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WELCOME

Welcome to the 44th edition of the Quality Network for Forensic Mental Health Services' newsletter on '**Research and Quality Improvement**'. In this edition, we're showcasing a range of projects that have been designed to improve service delivery, patient and carer experience, and patient outcomes. Thank you to those who have shared their work!

The first peer-review visits started at the end of September and by the time this newsletter is published we'll be a third of the way through already! We really do value the time and commitment given by services to enable the visits to go ahead. We heavily rely on staff members volunteering to participate in the review process and this Network wouldn't be able to function without your support. We're always looking for more reviewers and we have training scheduled throughout the year. If you or anyone you know would like to be involved in reviews, please do get in touch.

We recently published the aggregated reports for medium and low secure services (2017-2019). If you haven't yet seen them, you can find both reports on our website (details

inside). In addition, we have published the New Care Model reports for those areas that requested one. We hope you find these reports useful. Please do share any feedback you have with us.

Furthermore, we hosted an event on trauma-informed care in secure and prison mental health services at the end of November. We had a packed and varied programme, with excellent speakers and plentiful discussions. The presentations will be uploaded onto the Knowledge Hub group; please do take a look if you couldn't be with us on the day.

Lastly, from all of us at the Quality Network, we would like to wish you a very Merry Christmas and a Happy New Year!



Dr Quazi Haque and Megan Georgiou



Priory Healthcare

Improving the Physical Health Care of Inpatients with Serious Mental Illness (SMI): Upskilling Mental Health Nurses Through Education and Training to Meet the Growing Needs of the Patient Group

Background

Evidence suggests patients with SMI die on average 20 years earlier than the general population due to preventable physical health issues. In general, people with SMI have similar physical health problems as the general population; these are exacerbated by a number of factors including poor diet, smoking, sedentary lifestyles and diagnostic overshadowing.

Diagnostic overshadowing may arise due to stigma, negative attitudes of healthcare practitioners, together with a lack of education, training, confidence in clinical skills and symptom recognition in physical health including the use of the 'Lester Tool'.

Priory Healthcare 'Physical Healthcare Strategy 2019-2022' and Mental Health Taskforce (2016) 'The five year forward view for mental health' highlights the need to upskill mental health nurses in the physical health needs of patients through education and training to improve the physical health outcomes of patients with SMI.

With the aim of meeting these recommendations, working with Registered Mental Health Nurses (RMNs) from Kemple View psychiatric hospital, I developed and carried out a physical healthcare training needs analysis (TNA). The results of the TNA drove the subject area for the pilot training session developed and delivered.

Aim

To improve the physical healthcare of inpatients with serious mental illness (SMI) through the upskilling of RMNs using education and training to meet the growing needs of the patient group.

Method

Following ethics and organisational approval a training needs analysis (TNA) was distributed to all the team.

The questionnaire included questions on past experience and training on physical healthcare, skills/knowledge RMNs would like to develop and preferred methods of learning.

From the TNA's, I developed and delivered my own pilot training session to RMNs titled 'Action for Coronary Heart Disease'.

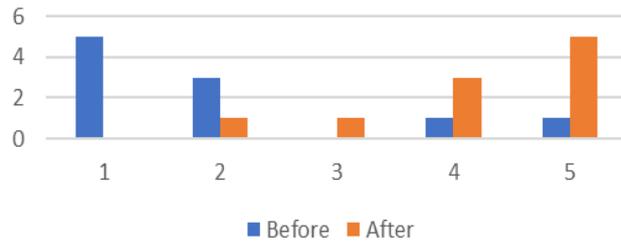
Post-session questionnaires were completed by the RMNs and a 'Lester tool' review for those RMNs involved in the pilot study will be carried out to further assess efficacy of training and whether knowledge is being used on the job.

Results part 1: TNA analysis

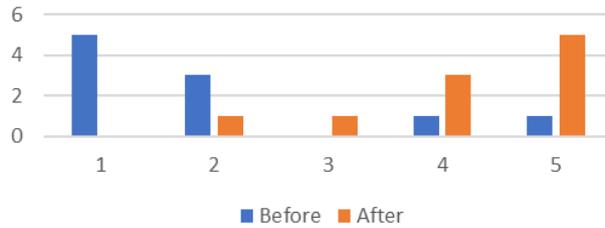
- 50 TNAs were sent out to RMNs, 43 were completed and returned.
- 16% of staff reported they had had no formal training in physical healthcare although 91% of staff reported they provide physical healthcare to patients; 42% on a daily basis, 23% every 2-3 days, 21% weekly, 14% monthly.
- Respondents rated their knowledge on general physical healthcare 47% 'fair', 37% 'good', 16% 'very good'.
- 100% of RMNs reported they would be willing to attend training on physical healthcare.
- 33 RMNs identified coronary heart disease as a subject area they would like more training on, 36 identified they prefer 'face to face' training methods.
- The TNA offers a baseline of ongoing training needs on physical healthcare and will inform the development of future training.

