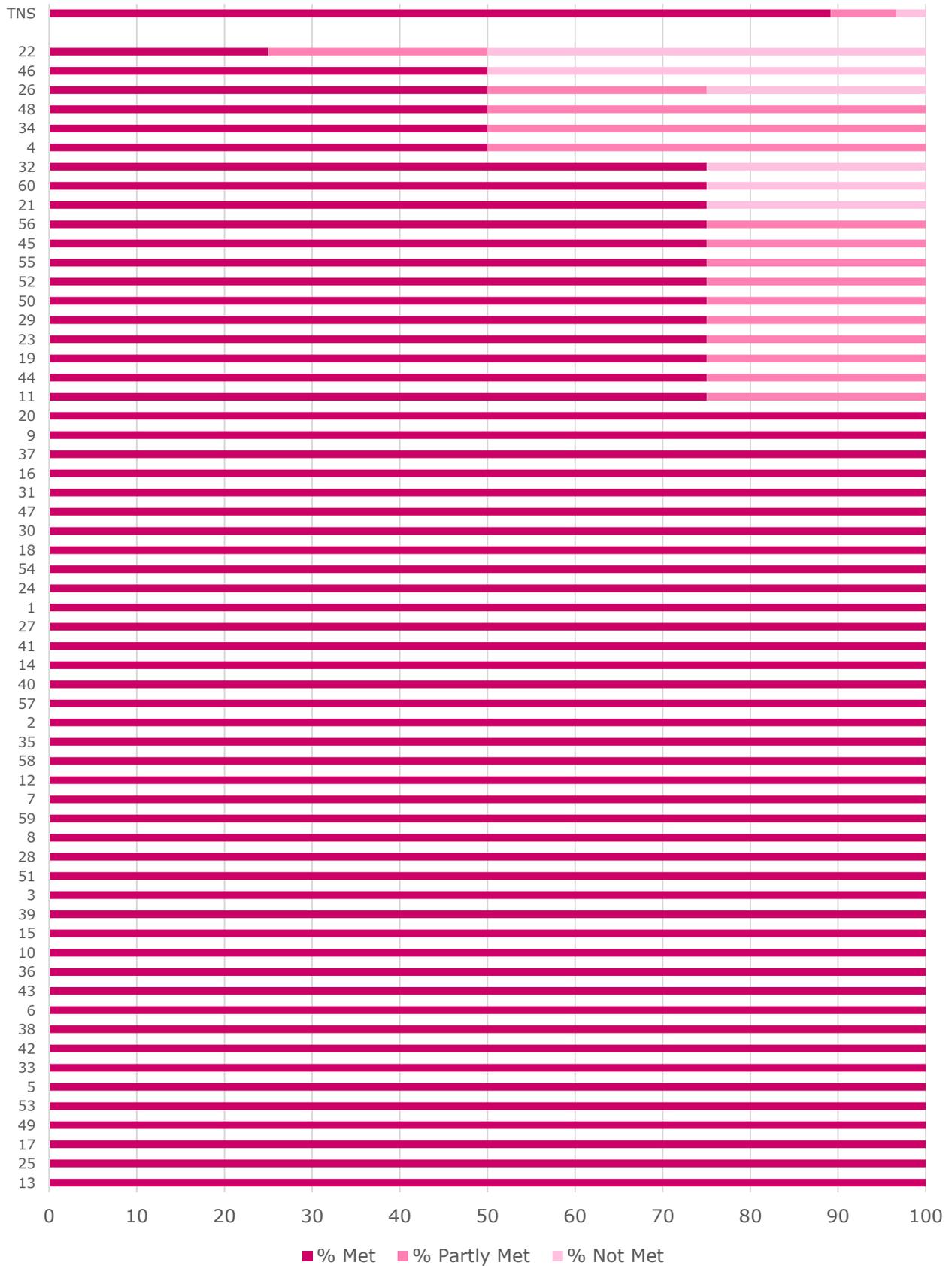


Figure 6: Percentage of criteria met, partly met and not met for each service relating to Safeguarding.

Patient Focus

On average, services fully met 69% of standards in this area, ranging from 22% to 94% compliance.

Patient Information

98% of services record patient consent to the sharing of clinical information outside of the team.

In 78% of services, patients reported receiving information in a format that is easy to understand and 63% of services provide patients with a 'welcome pack'.

32% of services do not explain confidentiality and its limits to patients verbally and in writing.

Only 60% of services are providing patients with information on their rights, access to advocacy and interpreting services, access to own health records and a second opinion, and how to raise concerns, complaints and compliments.

Good practice examples

A co-produced patient and carer guide, which includes information about the service and the care and treatment provided, has been developed.

Cheswold Park Hospital

A DVD for deaf patients has been established in which their Care Programme Approach (CPA) is summarised in sign language. The patient is then able to share this with their advocate, OT or use in one-to-one meetings.

Cygnet Hospital Bury

There is a strong sense of co-production embedded in the service. The service's welcome booklet for patients has been developed with the help of patients.

Brockfield House

The service has produced a version of the HCR-20 that is accessible and easy for patients with learning disabilities to understand. There are easy-read posters for patients throughout the ward environment and in the retreat area. For example, in the multi-faith room there are posters on different religions. Posters are bright, contain images and clear written information.

Brooklands Hospital

The staff and patients alike are complimentary of the new format of ward rounds, whereby patient information and individual care plans are displayed on screen for all to review. Staff feed into the ward round before the meeting with the patient, which takes place every two weeks, to ensure that the focus of the meeting is given to patients providing their view.

Cygnet Hospital Stevenage

Meals

In only 47% of services, patients reported being provided with meals that offer choice, address nutritional/balanced diet needs and specific dietary requirements, are sufficient in quantity and reflect individual cultural and religious needs.

Good practice examples

Patients reported having enough choice, receiving good portion sizes and healthy options at meal times. Patients are able to request what they would like to see on the menu.

Wellesley Hospital

A seclusion food menu has been introduced to enable patients to receive the same finger food as what is available on the ward.

Cheswold Park Hospital

There are lots of noticeboards across all the wards with information for both patients and staff that are colourful and eye-catching. Noticeboards include information about menus for the canteen.

Ravenswood House

There is a food forum where patients can meet with caterers to discuss improvements to meals.

Chadwick Lodge

Patient Involvement and Care

In 95% of services, patients knew who the advocate was and how to contact them.

In 73% of services patients and carers are given an opportunity to feed back about their experiences and in 70% of services, patients are consulted about changes to the environment.

In 65% of services, patients feel listened to and understood by staff and in 63% of services they feel treated with compassion, dignity and respect.

In 90% of services there is at least one community meeting per month and in 67% of services, patients' preferences on medication, therapies and activities are acted upon as far as possible.

Good practice examples

Patients expressed that they can bring their concerns to community meetings and appeared aware of the boundaries in which this takes place, for example, to discuss service matters rather than personal ones. It was positive to hear patients are involved in staff recruitment by sitting on the interview panel for new staff. Patients also attend a monthly service user forum where they can discuss challenges they may experience on the ward.

Three Bridges

Patient and carer feedback is considered when developing policies and procedures. Carer groups are presented with a list of policies, and they can choose which documents they would like to feed into. Staff representatives for each discipline are also consulted.

Central Mental Hospital

Real-time feedback screens are located around the ward, easing the ability for patients to share their comments and opinions regarding the service. The data obtained from these screens are then displayed in staff areas, providing staff with an opportunity to actively respond to patient concerns.

Shaftesbury Clinic

Patients are part of the interview panel for new members of staff. This gives patients a higher level of responsibility for the direction of the service and allows their perspective to be taken into account when staff are selected for positions.

Wathwood Hospital

The service run a monthly residents' council and a weekly community meeting for patients to feed back their experience of the service and any issues they may have. All patients are invited to the residents' council; however, they can always pass information onto the ward reps to take forward if they are unable to attend the meeting. Several patient suggestions through the residents' council have been taken forward by the service and evoked change, such as the price of e-cigarettes.

Tamarind

There is an involvement group and a patient is part of the 'no force first' group. Patients are involved in the media crew and speak up group. Patients reported that during their community meetings they are involved in decisions about the environment and how it is decorated.

Woodview

Patients feel listened to and included in the decisions made about the wards. The hospital has in place a monthly patient forum and regular ward community meetings which help communication between patients and the hospital. Up to five quality walkarounds occur on each ward monthly.

Priory Hospital Burgess Hill



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

Family and Friends

On average, services fully met 73% of standards in this area, ranging from 14% to 100% compliance.

Carer Communication

95% of services facilitate section 17 leave, with carers being contacted beforehand and with carers agreement.

However, 52% of services do not have a protocol for communicating with carers when their loved one does not give consent for their involvement. In 40% of services carers are not provided with a carers' information pack.

Good practice examples

Staff members are monitored via supervision on their contact with carers. There is an expectation that all engaged carers, where patient consent has been given, are contacted on a monthly basis to ensure that their needs are met and that they feel involved in their loved one's care. Furthermore, themed events are organised for the family and friends of patients on a quarterly basis, including a curry night and a summer BBQ.

Bracton Centre

Patients reported that there was a regular communication between the service and their carer, as well as their family and friends being invited to attend Care Programme Approach (CPA) meetings.

St Andrew's Healthcare Birmingham

With patient agreement, regular communication is maintained with their carers as to their treatment, medication, care planning and any incidents that have occurred. This contributes to carers being well informed regardless of restrictions on what can be communicated.

St Nicholas Hospital

Communication with carers appears to be of a good standard. Those who are involved in their loved one's care are invited to attend discussions about treatment planning. Carers are also able to ring the ward to talk to staff about any relevant issues.

Guild Lodge

The service's liaison with family members during the arrangement of patient leave was noted as an area of good practice. The service has a full-time family therapist who visits and communicates arrangements with the family prior to leave being granted. This contributes to ensuring that leave is well organised and managed.

John Howard Centre

Carer Support

68% of services offer carers individual time with staff to discuss their apprehensions, family history and their own personal needs.

77% of services give advice to carers on how to access a statutory carers' assessment.

In 30% of services, carers do not have access to a carer support network or a group.

Good practice examples

A carer contact care plan is jointly produced with a patient's named nurse and the social worker, and ensures regular contact is made with carers. A carers' charter is provided to all carers, detailing what they can expect from the team and how the team will support them.

Broadland Clinic

There are bimonthly family and friend support groups scheduled and delivered in partnership with Rethink, who are commissioned to provide advocacy for family and friends. Staff, including service managers, have been invited to meetings to give presentations and answer questions. Also, a focus group of family and friends reviews service provision.

Fromside

Carers appreciated the financial and travel support provided to them which enables visits. On an ad hoc basis, the service has been able to financially support carers with public transport costs.

Arbury Court

Carers reported being kept informed of their loved one's care and feeling well supported by the social worker at the service. It was reported there was good communication and that they have received an information pack.

St John's House (LDS)

Each ward has a designated family and carer champion responsible for contacting families and answering their queries, forming a very strong relationship with carers. Carers are offered a range of supportive networks, such as a carers' council and carers' forum. These also provide an opportunity for carers to be involved in the development of policies and procedures.

Oxford Clinic

Throughout the year, the service hold events including Christmas lunch, afternoon tea at Easter and a BBQ in the summer. In these events, patients cook the food and work as waiters, serving their friends and family.

Stockton Hall Hospital

Co-production

Good practice examples

There is a range of opportunity for co-production with patients and family and friends. For instance, there are ward representatives that lead the ward community meetings and attend the user forum, as well as delivering face-to-face training and workshops, and sitting on the recruitment panels of new staff. Family and friends have been involved in developing a carers' information pack as part of the family and friends' forum.

North London Forensic Service

The service works proactively to engage with carers and involve them in their loved one's care when consent has been given. Carers are contacted when patients are admitted, home visits are arranged if required or requested, and carers are able to have regular contact with the matron and can ask staff on the ward for updates.

Ty Llewellyn

The service is trying to improve the involvement of carers in patients' care by opening a carers centre, where staff will be dedicated to meet carers' needs and deal with queries.

St Andrew's Healthcare Northampton Women's Service

The service has a local carer engagement strategy in place. Currently, there are carer representatives who attend governance and business meetings. One carer reported that they really valued the role and felt like they were being listened to. Carers are also involved in the staff recruitment process.

Langdon Hospital

The service maintains a strong effort to involve carers, such as inviting them to ward rounds, CPA reviews, management hearings, tribunal hearings and involving them in patients' discharge plans.

Shaftesbury Clinic

The carer spoken to reported feeling that they are currently very involved in the discharge planning for their loved one and is appreciative of the regular contact and meetings she is having with the responsible clinician, which are occurring on a monthly basis.

Ardenleigh

Family and friends are encouraged to review relevant policies and guidelines in place and are regularly invited to events and meetings with staff and their loved one. Carers are also involved in delivering face-to-face training at local induction days.