Results part 2: Action for Coronary Heart Disease: Feedback from training

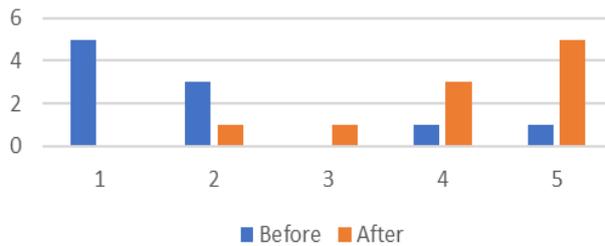
*Key: 1 = No knowledge, 5 = very good knowledge



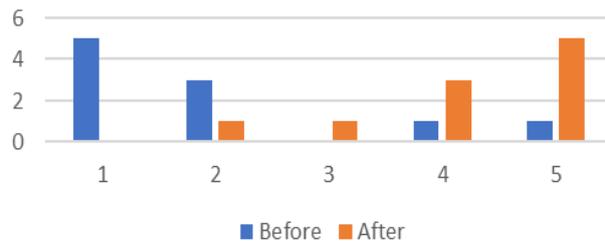
Graph 1: RMNs knowledge on recognising the **signs and symptoms** of CHD pre and post training.



Graph 2: RMNs knowledge on the **prevention and management** of CHD pre and post training.



Graph 3: RMNs knowledge on the **links** between CHD and SMI.



Graph 4: RMNs knowledge on the **implementation of the 'Lester tool'** in assessment of CHD.

- Post training session RMNs were asked to rate how confident they were in applying their learning in their job role, 33% very confident and 40% confident, leaving 27% not confident.
- 90% of RMNs advised they expected to be able to apply their learning in their job role very often/often.

- 100% of RMNs advised they would recommend the training to colleagues.

Conclusion

Initial results are positive; however, there is work to be completed to fully assess the impact of the training and to ensure confidence and competency in this subject area.

I have used Kirkpatrick's hierarchy to evaluate my training.

There are four elements to the hierarchical evaluation tool;

Level 1 Reaction – **Achieved** 100% would recommend to colleagues, reporting training highly relevant to role.

Level 2 Learning – **Partially achieved** 90% of RMNs expected to use apply their learning on the job.

Level 3 Behaviour – **Partially achieved** RMN feedback indicates confidence in

applying learning in practice. Forthcoming 6-monthly 'Lester tool' audit for those in pilot study will review whether new knowledge is being used on the job.

Level 4 Results – **Partially achieved** feedback indicates an increase in knowledge on CHD and the implementation of the 'Lester Tool' in the assessment of CHD. This will be further assessed as discussed in 'Level 3'.

Lianne Edwards, Substance Misuse Nurse/Trainee Advanced Practitioner/ Non-medical prescriber/CDAO, Kemple View Hospital

The Royal College of Psychiatrists

The Benefits of Patient Participation and Involvement in Research

I am currently quietly excited about a new role I may be about to take on in my own mental health Trust. For the last couple of years, I have been a patient member of the Trust's Forensic and Clinical Academic Group or FCAG as it is known for short. I have been thrilled by the extent to which I have been able to be involved in the work of the group in co-leading on the development of a Risk and Safety Menu of Interventions. My involvement has felt authentic and I have felt able to express my views and make suggestions which although aligned to current research into risk assessment and management, have conflicted with current practice in the Trust.

Last month I was summoned to a meeting with the two heads of the FCAG. To be honest part of me was a little anxious that given my progressive recovery oriented views I might be about to be told I was going to be 'let go'! Thankfully and much to the benefit of my blood pressure levels, this turned out to not be the case. Instead I was informed that it had been decided to give me a new role within the FCAG; that of actively encouraging and supporting forensic patients to participate and be involved in research in the Trust.

I was warned that initially there would be very little work to do until certain research projects were approved. I didn't care. I was thrilled. My own recovery was precipitated and has been sustained by my own patient involvement work, especially that within research. Without such opportunities I don't think I would be anywhere near as well as I am today. The idea of being able to talk to my peers about participation and involvement in research; what it entails, the potential benefits, what 'consent' means, their rights with respect to their data and under the legislation regarding Good Clinical Practice (GCP), felt like the icing on the cake of my recovery journey to date.

Even better, I have relevant practical experience. A few years ago I was given the opportunity to build a beta version of an online clinical trial recruitment portal for the NIHR Maudsley Biomedical Research Centre. I made the portal as user friendly as possible, consulting with patient groups in the process to develop an accessible platform that provided information on what it is like to participate in clinical research and how to get involved. I even managed to have a paper on the process of creating the site published in the Journal of Research Involvement and Engagement.

What excites me most about this role with the Trust is the hope that by encouraging and supporting my fellow forensic patients (both inpatient and community) to participate in research (should it be the right thing to do given where they are on their

individual recovery pathways) is the hope that this may have as much positive impact on their recoveries as it has on mine. The notion that the work I do may inspire and give confidence to others to engage in research is as humbling as it is meaningful.

I really hope I get the chance to realise my aspirations regarding my new role.

Dr Sarah Markham, Patient Reviewer, QNFMHS

Priority Healthcare

The Use of Safety Pods for De-Escalation and During Restraint

As part of the Kemple View's on-going commitment to reducing restrictive interventions, safety pods were introduced to enhance safety, reduce injury and improve the experience of using physical interventions. They were developed in 2014, in an attempt to reduce ground, prone and prolonged restraint due to the risk to patients and staff.



Since the introduction of the safety pods at the beginning of 2018, by the prevention and management of violence and aggression (PMVA) team at Kemple View, there has

been a marked reduction in prone position, ground and prolonged restraint. The physical interventions used are no different to how approved PMVA techniques are utilised, in relation to supporting a patient into a seated position, as the same techniques apply.

However, the safety pods are easier to transport, so the team can manoeuvre the pod to the patient thus minimising the higher risk movement of patients during restraint. This reduces the likelihood of injury to both staff and patients and minimises moving and handling issues related to health and safety.

The safety pod needs to be primed prior to use and this takes seconds to do and is repeated prior to every use. Once primed, when used, the designed hood of the Safety Pod will inflate in an ergonomically driven response to whatever size head, neck and width of shoulders enter the pod.

This allows the patient to receive a completely individualised response in terms of head and neck support, provides a much more comfortable experience than floor restraint and reduces higher risk interventions by staff. It also reduces the time it takes for the patient to stand up, allowing staff to exit rooms safer and to be able to disengage holds more effectively.

Patient feedback after restraint has been positive and there have been no issues in relation to the use of the safety pods.

Kemple View's restraint statistics can be seen on the next page.

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And use #qnmhs for up-to-date information

Year	Ground Re-straint	Prone (Position)	Prolonged (10 mins or more)	Injuries to staff (due to restraint)	Injuries to Patient (due to restraint)
2015	68	20	62	12	0
2016	25	10	36	9	3
2017	42	17	33	16	3
2018	8	3	29	4	1
2019	5	0	8	4	0

The following narrative is in relation to two occasions when Patient X was secluded. Although the circumstances of seclusion have been different, Patient X did exhibit similar behaviours and actions leading up to being transferred to seclusion. It shows the effectiveness of the use of the safety pod within the process of exiting a seclusion room. The frequency and duration of restraint is greatly reduced and ground restraint has been avoided. Within the first incident, attempts to leave the room lasted for almost two hours, with prone restraint being required along with rapid tranquilisation.

The second incident when the safety pod was used, the staff were able to exit immediately and no prone restraint or rapid tranquilisation was required. This is because it takes the patient longer to get out of the safety pod. Patient X also placed the mattress against the door to block the observation window, which was not possible when the safety pod was utilised during the second incident, due to its size and design:

Case Study

December 2017

For almost 2 hours, staff attempted to safely exit seclusion – Patient X continued to grab at staff, and various attempts to exit seclusion were attempted but failed. Patient X would get up and immediately grab hold of staff and their clothing, as they were exiting the seclusion room. He also placed his hand between the seclusion room door as staff attempted to exit, which increased the risk of injury to his hand. This resulted in the team having to go back into the seclusion room to implement PMVA interventions.

When staff eventually managed to exit the seclusion room safely, staff had to return to the room as Patient X had placed his

mattress against the door restricting staff from observing him. Eventually Patient X became fatigued and allowing staff to lock the door safely.

May 2018

Patient X was secluded due to being significant risk towards others, due to a deterioration of his mental state and the behaviours exhibited. The safety pod was used to assist the staff in exiting the room, which was completed without any issues.