Trevor Gibbens Unit

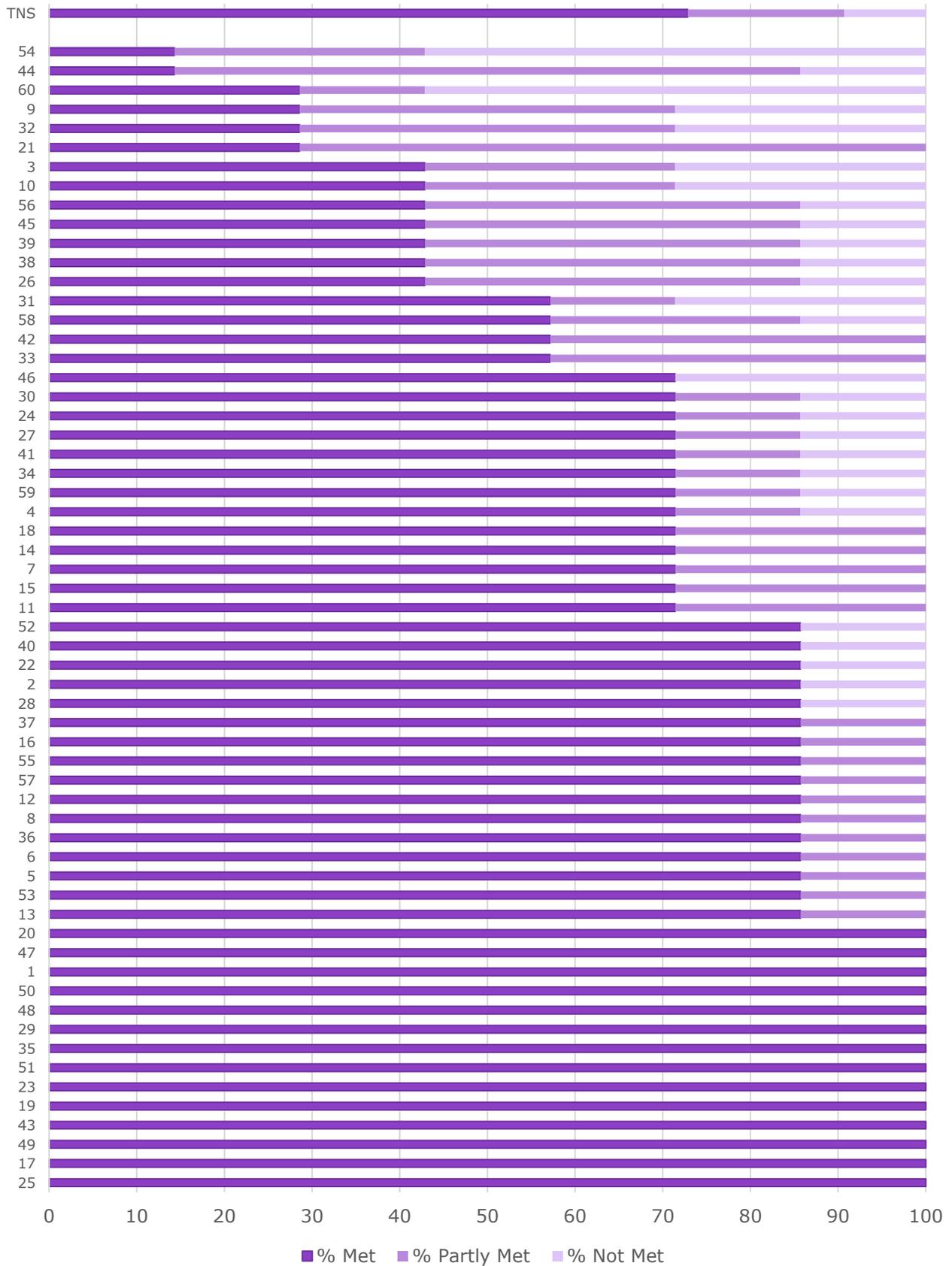


Figure 8: Percentage of criteria met, partly met and not met for each service relating to Family and Friends.

Environment and Facilities

On average, services fully met 82% of standards in this area, ranging from 40% to 100% compliance.

Patient Facilities

88% of services have video conferencing facilities for patients to use.

In 85% of services there is a multi-faith room which provides faith-specific materials and facilities that are associated with cultural or spiritual practices.

20% of services do not have facilities for patients to make their own hot and cold drinks and snacks.

Good practice examples

There is a farm at the service, with pigs, goats, alpacas, donkeys and a beehive that are cared for by the patients. On the farm, the patients grow vegetables that are sold at the farm shop on site each week. Patients run a café and a pop-up restaurant that is open to the public.

Wathwood Hospital

There is an on-site workshop that fosters a range of activities for patients, which is advertised to all patients clearly to increase involvement. There is a set of family visiting flats which can be used by families or friends when visiting patients at the service and further enhance engagement.

Caswell Clinic

There are a range of facilities within the service to support patients to engage in therapeutic and recreational activities. Patients can take part in activities such as horticulture, woodwork, looking after the chickens and IT classes.

Eric Shepherd

The multi-faith room, known as 'The Sanctuary', provides a dedicated and peaceful place for patients to practice their faith. Illustrations have been carefully added to the room to assist patients in their religious practice such as a wall display pointing in the direction of Mecca.

Guild Lodge

The occupational therapy facilities included: access to animals (pigs, chinchillas, fish, rabbits); DIY; gardening; and a café. There is also a relaxation room and a massage room.

Kneesworth House Hospital

Physical Environment

In 63% of services there is a specific de-escalation space to reduce arousal/agitation specifically.

93% of patients can personalise their bedroom spaces.

32% of services do not comply with current legislation on disabled access.

Good practice examples

On each ward there is a 'de-escalation pod' that is used as a low stimulus area, as well as a quiet space for patients to use, this is in addition to a quiet room and seclusion suite.

Ardenleigh

The environment appeared to be bright, homely and welcoming with numerous displays of photographs and artwork across walls.

Newton Lodge

The 'communication wall' or 'COWall' was recognised as an innovative approach to improving the experience of patients in seclusion. The wall, a door-sized touch screen device embedded into the wall in the seclusion room, has a number of applications, including televisual and audio functions, exercise programmes, reading material, mood lighting and telephone functions.

Arnold Lodge

The newly refurbished seclusion rooms are of high quality; there is a nursing office situated between the two new seclusion suites where nurses can be positioned to observe both suites at the same time.

Cygnets Hospital Stevenage

The shared communal area between the wards includes a gym, a cosy and relaxing retreat room, a shop and café, an education room, a music room and an art therapy room. The ward environment in general is spacious with a large garden on each ward.

Hellingly

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

St Nicholas Hospital

Patients are able to personalise their bedrooms which creates a homely environment.

St Andrew's Healthcare Northampton Women's

There is a farm in the unit which patients without leave can access. There is an art exhibition with one patient's artwork and the exhibition is rotated every few months.

Trevor Gibbins Unit

Visiting facilities

100% of services had lockers for visitors to store restricted or prohibited items away from patient areas whilst being at the service.

In 90% of services, child visits are facilitated safely and are fully equipped with child appropriate items such as toys, games and books.

12% 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 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.

Reaside Clinic

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

Wellesley Hospital

There is a set of family visiting flats which can be used by families or friends when visiting patients at the service and further enhance engagement.

Caswell Clinic

The entrance to the service and reception is welcoming and well organised. There is an open reception desk that visitors can approach prior to making their way through the secure airlock. The facilities for child visits are of high quality. Dedicated rooms are separate to the ward areas, incorporate CCTV and have a range of facilities suitable for children of different ages.

Ridgeway

The child visiting facility in the medium secure unit was regarded by the review team as excellently equipped. This included a baby changing facility that was built within the private child visiting room, along with a wide range of child appropriate toys and entertainment.

Newton Lodge

At reception, there is a café for visitors, which is run by several of the patients.

North London Forensic Service

There is a dedicated child visiting area within the clinic. General visiting takes place in two rooms in each of the ward's vestibules. Some patients can have access to the café area with their visitors.

Rohallion



Figure 9: Percentage of criteria met, partly met and not met for each service relating to Environment and Facilities.

Admission

On average, services fully met 89% of standards in this area, ranging from 33% to 100% compliance.

Patient Admissions

98% of services ensure that patients receive a pre-admission assessment of need which ensures admissions to services are suitable and that patients' needs are identified.

In the majority of services, the multi-disciplinary team makes decisions about patient admission and can refuse to accept patients if they believe that patients will compromise safety/activities.

Good practice examples

A pre-admission CPA meeting and a pre-admission conference are now facilitated by the service prior to patients being admitted. Staff reflected positively regarding this, stating that it is very helpful, as it enables staff and patients to become settled at a quicker rate.

Bracton Centre

On admission to the service, patients are given a welcome pack which is of a high quality. This is well presented, recovery oriented and contains positive quotations from previous patients and members of staff. Furthermore, it promotes inclusiveness through its descriptions about patient involvement, promoting contact with family and friends and patient artwork.

John Howard Centre

Current initiatives to assist with prison transfers to the medium secure unit demonstrate good practice. Links are being made with relevant prisons and plans are in place to join multi-disciplinary teams in order to discuss referrals.

Ridgeway

Clinical Model

72% of services have a clinical model that details the clinical approach that relates to key therapeutic outcome areas.

Good practice examples

The clinical model SCALE (stabilisation, collaborative responsibility, active intervention, learning and consolidation, and exit planning) is a useful way to keep patients on track with their recovery.

Reaside Clinic

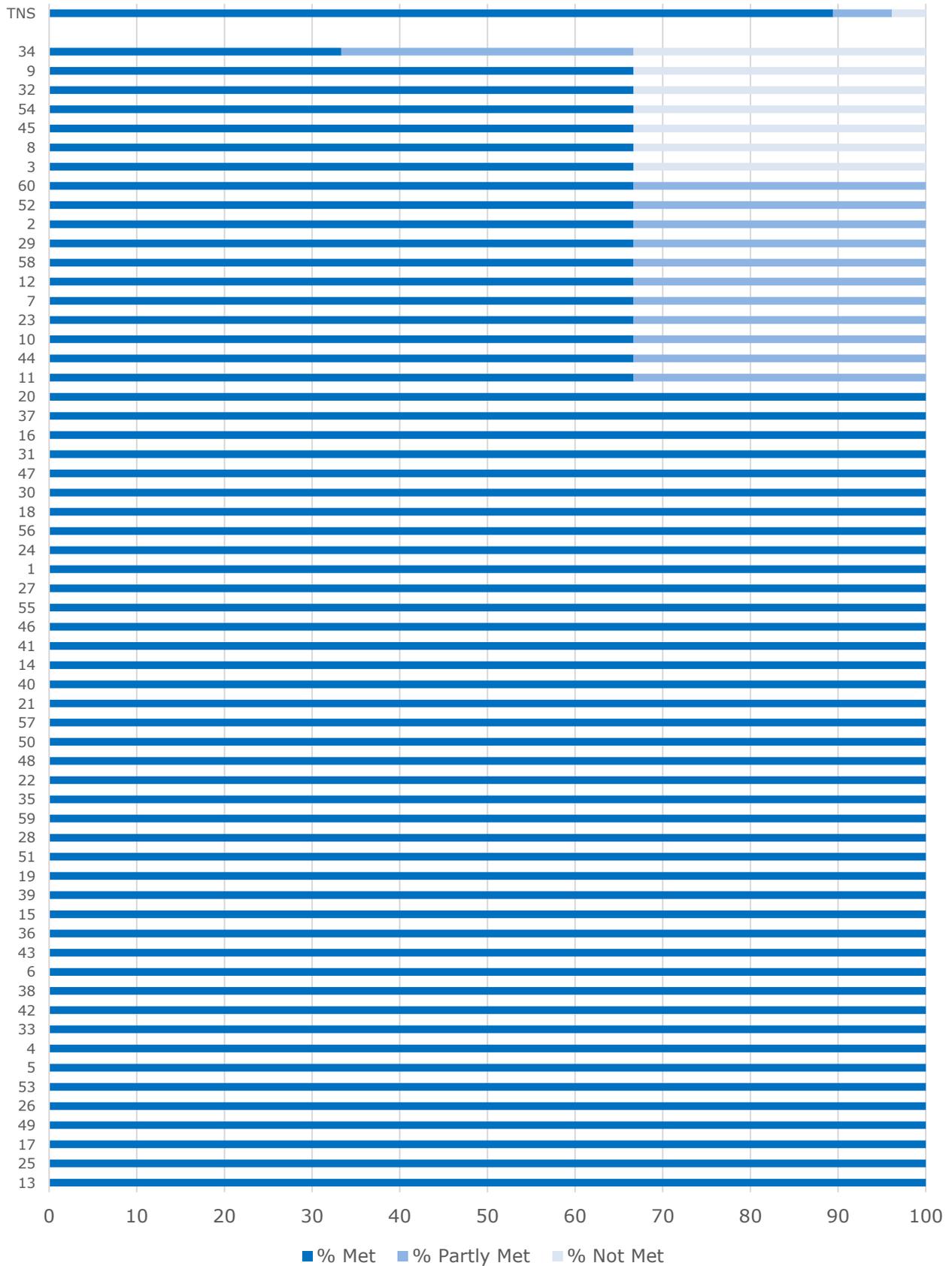


Figure 10: Percentage of criteria met, partly met and not met for each service relating to Admission.

Treatment and Recovery

On average, services fully met 84% of standards in this area, ranging from 50% to 100% compliance.

Care Planning

93% of multi-disciplinary teams review and update care plans according to clinical need or once a month.

Patients spoken to in all services reported that they have a care plan that reflects their specific needs which includes treatment for physical and mental health, medication management and specific personal care arrangements.

In only 27% of services, the multi-disciplinary team does not develop care plans collaboratively with the patient and their carer.

Good practice examples

Patients spoken with were clear on exactly what was required of them in order to progress to the next level of care, as well as what their personal recovery goals and outcomes are. Patients are actively involved in the development of their care plan and receive copies of these.

Hatherton centre

The service uses the DUNDRUM tool as part of the access assessment and during CPA meetings. This is a tool that determines a patient's level of security and the urgency of admission. A different form of the tool will be used during a patient's CPA meeting which will measure the extent of which a patient has engaged successfully in different treatment programmes, and assess whether they are ready to move a less secure placement. 90% of staff who undertake assessments have been trained in how to use the tool.

Farmfield Hospital

Patients feel involved in their care and the development of their care plan. Patients receive copies of their care plans and are given an opportunity to speak to staff if they do not agree with it.

Thornford Park Hospital

The team individualise patients' care and treatment to best support them. To support patients in their recovery journey, the team use the Outcome Star, using each adaptation for the specific needs of the patient, for example the Recovery Star or the Life Star for those with learning disabilities.

Humber Centre

Therapies

Most services offer patients evidence based pharmacological and psychological interventions, and any exceptions are documents in the case notes.

37% of services do not provide patients with clear personalised outcomes in key recovery areas, to help them understand which outcomes are pathway critical.

Good practice examples

All patients receive a psychological assessment. A wide range of evidence-based groups and one-to-one treatments are offered, including the 'I can feel good' group which was created by staff and patients, focusing on emotion regulation and interpersonal skills.

Calverton Hill

Patients spoke positively about therapies, such as offence related work and family therapy.

Eric Shepherd

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

Brooklands Hospital

The service hold Alcoholics Anonymous and Narcotics Anonymous groups from within the service on a regular basis, meaning all patients have access to support groups if appropriate and relevant. Posters advertising meetings were observed throughout the service and patients spoke highly of this innovation.

Fromside

Patients have a wide range of psychological and occupational therapy options available to them, which are reviewed by the multi-disciplinary team every three months.

Oxford Clinic

A full and varied programme of therapies, interventions and activities is available to patients. Patients commented on how they valued the mental health awareness and psychoeducation sessions. Education is provided by guest speakers on a variety of topics, for instance paranoia, diagnosis, and self-harm.

Arnold Lodge

There is an effective psychological formulation process in place at the service, which is facilitated by psychology and is adopted by all staff. The formulation covers topics such as patients' protective factors, historical background and their personal beliefs, which forms part of an action plan.

Newton Lodge

Activities

In 73% of services patients have a personal plan of therapeutic and skill developing activity directly linked to their outcomes plan.

93% of services provide information to patients to access local organisations for peer support and social engagement.

Good practice examples

The recovery college, workshops and multimedia suite are well resourced and provide opportunities for patients to develop a wide range of skills.

Cygnets Hospital Bury

Patients at the service utilise their skills from the woodwork shop to be involved in the refurbishment and decoration of the ward environment. More recently, patients have been involved in painting, decorating and construction work for the new IT facility as well as the new 'Craft Cabin' shop which has opened.