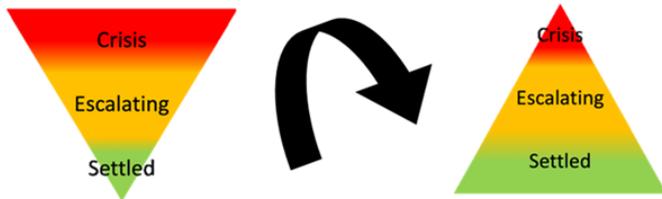
The MDT provided the following information during a seclusion review, soon after seclusion was initiated:

At 5pm Patient X was secluded but fortunately the seclusion process was uneventful with Patient X not displaying severe challenging behaviours as he has done in the past. He appeared calm as compared to seen before. There was no evidence of EPSEs. He denied any injuries or any physical distress.

The safety pod is one of the interventions utilised by Kemple Views PMVA team, in conjunction with; SafeWards, Least Restrictive Practice, Patient Views, Lessons Learnt, Positive Behavioural Support (PBS) and Legislation. The PMVA team also provide theory sessions with the aim to develop staff's knowledge around the risks associated with restraint, in order to prevent/reduce the risk and preventative measures, de-escalation skills and knowledge of patients PBS plans. The PMVA team has been a contributing factor in assisting Kemple View to attain its current outstanding rating in all five CQC domains.

Rob Holcroft, Quality Improvement Lead, Kemple View

Flip The Triangle: Positive Behaviour Support in Action



Flip The Triangle is a Quality Improvement project aimed at changing the culture on Shoreditch ward, a 14-bedded medium secure service for men with intellectual disabilities. The 'Flip the Triangle' model of care aims to adopt an embedded and multidisciplinary Positive Behaviour Support (PBS) approach to increase focus on positive and proactive interventions to manage challenging behaviour.

As a forensic service, we are very good at thinking about our service-users and managing risk when they are in 'crisis'. However, crisis interventions are the most high risk and often involve physical and restrictive interventions. Focusing on crisis situations can also mean patients displaying 'settled' behaviours can sometimes be overlooked and 'forgotten'. Flip The Triangle aims to 'flip' our whole team's thinking into re-focusing our care to proactively keep patients at their personalised 'baseline' in order to prevent escalation, reduce use of physical and restrictive interventions and make sure no patient is forgotten. The project's primary aim is to increase and maintain our positive and proactive interventions to a rate of 95% by January 2020.

Expanding repertoire of proactive interventions

Before the QI project, PBS plans were classically held by psychology and rarely developed with the whole team in mind. The lack of contextual fit presented as a barrier to their implementation. In order to successfully implement PBS, we have upskilled our staff through formal and informal trainings, formulation meetings and rigorous induction processes in order to empower them to use PBS as an active

process of formulation and hypothesis testing. Our team's learning, combined with input from service-users, is then documented in 'Collaborative Safety Plans' (originally developed by Dr Amy Canning, Fromeside) and are now 'live' documents that are constantly reviewed and updated by all members of the team to inform our care on a daily basis. We recognise the importance of joint and collaborative working across professions and often distribute therapeutic input across disciplines. This has helped the ward develop a model of integrated care across therapeutic and medical staff to provide a holistic approach to managing challenging behaviour.

Supporting staff wellbeing and resilience

Just as we have better understood the escalation cycles of our patients, we also appreciate the escalation cycles of our staff and team dynamics. We have used the embedded approach to PBS to apply the model to ourselves and recognise our human responses to daily exposure to behaviours that challenge. We use a 'traffic light' wellbeing system to monitor staff members' resilience to manage the day ahead and use that information to match staff to challenges throughout the shift and offer informal support. We have also developed a team PBS plan to develop strategies to proactively respond to team dynamics as they occur.

Increasing access to positive engagement opportunities

Due to the nature of the restrictive environment, many of our service-users have limited access to positive engagement opportunities and struggle to experience and explore new roles and relationships with others. We have increased our patients' access to positive engagement opportunities within the domains of employment, therapeutic, sports, access to the community, roles of responsibility and quality time with families and carers.

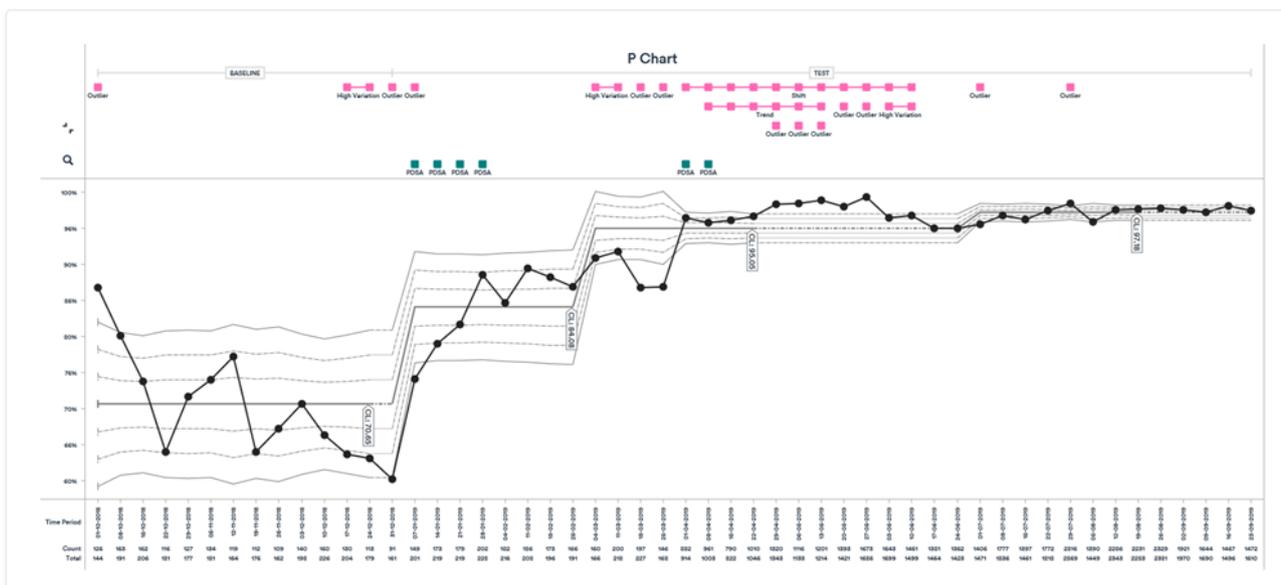
We began to monitor our positive and proactive interventions with 'blue dots' which are placed onto a chart as and when care is provided. Blue dots have increased our staff's self-awareness of the positive and proactive interventions they provide and also encouraged the provision of additional

opportunities for positive engagement. Service-users have co-produced a 'Dotting the Disc' Wheel (based on domains of care they experience and value) which they 'blue dot' when they recognise and value the care they receive. The team then uses the wheel to reflect on how our patients perceive their care and what is most and least valued. We can then reflexively tailor the care we provide for the specific service-user group currently on the ward.

The Flip the Triangle QI project has significantly impacted the care provided on Shoreditch ward. We are currently meeting our aim of increasing and maintaining our positive and proactive interventions at a rate of 95% and above. We have recorded

reductions in restrictive practises as well as increases in staff confidence and knowledge to proactively respond to challenging behaviours. Staff and patients have reported feeling safer on Shoreditch ward and we have also noted a reduction in staff sickness. The project is continuing to develop and evolve and the future will involve the development of systemic and dialectical behavioural therapy approaches to continue to improve the care of people with intellectual disabilities within secure settings.

Dr Charlotte Whittle, Clinical Psychologist; George Chingosho, Ward Manager; and Kate Parker, Speech and Language Therapist, John Howard Centre



Reviewer Training

Reviewer training is free for staff from member services from any discipline to attend. The training will give potential reviewers the opportunity to gain practical knowledge about how to conduct a peer-review visit.

Dates:

- 21 January 2020 (14:00 - 17:00) – Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.
- 20 April 2020 (14:00 - 17:00) – Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.

Booking forms can be found on our [website](https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services): <https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services>

Lancashire Care NHS Foundation Trust

Occupational Therapy and Seclusion – an Anathema or Opportunity?

Seclusion can be understood to be the last resort in order to contain severely disturbed behaviour, which is likely to cause harm to others (Department of Health, 2015). Within Guild Lodge, occupational therapists (OTs), as part of wider clinical teams, do work with service users who may become restricted within these environments at any stage in their recovery journey. However, there is limited research into the role of occupational therapy working within seclusion, as well as teams seldom considering the use of occupational therapists in this type of restricted environment.

So what did we do about this? We decided we needed to garner more information off of our OT staff group as well as our service users. This started with conversations within our OT meetings – culminating in a poster presentation on the role of OT in seclusion at the RCOT Conference in Birmingham June 2017. In order to further embed this, we added in all our staffs' personal development plans (PDP) "seclusion and the role of OT" as an objective. This ensured it was being discussed by supervisors and was on individuals staffs' agendas. Our bimonthly OT best practice meeting has as an agenda item "the role of OT in seclusion" – and this monitors our progression.