St Mary's Hospital

The occupational therapy department offer sessions in woodwork, horticulture, arts, sports, and education. There is a recovery college that delivers a wide range of courses for students to enrol in and develop skills/gain work experiences or participate in delivering training to others.

Northgate Hospital

Patients engage in a furniture restoration project, musical activities and sports groups. There are facilities which promote skill development, for instance patients can work in the onsite shopping outlets Chescos and Chesbucks.

Cheswold Park Hospital

There are excellent links with local community organisations, including a football club, rugby league and access to an alcohol-free bar for social engagement. Some patients have also worked in a car mechanics in Manchester which has provided them with an employment reference.

Scott Clinic

Staff support patients to access a wide range of community activities. This includes community drop in centres and gyms in the city centre that provide 24-hour access and the occupational therapy team are working to provide patients with opportunities to gain cooking qualifications.

Northside House (formerly Norvic Clinic)

Patients are able to plan their activities for the day in the morning, such as music group, gym or cooking, and staff try to accommodate these where possible. The service offers patients a wide range of educational activities, including the newly developed recovery college. The service already has 50 students taking various courses, such as understanding mental health.

Oxford Clinic

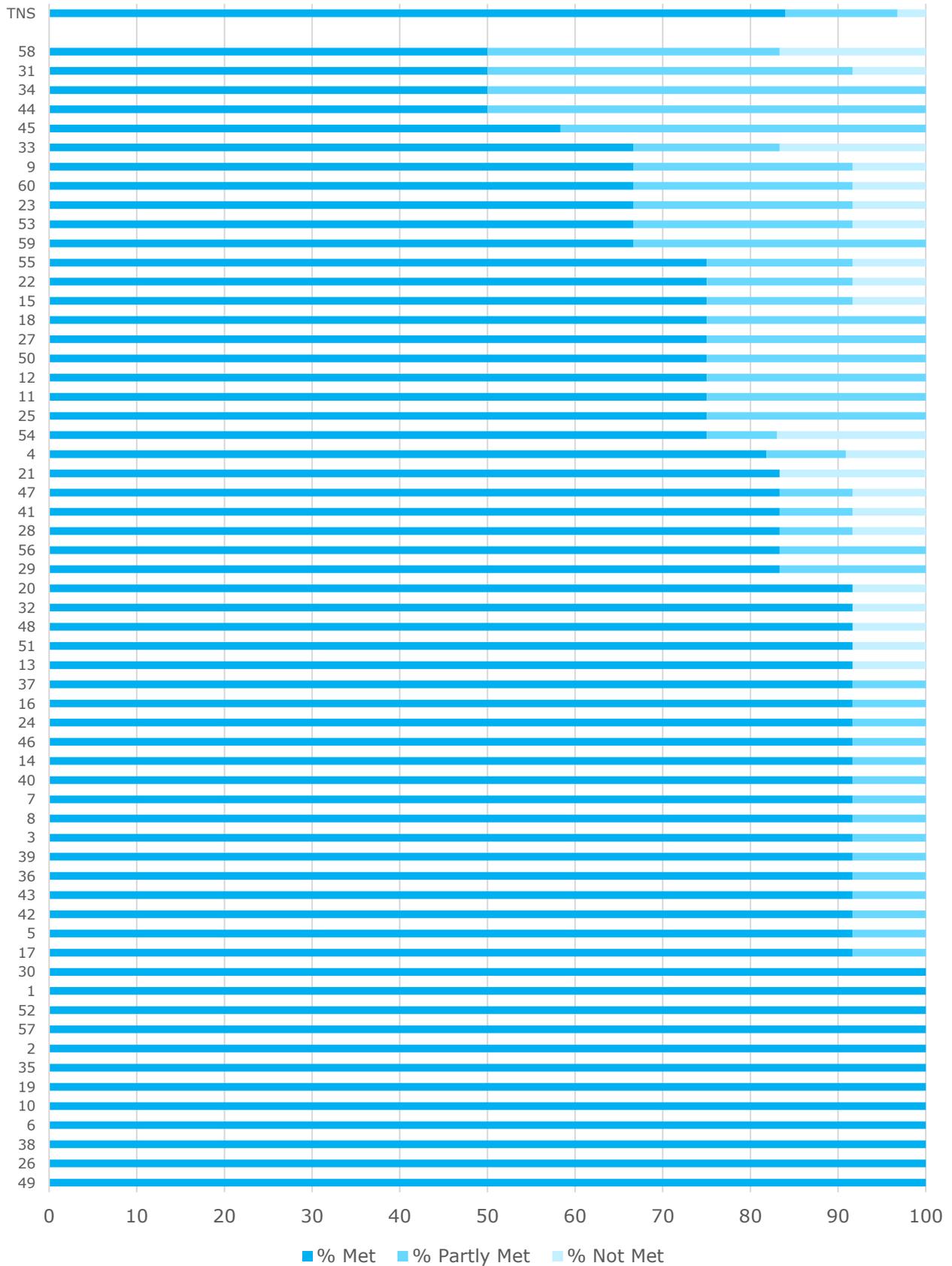


Figure 11: Percentage of criteria met, partly met and not met for each service relating to Treatment and Recovery.

Medication

On average, services fully met 77% of standards in this area, ranging from 20% to 100% compliance.

Pharmacological Interventions

97% of services set treatment targets for the patient, review risks and benefits and set timescales for response.

In 48% of services, the safe use of high risk medication is not reviewed and audited annually.

Patients in a majority of services are supported to understand the functions and side effects of their medication.

Good practice examples

The service has introduced an e-prescribing system to improve the efficiency of prescribing and eliminate errors.

Arnold Lodge

The service has employed a pharmacist, which has proven to be successful in providing patients with in-depth information about their medication and mental illness. This was noted to be highly regarded and helpful for both the MDT and patients, in terms of gaining and supporting an understanding of their illness and forms of treatment.

Hatherton Centre

As a way of tackling the challenges of not having a GP on site, the team have just finalised setting up a weekly physical health clinic that will be called the 'Monitoring of Treatment' (MOT) clinic and this will be run by newly qualified nurses. The clinic will focus on assessment tools for side effects of medication and physical health monitoring, and all staff will undertake physical healthcare training including healthcare assistants.

Marlborough House

Each team has a pharmacist who attends ward round and is involved in monitoring prescriptions and auditing medication. Pharmacists are also part of the multi-disciplinary team.

Tamarind Centre

Patients receive good information regarding their medication with discussions being held on the reasons why they are on certain medications and their side effects.

The Orchard

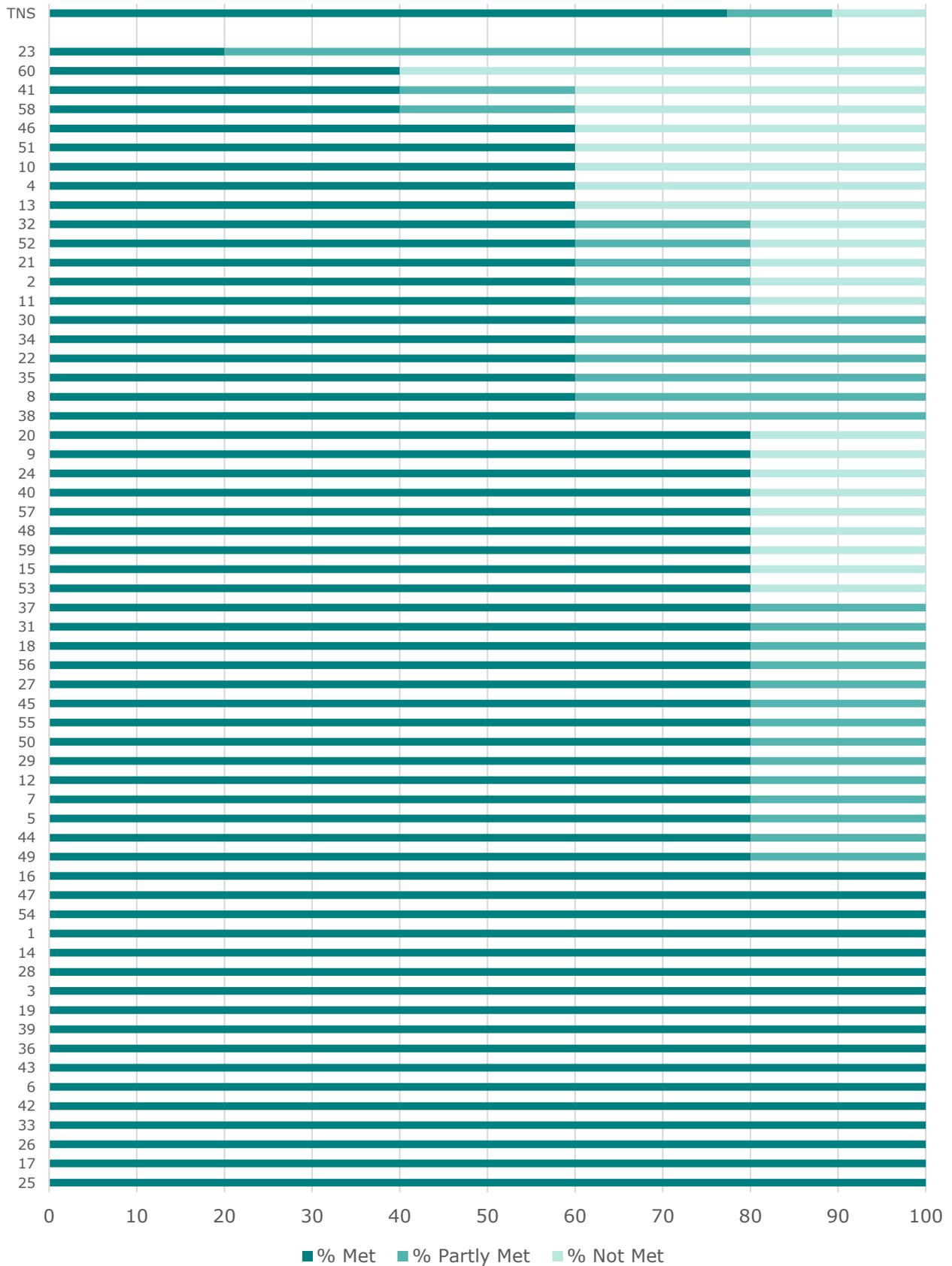


Figure 12: Percentage of criteria met, partly met and not met for each service relating to Medication.

Leave and Discharge

On average, services fully met 95% of standards in this area, ranging from 40% to 100% compliance.

Discharge Arrangements

98% of services are working proactively with the home area care coordinator and the next point of care to develop robust discharge and transfer arrangements and to minimise delay.

Good practice examples

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. The whole MDT remains consistent for the patient on discharge as long as they have the same responsible clinician.

Edenfield Centre

Staff support patients with practical arrangements in relation to discharge or transfer, working closely with the community nurse or receiving team to ensure medication compliance and to address any immediate needs or concerns. Trial leave provides the opportunity for patients to transition gradually and enables the service to identify potential issues.

North London Clinic

The service has a vocational specialist who assists in securing paid roles for patients, and some patients have secured paid apprenticeships in horticulture and fitness instructing. There are useful courses for patients to attend, covering topics such as money management and budgeting in order to prepare for discharge.

Brockfield House

The establishment of a dedicated Service Outreach Transitions Team (SOTT) has resulted in a more streamlined process for discharge. The team are confident in their work and continue to establish and strengthen relationships with community providers.

Northgate Hospital

The implementation of the Forensic Outreach Liaison Team (FOLS) as a new initiative and the team's relationship with them has evidently been a success. It enables community links and can prove extremely useful in preparing patients for discharge and in guiding them through the discharge process. The FOLS helps set patients up with a GP local to their discharge area, in addition to a membership with the gym and the library.

Trevor Gibbens Unit

Support

97% of the services support patients to access organisations which offer housing support and financial support, including benefits and debt management and 97% identified and addressed immediate needs of patients regarding transitions.

Good practice examples

Aurora ward was observed as a fantastic pre-discharge ward for medium secure patients who are approaching discharge into the community. It is formed of 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

Recovery activity staff on Newstead ward organise scenario planning to help prepare patients for discharge. This entails orchestrating activities with patients, such as role playing and budgeting for real life scenarios. Patients are encouraged to use the internet to view properties and to facilitate imaginary online shopping sessions, enabling them to practice budgeting and handling finances.

Calverton Hill

There is an occupational therapist on each team in the hospital and they are involved in developing new initiatives. There is currently a particular focus on patients developing functional skills to support them to progress through the pathway and transition between services.

Central Mental Hospital

Eric Shepherd Unit are able to provide continuity of care between the medium and low secure unit. As the MDT work across both parts of the service, patients are able to develop strong therapeutic relationships with their care team.

Eric Shepherd

The service has a separate flat for two patients on one of the wards for independent living. Flats include a kitchen for patients to cook their own meals, and these patients have leave to buy their own food shopping.

Ravenswood House

The service is able to provide continuity of care to patients when discharged to the community. This is done by inviting the integrated community team to discharge meetings, where they are also able to meet carers, and by maintaining patients in the consultant's caseloads.

Tamarind

Leave

97% of services develop a leave plan jointly with the patient that addresses the relevant areas, including: the aim and purpose of section 17 leave; conditions of the leave; a risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; and contact details of the service.

Good practice examples

Patients who have leave were very positive about the wide variety of activities available to them, which is evidenced by the comprehensive Bracton Therapies Programme.

Bracton Centre

There are a range of good links with community services for those with leave, giving patients 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.

Caswell Clinic

The service has excellent links with community organisations and it offers a wider range of activities and educational opportunities for patients with unescorted leave. For patients that do not have leave, they are able to engage several in-house vocational activities. Patients can also enjoy the multi-faith space and ground leave to visit the pond.

Cheswold Park Hospital

Chaffron Ward is a progressive and supportive environment for patients who are at a more stable point in their pathway and are approaching potential discharge. Patients have their own mobile phones and cook their own meals which patients feel is useful in helping them move on. All patients on Chaffron have leave, the majority unescorted, and risk is well managed.

Marlborough House

Patients are able to propose suggestions for activities to undertake on therapeutic leave, such as volunteering, a walking group, or attending the gym.

Oxford Clinic

Prior to patients going on home leave, their family members are consulted in a timely manner to seek their agreement. The social worker also visits family members at home before the leave takes place, to ensure carers feel comfortable before home unescorted leave.