We interviewed service users about: *who were the staff who were in seclusion with them? Were you engaged in any type of activity? Did you ever complete an interest checklist/advance statement before going into seclusion? Do you think engaging in activities would help your time in seclusion? What are the barriers to engaging in activities and what ideas do you have for improving time in seclusion?*

Service users stated it was predominantly nursing staff that were present in seclusion. Only one stated they managed to maintain their OT programme whilst in this environment. Most interviewed stated that staff present did not engage "in any type of activity with them; it would have been

helpful if staff just talked to me. I wanted human compassion; not being stared at". There was little information about what they needed to do to "get out of seclusion"- and the majority had no idea about any care plans or advanced statements. Positively, service users came up with numerous ideas that would enable them to engage – these included:

- Having staff to talk to, who are compassionate and listen to you – make you feel safe and calm.
- Having things to do to distract you – so keeping an activity programme running.
- Being able to telephone family.
- Access to music, books, newspaper, quizzes and the radio.

We had several meetings with the OT staff group looking at how they felt and what they perceived their role to be in seclusion. All agreed it provided an opportunity for assessment through activity and supported the MDT - and would enable service users to have a "better quality of time" and may lead to them spending less duration in seclusion. Some acknowledged the difficulty of working in such a heightened emotional environment and it can affect therapeutic engagement. Staff also requested to have "more training" in this area to improve their confidence.

From a governance perspective, OT staff have become an integral part of the trust wide seclusion steering group. In addition we have set up a template called a "battery of ideas" and these describe a range of low risk activities in numerous domains – such as leisure, creative, physical health etc. that can be carried out in seclusion. These are stored within the OT department – with the idea that anyone can use these when engaging with service users in seclusion. Future ideas are to have these accessible in all the seclusion rooms and wards. We are also currently looking at how we can develop within our clinical record system an interest checklist that all service users complete identifying a range of activities that they can be involved in if they are in seclusion - making it more person centred.

Our staff group have started to have seclusion workshops – and have had an expert by experience present at this and

discuss how beneficial activities were to them when in seclusion.

We acknowledge as a team that this is an ongoing and challenging piece of work and are really keen to see how this benefits not only service users within seclusion – but offers a comprehensive meaningful range of activities to be used within restrictive environments – promoting the role of occupational therapists in seclusion.

Mark Love, Clinical Specialist Occupational Therapist, Men's & ABI Services, and Jennifer Gardner, Clinical Specialist Occupational Therapist, Women's Services, Guild Lodge



University of Oxford and National Institute of Health Research

Outcomes that Matter in Forensic Mental Health Services: Progress Report

If you are a professional working in forensic mental health services your views are needed! Please complete the survey by clicking on the link below and forward it to any interested colleagues.

https://psychiatryoxford.qualtrics.com/jfe/form/SV_5tGinZnYTamsnD

For more details about the survey, please see below.

Summary of the project's aims

Service user organisations, professionals and the Government have all recognised the importance of measuring the impact of the care provided by the NHS and other providers. Increasing emphasis is being placed on the tools to measure these outcomes, ensuring that these are evidence based and include the priorities of patients, carers and professionals.

The Quality Network for Forensic Mental Health Services has been supporting a research project that aims to find out what it means for patients in forensic psychiatric services to be making progress in their care. It considers the perspective of service users,

their friends and family and the professionals working with them. It is hoped that if we can measure what is most important for the people using forensic psychiatric services, then we can ensure that the care they receive is the best possible.

The research is being conducted by a team at the Department of Psychiatry at the University of Oxford. It is funded by the National Institute for Health Research and has been approved by the Health Research Authority.

Survey – get involved if you are a clinician working in forensic services!

One component of the research looks at what has already been published in this area. The outcome tools that exist are being systematically identified and evaluated using the approach outlined by the Consensus-based Standards for Health Measurement Instruments (COSMIN). A systematic search of the literature has identified almost 500 articles describing over 400 different outcome measures, or variants of outcome measures, used in the context of forensic mental health services.

The top ten outcome measures have been selected. These have been chosen because they are specifically designed for use in forensic contexts and also measure at least two broad outcome areas (including risk, symptoms, functioning and quality of life). All of them are at least partly dynamic, measuring change over time and so can be

used to assess an individual's progress. All of them are wholly or partly rated by clinicians. Some instruments also have other scales which can be completed by service users or other informants.

The purpose of the survey is to augment the information obtained from the scientific literature with information about the real-world use of these instruments and clinicians' views on their qualities, such as relevance, comprehensiveness and ease of use. This seeks to provide a holistic assessment of each instrument to help inform decisions about how they can be best used in clinical practice.

Please click on the link below to take part:

https://psychiatryoxford.qualtrics.com/jfe/form/SV_5tGinZnYTamsnnD

Update on progress so far

There has been some exciting progress on other aspects of the project. A total of seven focus groups took place, four of which were supported by the QNFMHS. Fifteen patients at all levels of security took part in interviews. The recordings of these conversations were carefully analysed to see what the common themes were. A framework emerged of six overall domains, encompassing 42 outcomes. These domains have been framed in the first person to emphasise the central importance of the patient perspective.

The domains are:

- About me

- My quality of life
- My health
- My risk and safety
- My life skills
- My progress

The outcome areas were then fed into a Delphi process, which is a type of survey designed to help form consensus between groups of experts. Panels of service users, carers and professionals participated in the Delphi process. Each participant rated each outcome area twice, firstly with just the description of the outcome itself and a second time where they could see the average scores that the other participants gave to that outcome in the first round.

What now?

The next steps will be to very carefully consider the results of the Delphi, involving a variety of groups to consider if these make sense to them. The research team, supported by the study's patient and public advisory group, will use all this information to develop a new outcome measure that has a part that can be filled in by service users and another part for the clinicians working with them. This can then be tested to see how well it works in the real world.

Howard Ryland, NIHR Doctoral Research Fellow, Department of Psychiatry, University of Oxford

Nottinghamshire Healthcare NHS Foundation Trust

Research and Quality Improvement (QI) at Arnold Lodge

Arnold Lodge Regional Secure Unit (Nottinghamshire Healthcare NHS Foundation Trust; NHCFT) has demonstrated a long-standing commitment to support forensic research and quality improvement projects. For over 20 years the unit has collaborated with universities around the UK

and provided research placements and training opportunities for Doctoral and Masters-level students; the unit has also committed to raising the research capacity of its own clinical staff.

The unit provides a forum for prospective researchers to present their proposals and receive constructive feedback from research-orientated clinical and managerial staff; this process helps researchers refine their proposals and address practical concerns at an early stage in the formal research approval process. The unit currently has research studies, service evaluations, QI projects, systematic literature reviews and

CQUIN evaluations in progress; examples of some of these are provided below.

Longitudinal follow-up / PhD research

The ALACRITY research project is a long-term follow-up of patients admitted to, and subsequently discharged from Arnold Lodge medium secure hospital in Leicester. The project has been funded by NHCFT and the University of Leicester to support a doctoral-level examination of the outcomes of a 'first admission cohort' of 909 patients admitted to the service between July 1983 and June 2013. The ALACRITY project focuses on the important forensic outcomes of re-admission, re-offending and mortality.

Randomised controlled trial

Researchers at Arnold Lodge are co-ordinating the recruitment of NHCFT patients for the CALMED study which aims to investigate whether clozapine is effective in reducing symptoms of Borderline Personality Disorder (BPD). CALMED is a 'Phase III' clinical trial, with a multi-centre, double-blind, placebo-controlled design; the study is led nationally by Professor Mike Crawford and co-ordinated locally within NHCFT by Dr Simon Gibbon. The primary outcome measure of the CALMED study is change in mental health as assessed by the Zanarini rating scale for BPD at six months.

CQUIN activity evaluation

Arnold Lodge is engaged with the current NHS England CQUIN scheme to support patients to achieve a healthy weight. Patients, staff and carers have been involved in generating innovative ideas to support patients look after their physical health more broadly.

Wards and departments have developed initiatives tailored to the specific needs of the patients, to encourage increased activity/exercise and promote healthier food choices. All of the initiatives have been designed to follow the Quality Improvement (QI) model of 'Plan, Do, Study, Act'.

In one initiative, patients on Cannock Ward (male personality disorder) organised a 'Healthy living week' to coincide with a break in their treatment programme. With the support of staff, the patients devised a timetable of novel sporting activities and set themselves an ambitious step challenge.

Patients also planned the week's menu and cooked every meal on the ward using fresh ingredients and healthy cooking techniques.

The ward assessed the impact of the week using pre-post measures of wellbeing and qualitative patient feedback. The evaluation contributed to decisions on what sporting/cooking activities would be facilitated as ongoing and sustainable initiatives.

Quality Improvement project

Staff on Tamar ward (standard women's service) are conducting a QI project that aims to reduce the number of violent, aggressive and self-harm incidents, by providing structured evening activities for patients. The Tamar QI team have identified the primary and secondary drivers, and generated a range of change ideas within their model of 'Plan, Do, Study, Act'. The project's measurable outcome (number of incidents), has shown a significant decrease since the introduction of the structured evening activity intervention.

Evidence synthesis

Researchers at Arnold Lodge are being supported to conduct systematic reviews for the Cochrane Collaboration. Two reviews are currently being updated that will assess the high quality evidence available to support psychological and pharmacological interventions for anti-social personality disorder.