Hellingly

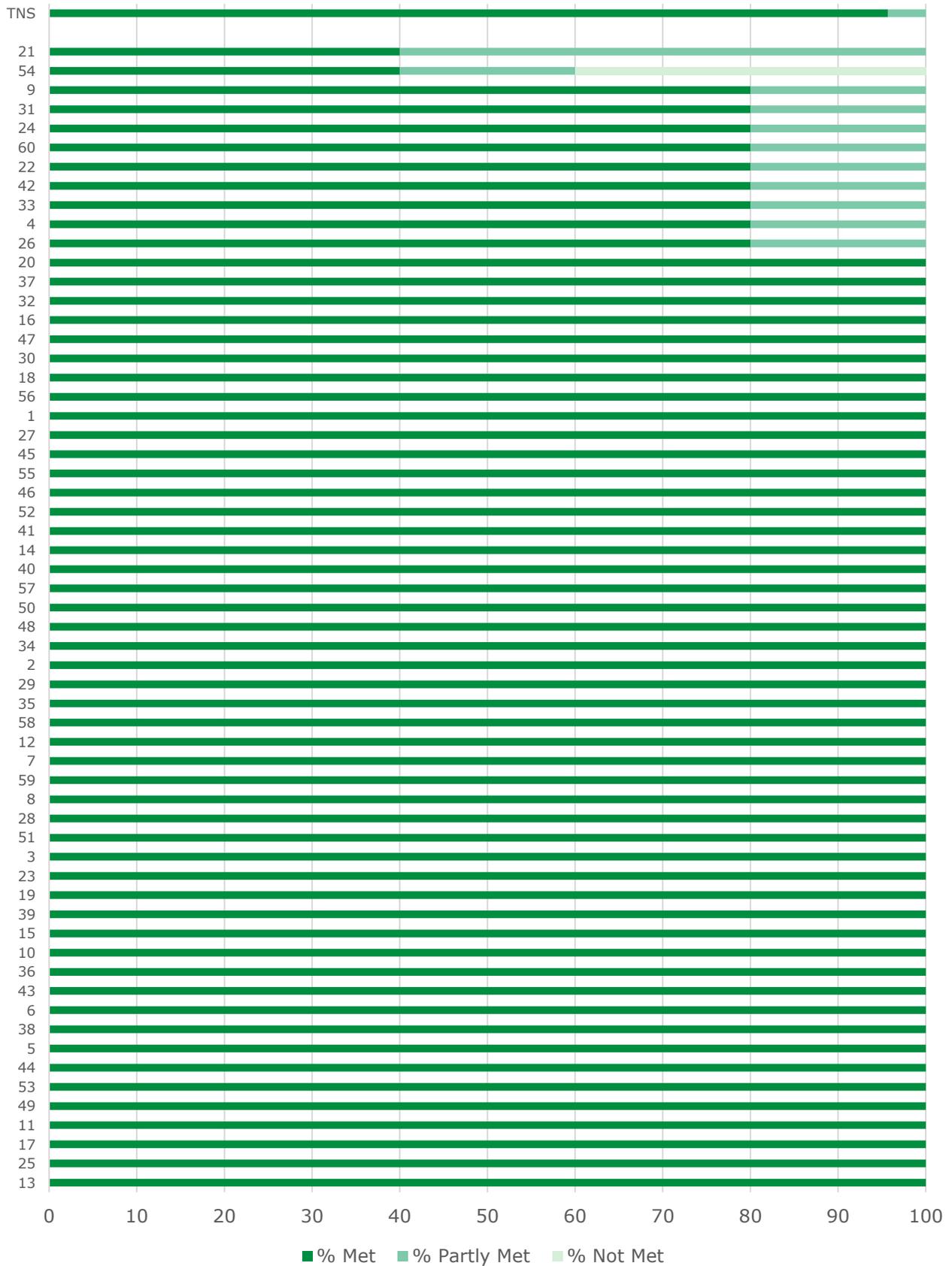


Figure 13: Percentage of criteria met, partly met and not met for each service relating to Leave and Discharge.

Physical Healthcare

On average, services fully met 83% of standards in this area, ranging from 38% to 100% compliance.

Physical Assessment and Examinations

95% of services have their healthcare needs assessed on admission, which is reviewed every six months or according to need.

Screening programmes are available to patients in line with those available to the general population in 92% of services.

73% of services offer patients a staff member of the same gender as them for physical examinations.

Good practice examples

The onsite physical health centre, Stour, essentially replicates a GP surgery that patients would access in the community, with its own full time GP and clinics. The aim is to give patients responsibility to make and attend their own appointments once they have the appropriate leave.

Langdon Hospital

A range of physical health initiatives are in place, such as a Men's Health Week, which involved 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.

Hatherton Centre

Patients have access to a GP, optician and chiropodist. Feedback was very positive from patients regarding their physical health assessments and being able to get effective healthcare advice.

St Andrew's Healthcare Birmingham

As a way of tackling the challenges of not having a GP on site, the team have established a weekly physical health clinic that will be called the 'Monitoring of Treatment' (MOT) clinic. This is run by newly qualified nurses. The clinic focuses on assessment tools for side effects of medication and physical health monitoring, and all staff undertake physical healthcare training, including healthcare assistants.

Marlborough House

The service has implemented the 'Wellman' checks that includes specific advice and information on 'checking yourself' and screening processes.

Woodview

Managing a Healthy Weight

97% of services have care plans that consider physical health outcomes and interventions, including: health awareness; weight management; smoking; diet and nutrition; exercise; and any patient specific items.

88% of services provide patients with targeted lifestyle advice and health promotion activities.

Good practice examples

There is a good focus placed on physical health monitoring, with the display of posters detailing healthy eating advice and physical exercise provisions. There are groups, such as a walking group that patients can partake in to gain physical exercise, as well as a very well-equipped gym and a sports hall.

Caswell Clinic

There are personal trainers working within the service who are motivating the patients to get involved with activities such as yoga and Zumba; something that is greatly appreciated by patients. There is a full-time physical health nurse working at the service who assists in providing regular physical health assessments.

Central Mental Hospital

Initiatives and opportunities for health awareness and interventions is extensive. This includes a diabetes clinic, a dietician, a health promotion group and various exercise groups. One current group initiative is 'lose 1000lb for £1000', incentivising patients to lose weight together in order to raise money for charity.

Cheswold Park Hospital

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.

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 Healthcare Nottinghamshire

'Mission Fit' is an initiative which has been developed to focus on regaining and retaining a healthy weight, including promoting exercise, a healthy lifestyle and goal-setting for patients. Additionally, there is a traffic light system for purchasing items within the shop, which acts as a form of advice and guidance for patients when selecting food. Red items are generally the least healthy items, and patients are allowed a restricted number of such items.

The Spinney

Good practice examples

The service is committed to providing physical health awareness to patients and promotes 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 a dietician that advises the patients on healthy eating. Exercise is encouraged through the use of the gym and Zumba sessions are also held for the patients. The service is actively involved in a number of physical charity events and patients are encouraged to take part in them.

Arbury Court

The 'Taking Control' initiative was developed as a result of a focus group being held with patients, who fed back that they would like to access Weight-Watchers and wanted a sense of belonging. 'Take Control' revolves largely around the branding, including T-shirts, offering patients an opportunity to identify and feel a sense of belonging, whilst also attempting to break down barriers between patients and staff. Groups available to patients consist of nutrition, goal-setting, fitness, and 'Take Control' booklets are in place, which are graded depending on patient progress.

Ridgeway

The provisions for physical health and exercise at the service are commendable. There is a large, fully-equipped gym which all patients have access to daily. A gym instructor has joined the service to deliver sessions at the gym and has developed a structured timetable to meet the needs of patients which has increased patient's engagement and motivation to exercise.

Scott Clinic

Patients reported their physical health being looked after, and weight being monitored. Staff encourage patients to go outside to exercise as much as possible and there is a gym available to patients.

Trevor Gibbens Unit

Patients are able to access the gym, receive support and advice on healthy eating, receive monthly weight checks, annual health checks and regular blood pressure checks and blood tests. All the patients spoken to on the day were aware of this and the service helps to ensure that patients are receiving the same support as they would in the community.

Woodview

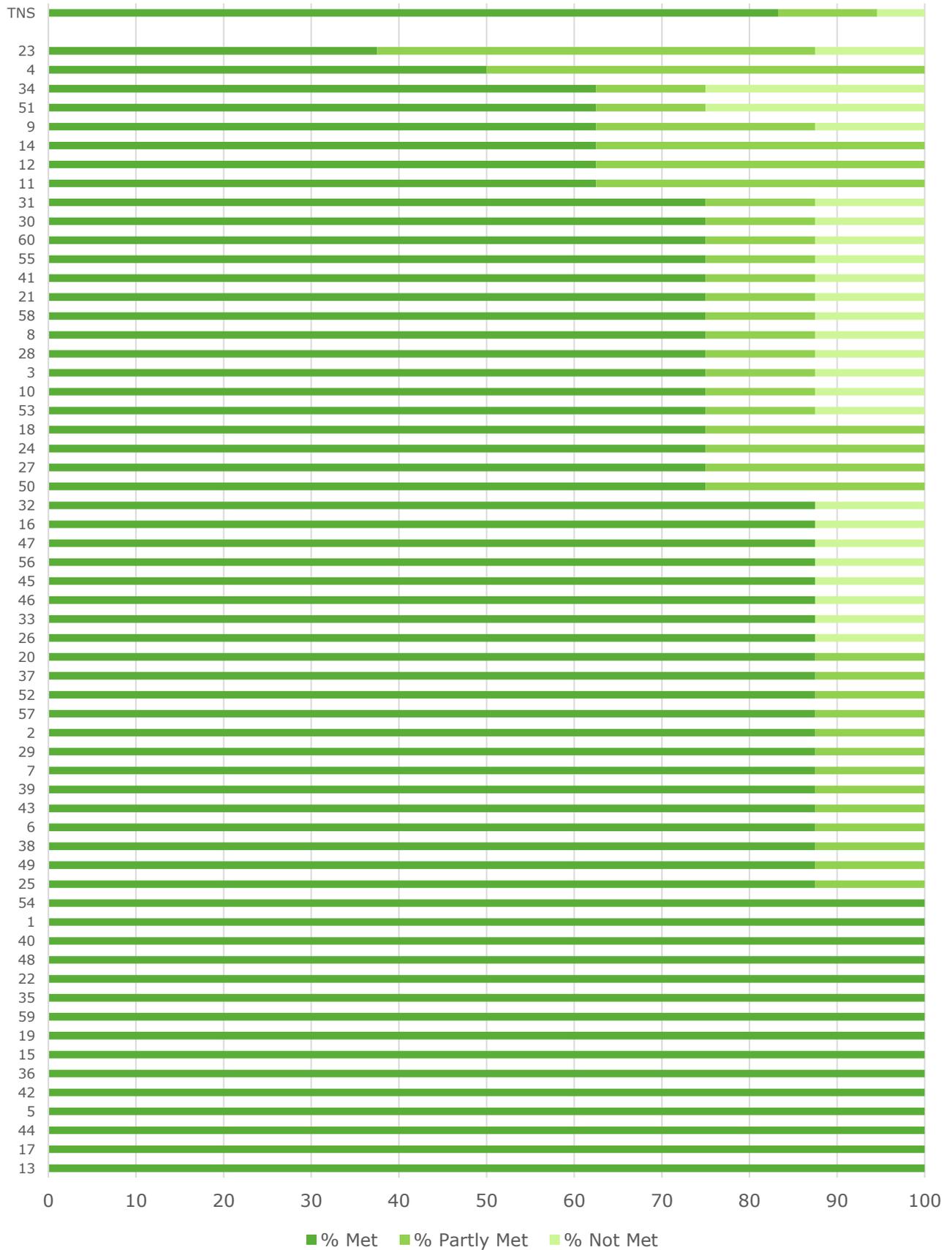


Figure 14: Percentage of criteria met, partly met and not met for each service relating to Physical Healthcare.

On average, services fully met 65% of standards in this area, ranging from 18% to 94% compliance.

Supervision

57% of services are providing weekly supervision for newly qualified staff members or those in training.

Clinical supervision is not provided monthly to all clinical staff members in 45% of services, and 55% of services are not consistently providing line management supervision for staff on a monthly basis.

87% of services are providing staff members with an annual appraisal and personal development planning.

Good practice examples

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.

Cygnnet Hospital Bury

Staff reported receiving good supervision and a new debriefing system has been developed. Staff highly value the clinical supervision being provided by the service. The service has also developed a new debriefing system where, two weeks after the initial debrief, the team meets again to discuss the incident and the implications of it on the staff, as well as an update on what has been done about it.

Fromside

Staff morale is high, and there are initiatives to help staff feel supported. Staff reported they are supported on the ward, and there are lots of opportunities for informal supervision.

Northside House (formerly Norvic Clinic)

Staff feel their health and wellbeing is supported by the service and good morale was observed throughout. Staff receive monthly formal clinical supervision but are able to access informal supervision when they feel they need it and managers facilitate this.

Shannon Clinic

Staff have regular access to reflective practice, with the ICU ward running it weekly. Their managerial supervision follows a 'Working Better Together' format, and newly qualified occupational therapists have access to preceptorship and Band 5 supervision.

Tamarind

Staff Well-being and Support

62% of services are providing formal reflective practice sessions on a monthly basis.

Staff members in 40% of services did not feel that their health and wellbeing is supported.

Staff from 88% of services felt that they could raise any concerns about standards of care and 78% felt confident to contribute to and safely challenge decisions.

Good practice examples

Staff health and wellbeing is being looked after by the service through three-weekly reflective practice sessions, a trauma counsellor attending the service after incidents, phoneline support access, access to six counselling sessions if needed and a physiotherapist is available.

St Andrew's Healthcare Birmingham

It is evident that the management team have made efforts to improve staff wellbeing and morale across the service. There is a 'Freedom to Speak Up Guardian' for staff to approach if they would like to discuss concerns confidentially, as well as a wellbeing steering group and weight management group for staff. The service has opened the gym to staff and offers sessions on yoga and mindfulness. There is also a robust occupational health department offering counselling, physiotherapy and other wellbeing initiatives for staff.

Newton Lodge

The staff team are highly committed and enthusiastic about the service. Management encourage the team to contribute to decisions and staff feel confident sharing their ideas. Staff also reported that they feel comfortable raising concerns and challenging decisions about patient care and treatment.

North London Clinic

Staff reported that there is a strong community feel amongst the staff group and good levels of support are available. Staff have regular supervision and access to support services such as trauma counselling. Management are supportive and open to suggestions as to how to improve the service. There are a large number of training opportunities available.

St Andrew's Northampton Men's Service

Staff reported feeling supported whilst on sick leave and having access to 'Be Well', which is a platform that provides different fitness activities for staff, such as boxing and dancing. A confidential helpline is also available for staff.

Shannon Clinic

Training

Over 80% of services provide new staff members, including bank and agency staff, an induction based on an agreed list of core competencies.

63% of teams receive training on risk assessment and risk management. This is refreshed in accordance with local guidelines.

However, patients and carers in 78% of services are not involved in delivering face-to-face training.

Good practice examples

The service runs annual training days for all staff members and the staff reported finding these highly beneficial for their professional development.

Brooklands Hospital

Staff reported being well prepared and trained for their role within the service. New staff are required to work on low intensity wards to get used to the environment before transitioning to more intense ward environments. It was positive to hear that staff benefited from their 24-day training package plus an additional two-week ward induction. One frontline staff member spoken to was very new to her role and it was clear she was very knowledgeable about the service and the policies and procedures.

The Orchard

Staff spoke of training opportunities provided by the psychology team, which include: dialectic behavioural therapy skills; coaching; and cognitive analytical training. Additionally, staff are supported through National Vocational Qualifications.

Cygnets Hospital Stevenage

The trauma-informed care initiative pilot has been very successful at the service, with increased compassion of staff and reduced burnout as a result. Staff receive a two-day training course around this and also focus on patient wellbeing, with the sole aim of bridging gaps between patients and staff and increasing awareness and understanding.

Ridgeway

In addition to the mandatory training and e-learning, the service holds bi-monthly in-house training days by using their internal resources. This allows staff to learn from each other and also deliver training to their peers. They use staff feedback to select which areas require training, previous examples include training on medication, sex offending, dialectical behavioural therapy (DBT) and Datix. The MDT meets on a monthly basis to review external training opportunities for staff to attend.

Ty Llewellyn



Figure 15: Percentage of criteria met, partly met and not met for each service relating to Workforce.

Governance

On average, services fully met 84% of standards in this area, ranging from 45% to 100% compliance.

Sharing Information and Lessons Learned

Nearly all services have systems in place to enable staff members to quickly and effectively report incidents, with managers encouraging staff members to do this.

88% of services have a meeting at least annually, with all stakeholders to discuss service developments, referrals, issues of concern and to re-affirm good practice.

Good practice examples

To improve communication the service has introduced a bulletin to ensure all staff are regularly updated on both service level and trust wide initiatives. A regular meeting is held for the whole staff team and there are good post-incident systems in place.

Broadland Clinic

The CEO communicates information of incidents, inspections, and peer reviews to all staff members. There is a quarterly lessons learned newsletter developed in collaboration with staff and patients.

Calverton Hill

The senior management team implemented a monthly quality walk around, in which questions are asked of staff which may be linked to the policy of the month and any lessons learned.

Kneesworth House Hospital

Lessons learned and findings from investigations are regularly reviewed and shared amongst the staff team through a number of avenues. These are brought to patient safety meetings for discussion, in addition to clinical local governance meetings, in which a member of staff will present on any lessons learned. There is a Quality Newsletter circulated monthly and a quarterly learning event. Additionally, complaints and incidents are reviewed and action plans devised as a result of this, which are also shared with staff. The service conducts audits on care plans, staffing numbers and the disciplines of staff attending reflective practice, to monitor and continually improve practice.

Trevor Gibbens Unit

The incident reporting system is clear and easy to use, and staff are provided with constructive feedback on their submissions during the daily meeting to ensure lessons can be learned.

Stockton Hall Hospital

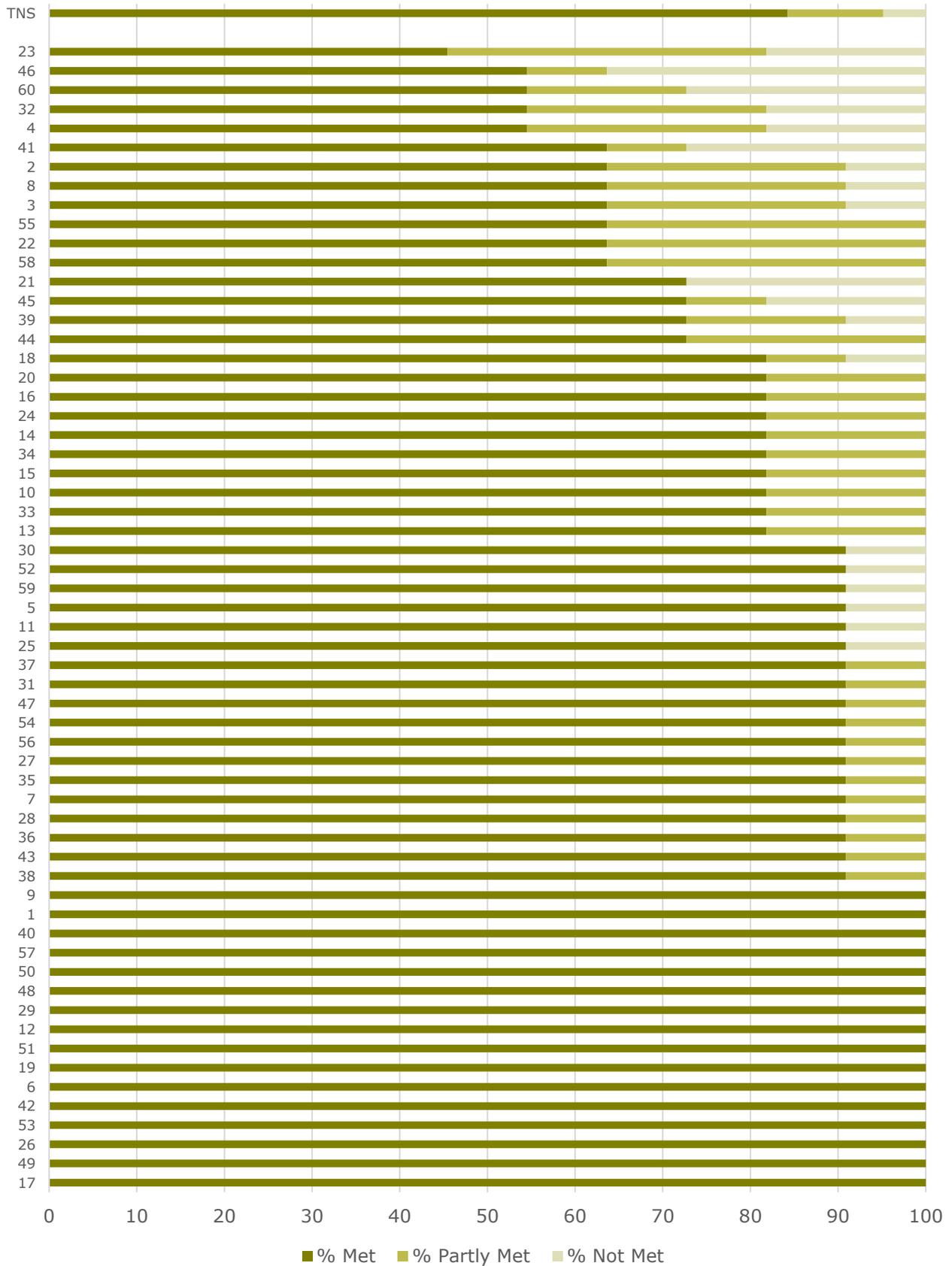


Figure 16: Percentage of criteria met, partly met and not met for each service relating to Governance.

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.

Mobile phones in medium secure units

A discussion thread was started to discuss the introduction of mobile phones in a medium secure forensic unit for males with learning disabilities and/or autism. This thread was to gather what other medium secure units are considering or have already got in place. This entailed whether there have been security procedures in place and if any issues have been faced when implementing this.

Respondents shared the following information:

- One medium secure service which is combined with a low secure unit, has introduced basic mobile phones in the low secure, which has no internet access or camera. The patients are only allowed to use their mobile phones in their bedrooms and they are on a pay as you go tariff. A protocol is now in place and they are looking to introduce this into the medium secure unit.
- A policy was shared on mobile phone guidance in medium secure units. *This can be downloaded from Knowledge Hub.*
- A further response from a combined service has introduced mobile phones and so far, there have been no issues experienced. Patients can retain their mobile phones at all times, with some agreed limits to usage such as not in therapeutic sessions. The default position is that all patients can have a mobile phone, which are individually risk assessed. Some patients also have personal smart phones which are used on community leave.

This discussion thread has demonstrated that low secure units are already implementing the use of basic mobile phones. Services that have implemented this successfully are now looking to implement this in a medium secure setting and this is risk assessed individually.

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 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 overall successful. 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.

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.

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.

Appendix 1 – Member Services’ Contact Information

Service Name	Key Contact Details	Patient Population
Arbury Court	Abi Scott Lead Administrator abi.scott@elysiumhealthcare.co.uk 01925 400600	Women
Ardenleigh Women's Service	Paula Ward Clinical Nurse Manager paula.ward8@nhs.net 0121 301 4770	Women
Arnold Lodge	Marimoultou Coumarassamy General Manager marimoultou.coumarassamy@nottshc.nhs.uk 0116 207 7700	Men & Women
Bracton Centre	Fiona Starkey-Norman Service Manager f.starkey-norman@nhs.net 01322 394349	Men & Women
Broadland Clinic	Homayoun Sepehrara Service Line Lead homayoun.sepehrara@nhs.net 01603 711180	Men & LD
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, Women & LD
Calverton Hill	Hayley Combe Administration manager / PA HayleyCombe@prioritygroup.com 01159 661 589	Men, Women & LD
Caswell Clinic	Sian Dolling Service Manager sian.dolling@wales.nhs.uk 01656 753 431	Men & Women
Central Mental Hospital	Sarah Hennessy Service Manager sarah.hennessy@hse.ie 00353-1-2157400	Women

Chadwick Lodge	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
Cygnet Hospital Bury	Fanuel Zendera Snr PDN fanuelzendera@cygnethealth.co.uk 01617 627 200	Men, Women & Deaf
Cygnet Hospital Stevenage	Sue Clements Hospital Manager susanclements@cygnethealth.co.uk 01438 342 942	Men & Women
Edenfield Centre	Terence Strong Operational Manager terence.strong@gmmh.nhs.uk 01613 582 111	Men & Women
Eric Shepherd Services	Charity Chitauro Matron charity.chitauro@nhs.net 01923 682 062	Men & LD
Farmfield	Malcolm Campbell Hospital Director malcolm.campbell@elysiumhealthcare.co.uk 01293 787500	Men
Fromeside	Lynn Bradford Performance and Business Manager lynnbradford@nhs.net 01173 784 315	Men, Women & LD
Guild Lodge	Mark Swan Service Manager mark.swan@lancashirecare.nhs.uk 01772 401695	Men & Women
Hatherton Centre	Melanie Watson Head of Operations melanie.watson@mpft.nhs.uk 01785 257 888	Men & LD
Hellingly	Nick Clark General Manager nick.clark@sussexpartnership.nhs.uk 01323 444 185	Men & Women
John Howard Centre	Dr. Clare Bingham Head of Psychology clare.bingham1@nhs.net 0208 510 2545	Men, Women & LD

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
Llanarth Court Hospital	Dr Damian Gamble Medical Director damiangamble@priorygroup.com 01873 840555	Men, Women & LD
Marlborough House	Trish Davies Service Manager trish.davies@oxfordhealth.nhs.uk 01865 902 601	Men
Newton Lodge	Catherine Eaves General Manager catherine.eaves@swyt.nhs.uk 01924 316 108	Men & Women
North London Clinic	Duncan Barton Hospital Director duncanbarton@priorygroup.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
Northside House (formerly Norvic Clinic)	Helen Lawrence Deputy Service Manager helen.lawrence@nsft.nhs.uk 01603 707 500	Men & Women
Oxford Clinic	Trish Davies Service Manager trish.davies@oxfordhealth.nhs.uk 01865 902 601	Men & Women
Priory Burgess Hill	Mark Taylor Hospital Director marktaylor@priorygroup.com 01444 231000	Women
Ravenswood House	Paul Gallagher Modern Matron paul.gallagher@southernhealth.nhs.uk 02382 310 000	Men

Reaside Clinic	Matthew Thomas Clinical Nurse Manager matthew.thomas6@nhs.net 01213 013 067	Men
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
Rohallion Clinic	Barbara Wilson Regional Service Manager barbarawilson3@nhs.net 01738 562 474	Men
Scott Clinic	Joey Dunn Senior Nurse joey.dunn@merseycare.nhs.uk 01514 727 591	Men & Women
Shaftesbury Clinic	Richard Stiles Forensic Manager richard.stiles@swlstg.nhs.uk 02035 136 065	Men
Shannon Clinic	Noel McDonald Operations Manager noel.mcdonald@belfasttrust.hscni.net 02895 046 100	Men & Women
St Andrew's Healthcare Nottinghamshire	Jo Baker Clinical Lead Joanne.Baker@standrew.co.uk 01623 665324	Men & LD
St Andrew's Healthcare Birmingham	Imelda Leon Operational Lead ileon@standrew.co.uk 0121 432 2173	Men & Women
St Andrew's Healthcare Northampton Men's	Cheryl Harrington Quality Business Partner Charrington@standrew.co.uk 01604 616139	Men, LD & Deaf
St Andrew's Healthcare Northampton Women's	Alastair Clegg Acting Director of Operations ABClegg@standrew.co.uk 01604 608704	Women & LD
St John's House Hospital	Fungai Nhiwatiwa Hospital Director fungainhiwatiwa@pioritygroup.com 01379 649989	Men, Women & LD

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
Stockton Hall Hospital	Bheks Nkomo Clinical Audit Lead bhekimpilonkomo@priorygroup.com 01904 400 500	Men, Women & LD
Tamarind Centre	Sarah Beasley Clinical Nurse Manager sarahbeasley@nhs.net 0121 301 0743	Men
The Humber Centre	Dave King Security Lead dave.king@nhs.net 01482 336 200	Men & LD
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 885637	Men
Thornford Park Hospital	Jo Sherman Hospital Director jo.sherman@elysiumhealthcare.co.uk 01635 273827	Men
Three Bridges	Sach Beeraje Senior Nurse Sachendra.Beeraje@westlondon.nhs.uk 02083 548 462	Men
Trevor Gibbens Unit	Claire Cloude Service Manager and Care Group Workforce Lead claire.cloude@nhs.net 01622 723100	Men & Women
Ty Llewellyn	Lisa Jones Matron lisa.jones17@wales.nhs.uk 01248 682 102	Men
Wathwood Hospital	Rick Fuller General Manager richard.fuller@nottshc.nhs.uk 01709 870 810	Men

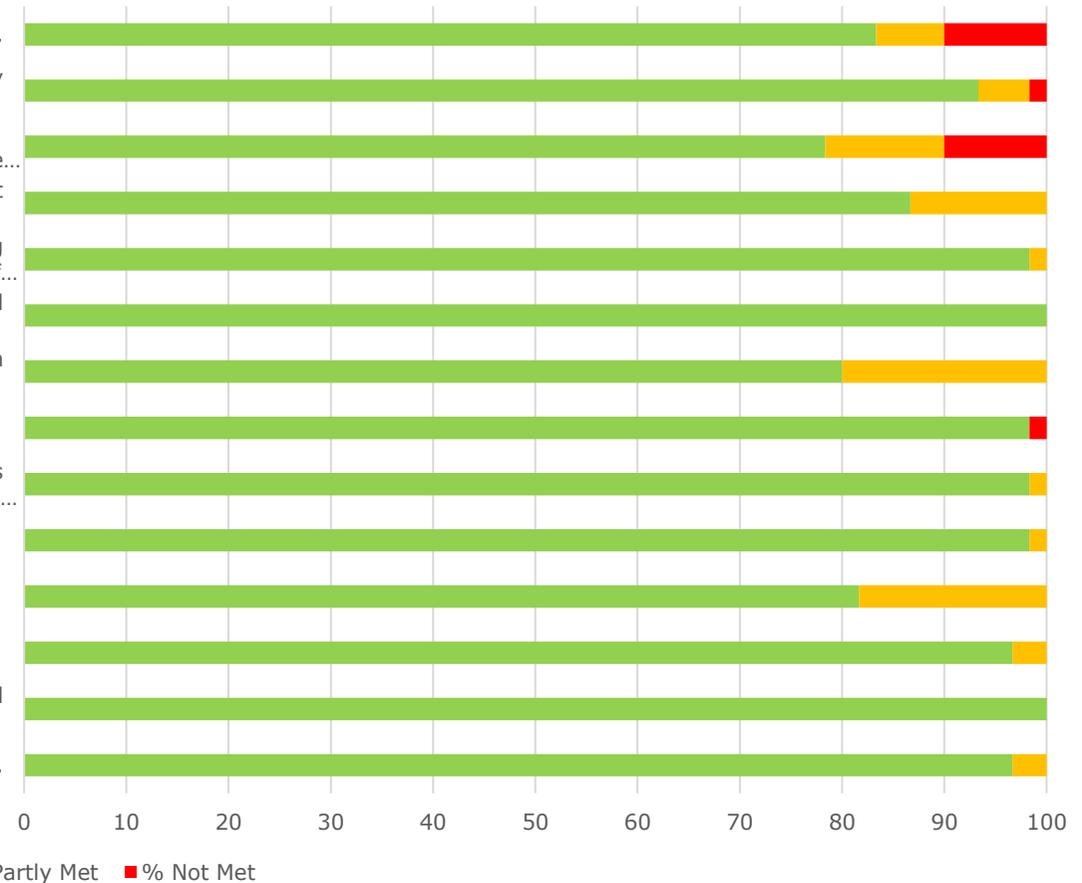
Woodview	Kim Seed Divisional Capacity and Flow Manager Kimberley.Seed2@merseycare.nhs.uk 01254 821346	Men
Wellesley Hospital	Gerry Graham Hospital Director Gerry.Graham@elysiumhealthcare.co.uk 01823 668150	Men & Women

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

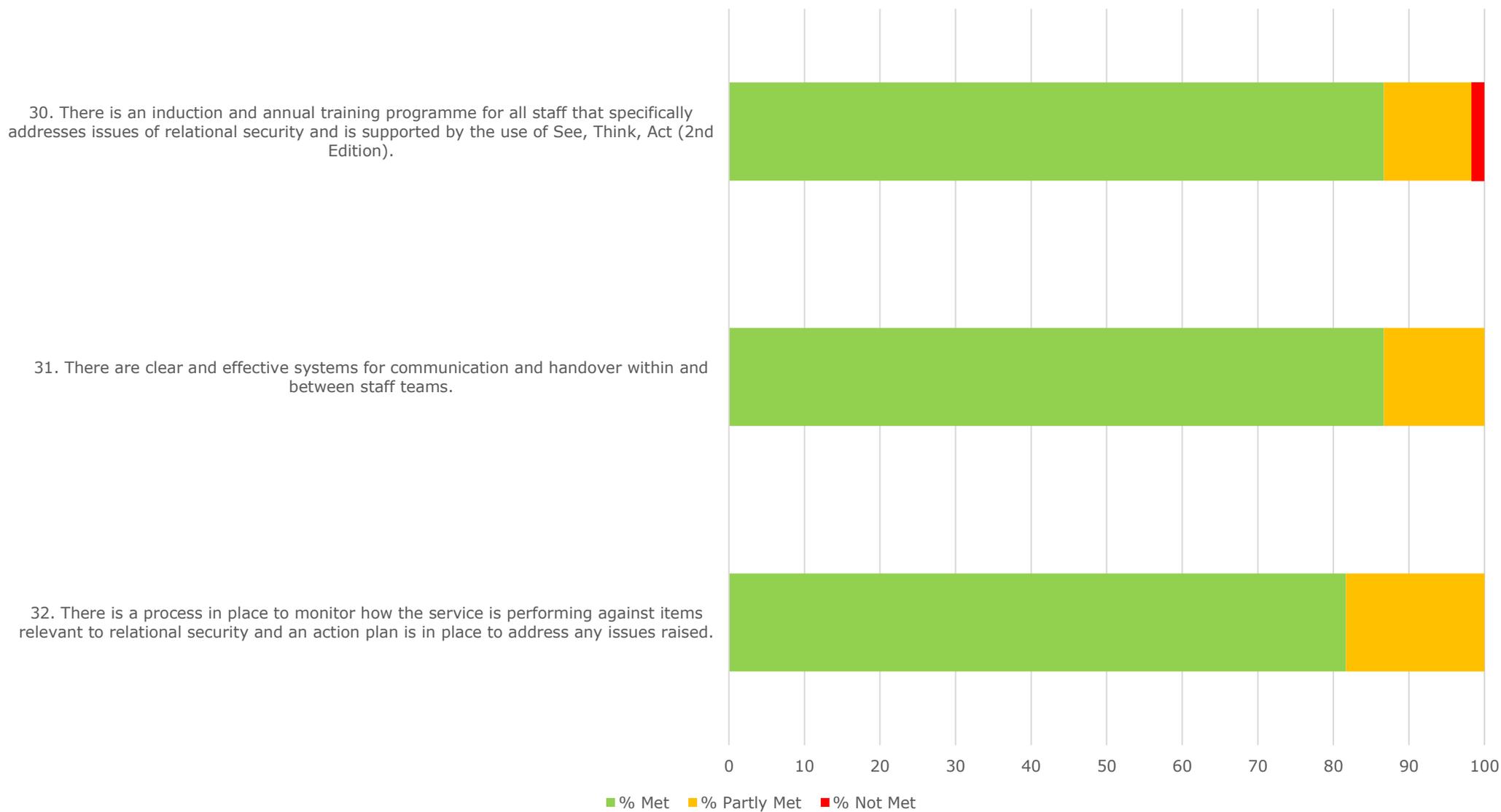
1. A physical security document (PSD) describes the physical security in place at the service.
2. The secure perimeter is in line with the planning specification for the level of security offered, is protected against climbing, and is easily observable.
3. There is a daily recorded inspection of the 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.



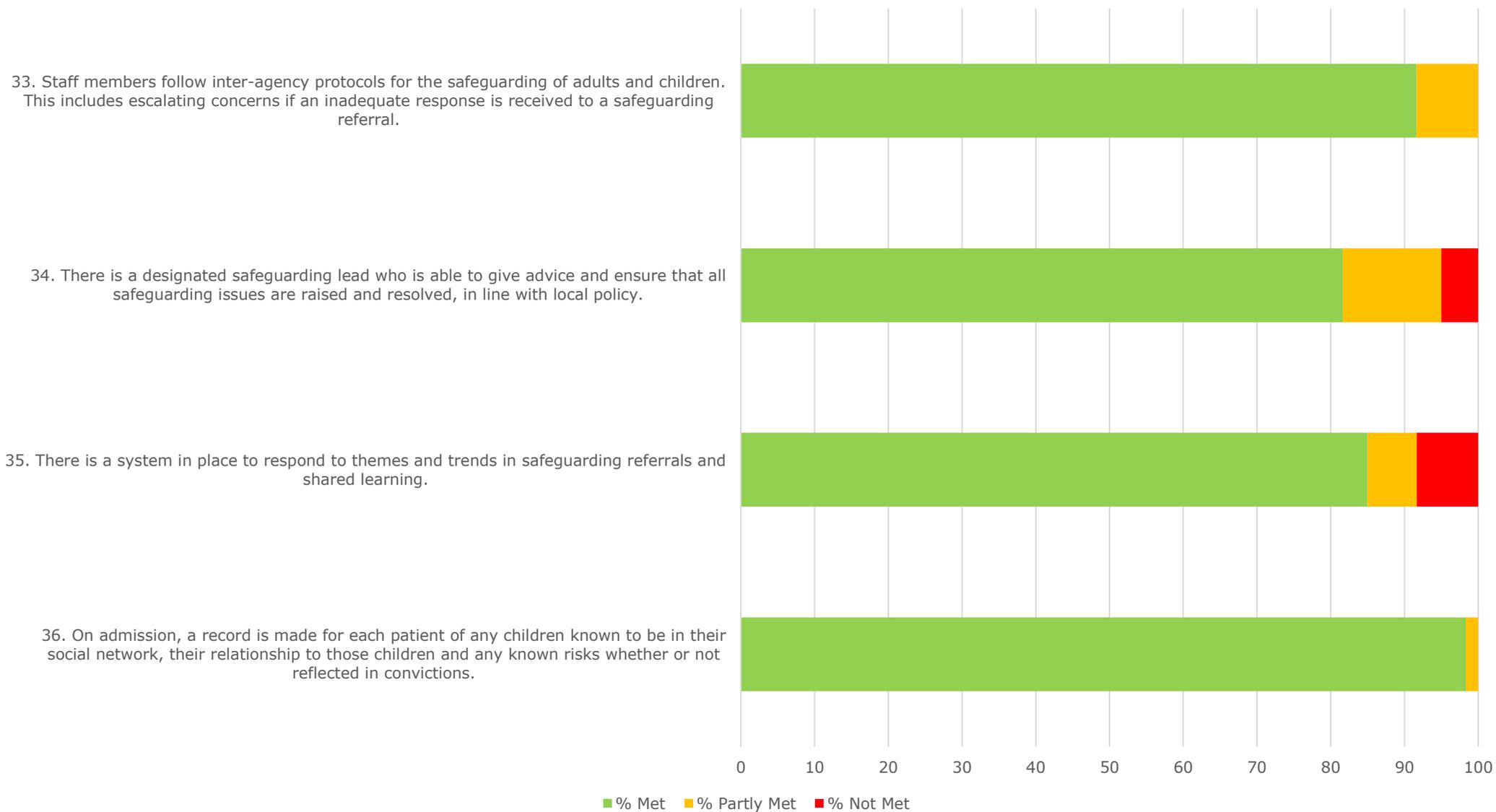
Procedural Security



Relational Security

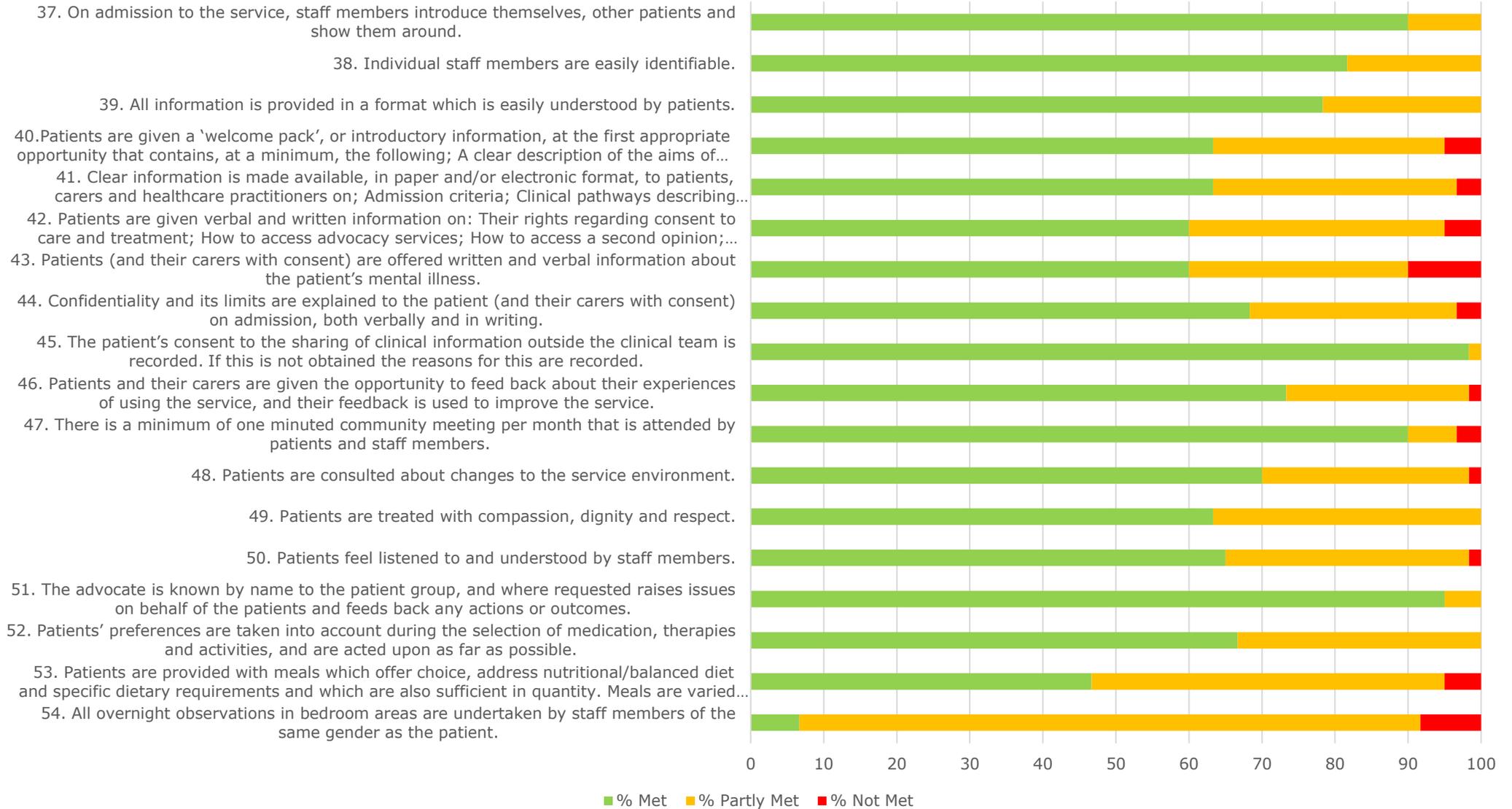


Safeguarding

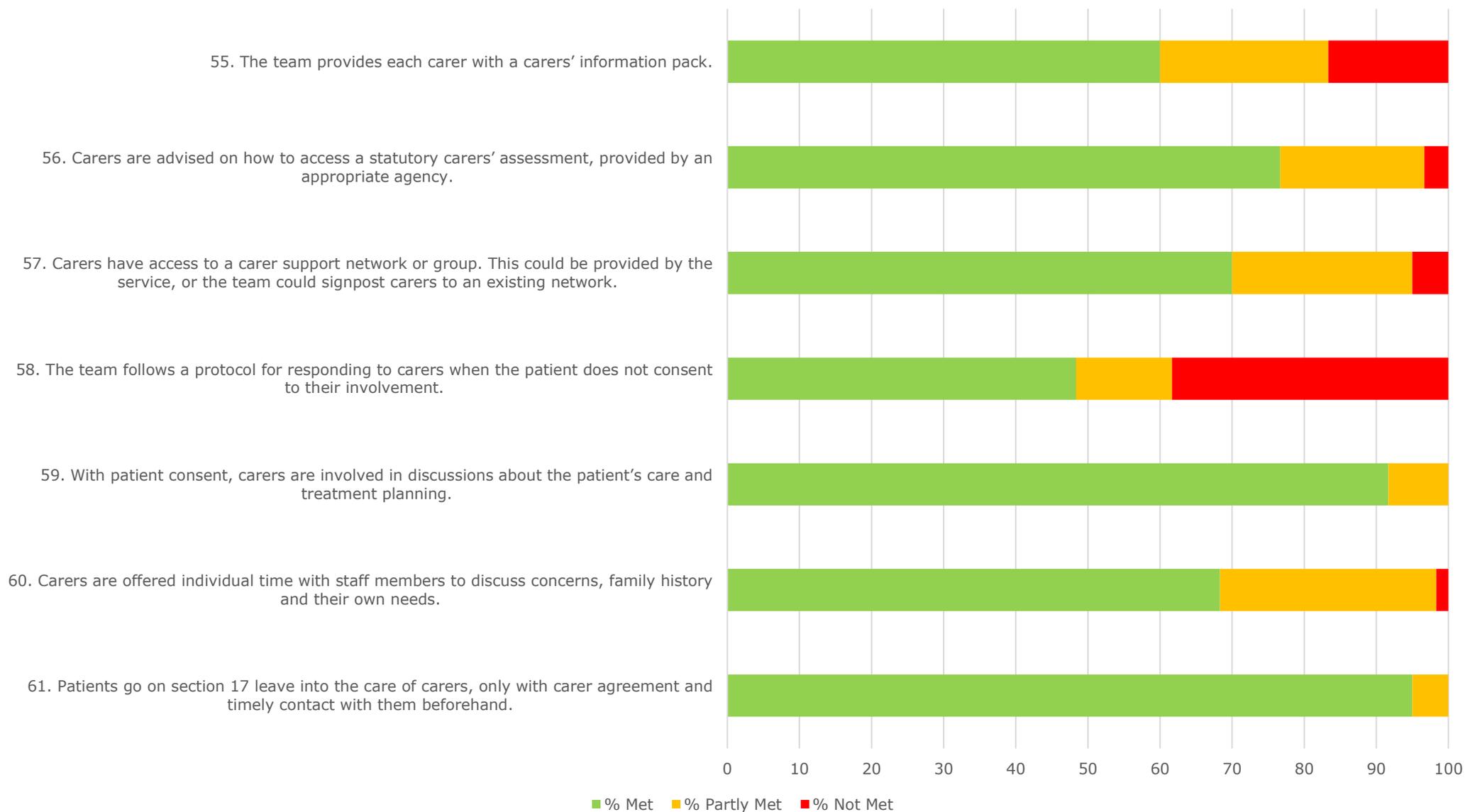


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Patient Focus



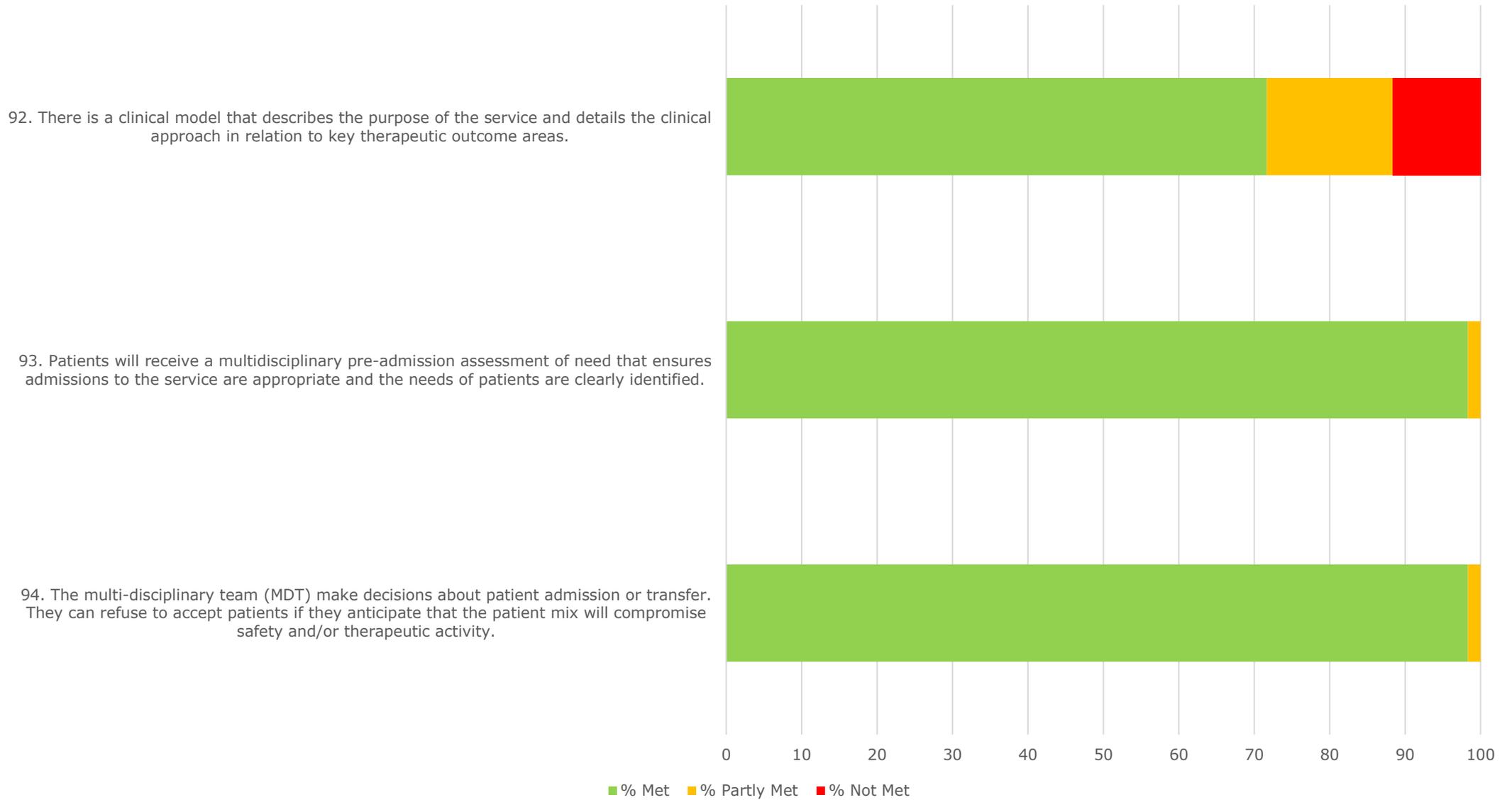
Family and Friends



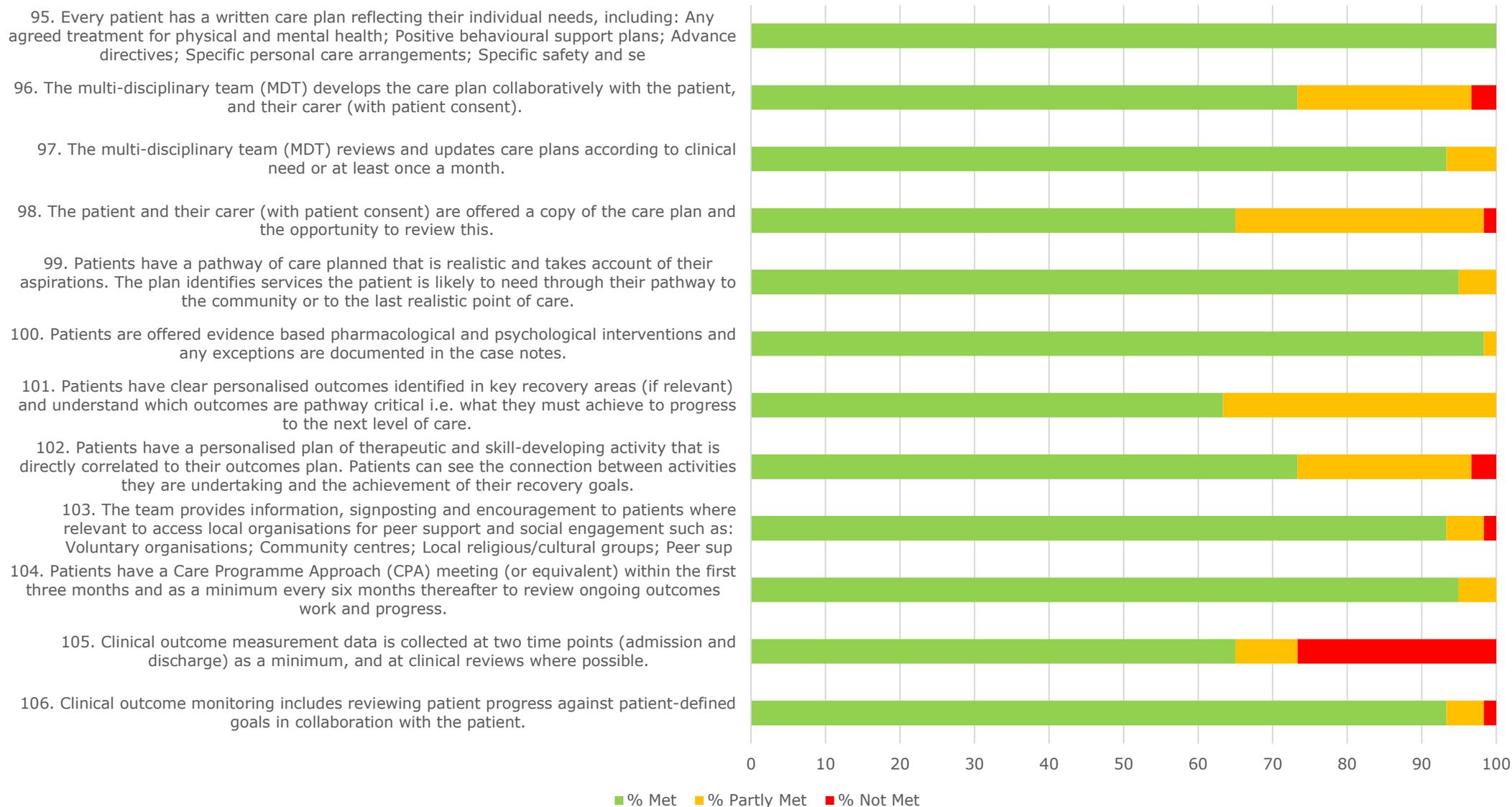
Environment and Facilities



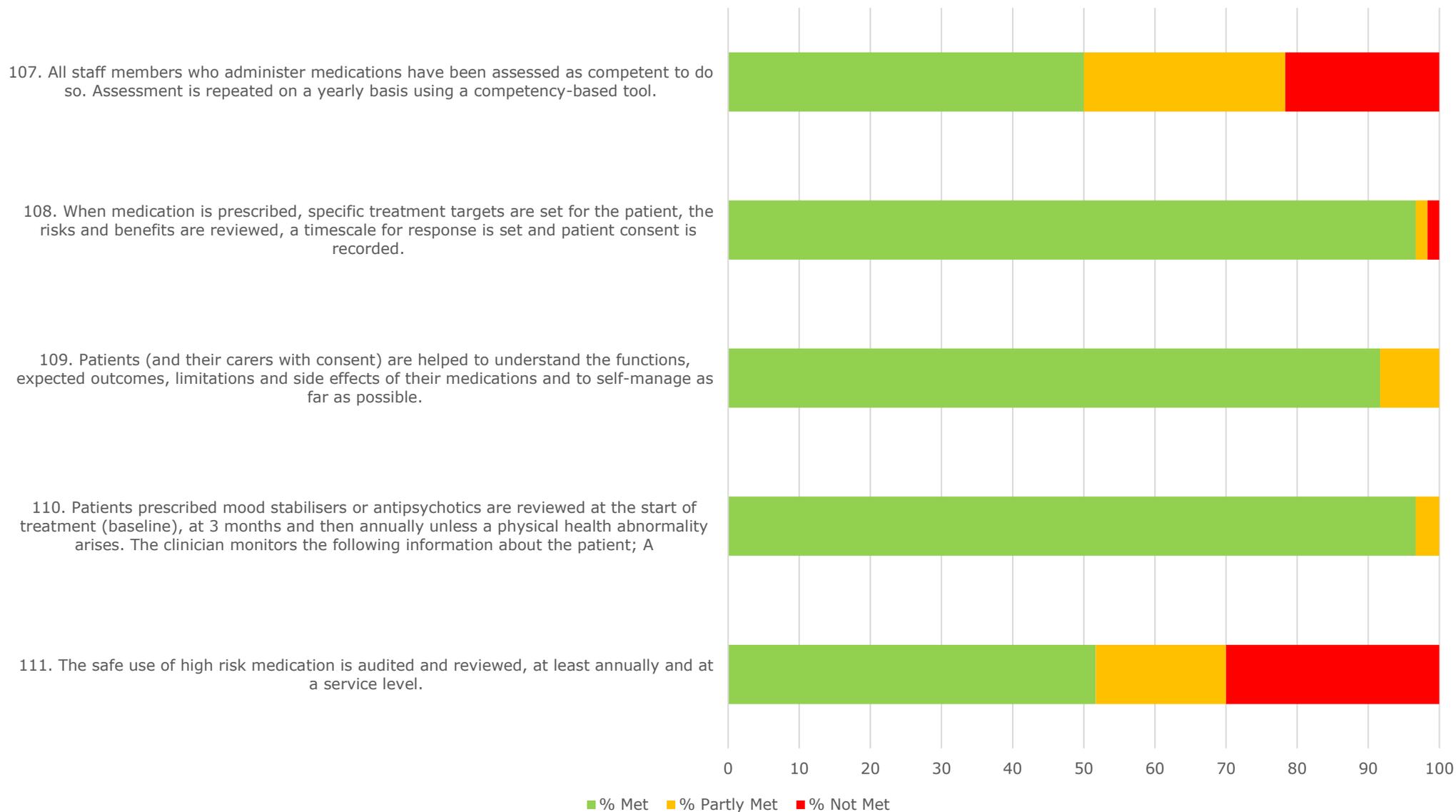
Admission



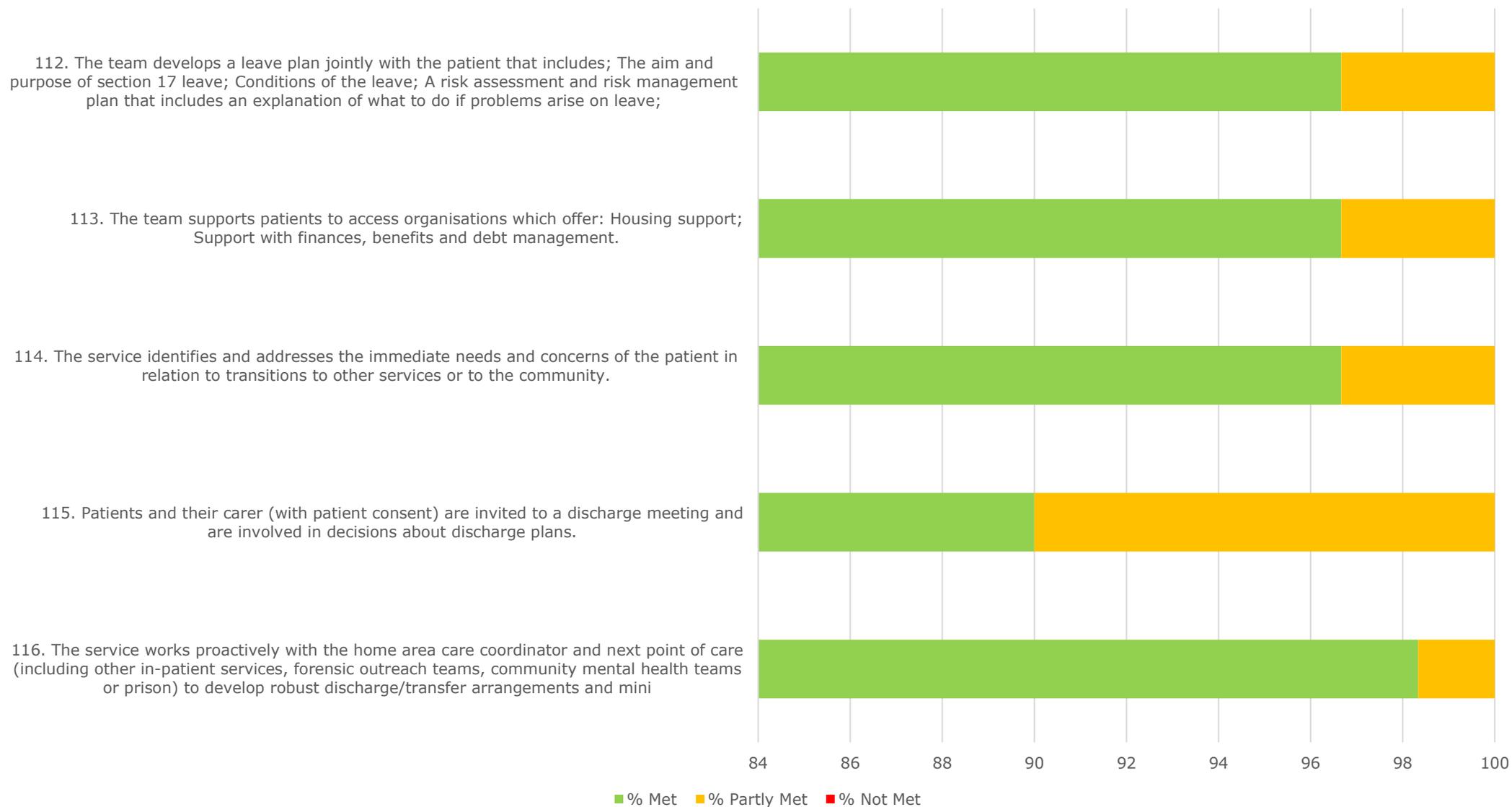
Treatment and Recovery



Medication



Leave and Discharge



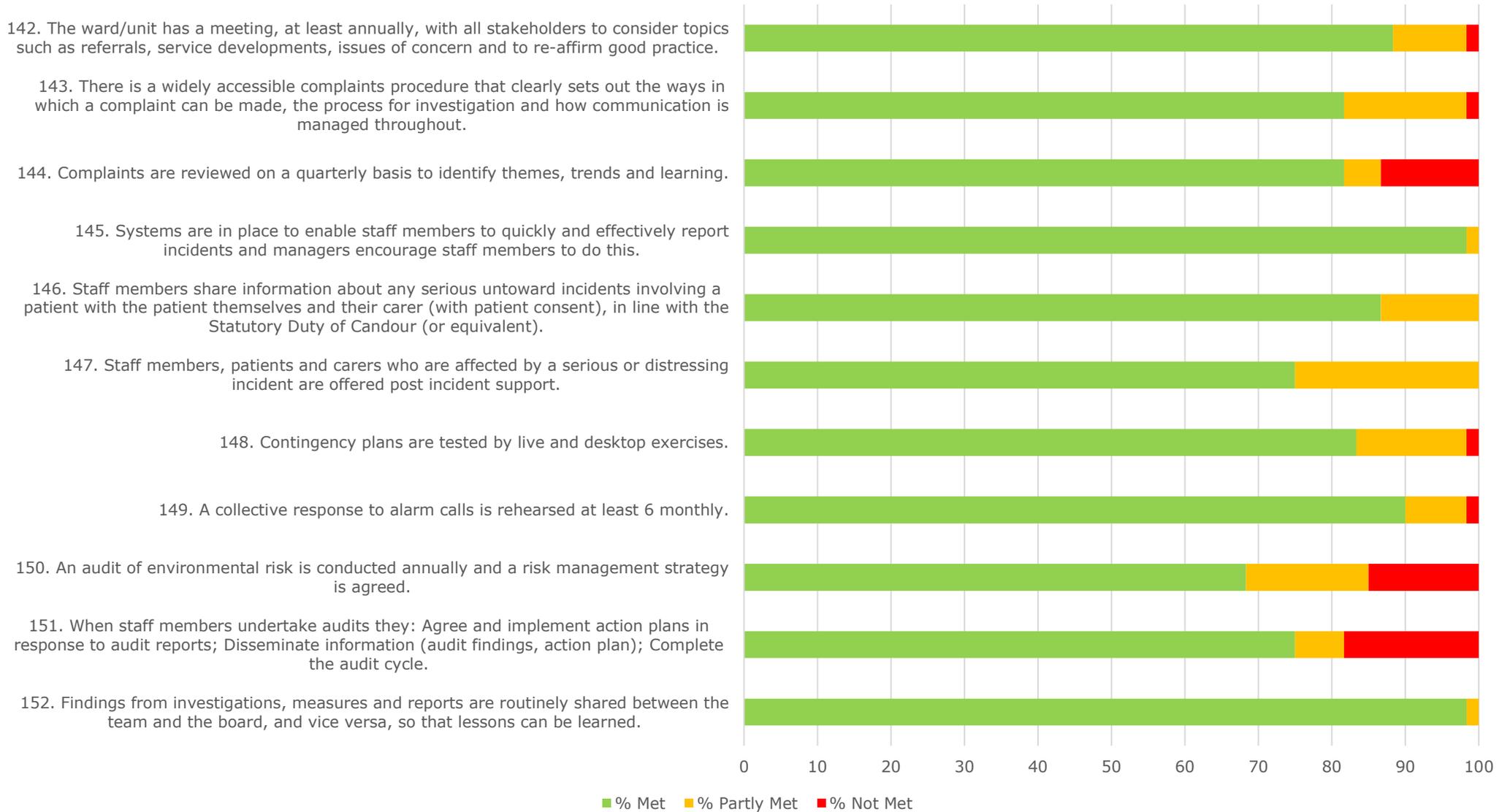
Physical Healthcare



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 – MSU Annual Forum, 22 May 2018.
Royal College of Psychiatrists, 21 Prescott St, London, E1 8BB.**

10:00 Registration and refreshments

10:30 Welcome and introduction

Quazi Haque, Chair, QNFMHS Advisory Group

10:35 Community forensic outreach services in Sussex

Dr Richard Noon, Consultant Forensic Psychiatrist and Clinical Director, Molly Lusted-Challen, Senior Social Worker, Marie Caliendo, Senior Social Worker, Sussex Partnership NHS Foundation Trust

11:00 Jay/Jail: Rapid prisoner assessment and management service

Dr Pratish Thakkar and Santosh Kumar, Tees, Esk and Wear Valleys NHS Foundation Trust and Richard Wood, 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

Recovery and Engagement

A: Our research findings: The additional recovery challenges facing forensic service users

Dr Deborah Alred, Consultant Occupational Therapist, and Richard Love and Chris Moxon, Peer Researchers, Hellingly Centre, Sussex Partnership NHS Foundation Trust

B: Relational Discovery: A framework for culture change, clinical and organisational practice

Louise Yorke and James McCarthy, Psychology Lead and Senior Clinical Pharmacist Prescriber, Langdon Hospital, Devon Partnership NHS Trust

Managing the Diversity Challenge

A: Supporting our staff in the face of hate and racism

Liz Allen, FrontFoot and Michael Humes, Patient Reviewer, CCQI

B: Promoting staff awareness of cultural competence within a medium secure environment

Piyal Sen and Grace Nyandoro, Medical Director and Head of Social Work, Elysium Healthcare, Chadwick Lodge and Eaglestone View

Family and Friends

A: How trauma affects family and friends involvement

Louise Maclellan, Family and Friends Representative, CCQI

B: OSCARS: Celebrating success together

Steven Clark and Leanne Bowditch, Lead Clinical Exercise Therapist and Lead Occupational Therapist, South West London and St George's Mental Health NHS Trust

13:00 Lunch and poster presentations

14:00 Managing the diversity challenge

Mat Kinton, National MHA Policy Advisor, Care Quality Commission

14:25 The value and purpose of the Carers' Toolkit

Mick McKeown, Professor of Democratic Mental Health, University of Central Lancashire

14:50 Refreshments and poster presentations

15:05 Workshop session 2

Women in Secure Services

A: Women's wellbeing

Hope Donnelly and Nancy Marsh, Therapeutic Working Day Coordinator and Forensic Recovery College Worker/Research Assistant, Bracton Centre, Oxleas NHS Foundation Trust

B: Empowering women in their recovery through secure services

Su Pashley, Patient Reviewer, CCQI and BG, Service User, St Andrew's Healthcare

Staff Support and Wellbeing

A: Learning from critical incident stress management – 110 debriefs over 6 years

Dr Michael Lawson, Consultant Clinical Psychologist, Hellingly Centre, Sussex Partnership NHS Foundation Trust

B: Valuing reflective practice in secure services

Karen Howell, Head of Psychology, Chadwick Lodge and Head of Psychology Profession, Northern Region

Promoting a Safe Environment

A: Making our services safer: using Safewards methodology in secure services

Kate Baker, Project Facilitator, and James C, Service User, Hertfordshire Partnership NHS University Foundation Trust

B: Use of technology to enhance the therapeutic impact of seclusion

Lucy McCarthy, Senior Research Fellow, Arnold Lodge, Nottinghamshire Healthcare NHS Foundation Trust

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 Medium Secure Annual Forum 2019, 21 May 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, Dr Sarah Markham, Patient Reviewer and Sheena Foster, Family and Friends Representative, QNFMHS

10:25 CQC's thematic review of restraint, segregation and prolonged seclusion

Jenny Wilkes, Head of Inspection (Mental Health), Care Quality Commission

10:50 (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

11:35 Refreshments

11:45 Preliminary findings from cycle 12

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

12:05 Workshop session 1

Restrictive practices

A: Reducing Restrictive Practice Collaboratively: Getting the balance right-working together

Rachael Aitken, Polly Hindle and Helen Goudie, Bamburgh Clinic, Northumberland, Tyne and Wear NHS Foundation Trust

B: Collaborative working supporting reducing restrictive practice and safe wards

Bhekimpilo Nkomo, Angus Wright and Shaun Wilkes, Stockton Hall, Priory Group

Novel Psychoactive Substances

A: NPS Substances 2019 – Where we are now

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

User involvement initiatives

A: Secure Carers Toolkit – Where are we now?

Sheena Foster and Louise Maclellan, Family and Friends Representatives, Quality Network for Forensic Mental Health Services

B: 'No Milk To-day' suicide awareness poem project

Kevin Scallon, Recovery Academy Edenfield Campus Lead, Edenfield Centre, Greater Manchester Mental Health NHS Trust

13:00 Lunch and poster presentations

13:45 Launch of the new standards for forensic mental health services

Dr Quazi Haque, Chair, QNFMHS Advisory Group

14:00 The Digital Evolution: Using technology to improve patient safety

Dr Tim Riding, Associate Director, Steve Bradbury, Deputy Director of Improvement and Innovation, and Dr Cecil Kullu, Consultant Psychiatrist, Mersey Care NHS Foundation Trust

14:25 Gender identity in secure care – pathways and survey data

Dr Callum Ross, Consultant Forensic Psychiatrist and Clinical Lead for Personality Disorder, West London Mental Health NHS Trust and Dr Paula Murphy, Consultant Forensic Psychiatrist, East London NHS Foundation Trust

14:50 Refreshments

15:05 Workshop session 2

Co-production

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

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

B: Involvement and co-production at Fromeside

Jacob Quinn, Service User Representative, Louise Maclellan, Carer Representative, Nuala Sheehan, Family and Friends Representative, and Luisa Suarez, Service User Involvement Coordinator, Fromeside, Avon and Wiltshire Mental Health Partnership NHS Trust

Blended security

A: Developing a blended secure service for women: The journey so far

Dr Katina Anagnostakis, Consultant Forensic Psychiatrist and Clinical Director of Forensic Services, St Andrew's Healthcare, and Clinical Lead, IMPACT (East Midlands New Care Model); Dr Ash Roy Chowdhury Clinical Director of Forensic Services Director and Consultant Forensic Psychiatrist, St Andrew's Healthcare and Dr Hugo Nel, Consultant Forensic Psychologist, St Andrew's Healthcare; Nicola Lintott, Head of Patient and Carer Engagement, St Andrew's Healthcare

Therapeutic Management of Violence and Aggression

A: The new (RRN) Training Standards and the (BILD) Association of Certified Training (ACT) Certification/Accreditation Scheme' for the therapeutic management of violence and aggression and challenging behaviour. How to get your training programmes accredited.

Terry Heenan, Management of Violence and Aggression Director, Elysium Healthcare

16:00 Final plenary

16:05 Close

Appendix 4 – Project Team Contact Details

Team contact information

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