Masters educational research project

Where possible, Arnold Lodge supports staff who undertake Masters-level research, especially when the question under consideration is of direct clinical relevance (e.g. burnout in nursing staff). One recently completed MSc, undertaken by a psychology assistant, examined the psychological and physical health impacts of workplace trauma on staff working with the personality disorder service. The unit acknowledges that support for such projects benefits both the researcher and the organisation as the research can provide insights into issues that affect staff working within the unit.

Dissemination

A crucial aspect of any research or quality improvement project is dissemination. Arnold Lodge consolidates its support for

researchers by enabling them to feed back the results of their research directly to the service, and facilitating participation at appropriate national/international conferences; the service also encourages

researchers to publish their results in peer review journals.

Lucy McCarthy, Senior Research Fellow, Arnold Lodge

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

The Involvement of Carers and/or Patients in Quality Improvement Projects: Westbridge Transition Group

Westbridge step down unit is a community service provided in partnership between Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Tyne Housing. The service is a specialist tertiary service commissioned by local Clinical Commissioning Groups in the North East region of England. Its purpose is to contribute to reducing the risks to others posed by men and women who suffer from mental illness and to offer a step down service from secure wards or prisons to independent living.

Westbridge step down unit aims to identify and meet the diverse rehabilitation needs of clients with a mental disorder who have been assessed as requiring a supported re-integration into the community.

Westbridge strives to continually improve the quality of service it provides via regular audits against local and National standards, being responsive to and requesting feedback from others and reflecting on what we can learn from individual cases we are involved in. Following feedback from existing and former patients it was identified there was a gap in secure care services for providing therapeutic support and interventions for patients transitioning from secure services to the community, therefore, the Transition Group was collaboratively developed.

The focus of the Transition Group is to improve the service delivered to patients who have been referred to and accepted for in-reach at Westbridge; to aid a smooth transition from inpatient to the community

and to ensure that transitions between services are seamless. The sessions encourage patients to think about their occupational identity and role in community, and what they want their future to look like by developing skills and synthesising these into everyday life.

During the planning stage group facilitators met with patients both in the community and in a secure hospital to ascertain their views and needs. It was mutually agreed that the group would be patient centred and recovery orientated by providing choice, hope and control which is what the joint commissioning panel for mental health services has indicated that secure care services should provide.

It was also identified that the time of highest risk for individuals is during the transition between different parts of the pathway, therefore, it is essential this transition is managed safely and effectively. Transition from secure institutional setting to increased independence and responsibility if supported, graded and planned is likely to be most successful.

For the majority of patients the main identified long term goal was discharge to a suitable accommodation in the community of their choice, with the maximum amount of comfort, safety and independence. Therefore, the Transition Group would also provide a therapeutic and supportive framework throughout the transition period including dealing with the practicalities of living in the community such as holding a tenancy at Westbridge.

It was acknowledged that some patients have not had the responsibility of holding a tenancy before, therefore, it was agreed that the group explore what this means and how it can be managed in greater detail. This is supported by Gustafsson, Holm, Flensner (2012) who reported that findings from their study indicated that client's transitions failed when patients didn't understand what was

expected of them for example; the consequences of not paying bills. Managing finances is often one of the areas which patients feel most worried about.

Research indicates that positive feelings of regaining freedom can be short-lived once the problems and frustrations of community living once again become apparent. Simple tasks such as shopping for food, dealing with new technology and moving among crowds of people can present challenges even for the most 'rehabilitated' offender. Thus

providing patients with further supported opportunities to model pro-social behaviour, explore and discuss the roles which will facilitate and underpin independent functioning and to provide a therapeutic and 'safe' space in which to discuss experiences and difficulties they may face is vital to support a successful transition into the community.

Craig Searle, Specialist Occupational Therapist, Westbridge Forensic Hostel

East London NHS Foundation Trust

Let's Talk About Sex (and 'Big I' Service User Involvement)

'Big I' service user involvement is when service users and carers are involved directly in a QI project development and delivery as part of the core QI team, as opposed to only asking people using the service for their opinions via surveys, focus groups etc. (known as 'little i' involvement). While the benefits of co-production are well espoused, Big I service user involvement is not always standard place in QI projects. We therefore thought we would outline our experience of working on a QI project with Big I involvement, as one model of how it can look.

Our service user representative's role in the project started at the conception of the idea. It was identified that the pornographic DVDs that he had previously been allowed contravened the hospital policy on pornography, which did not allow moving images. This contributed to the decision by a working group to review the hospital policy and permit moving pornographic images. But it also sparked wider discussions amongst professionals in the team and also the service user about how we support individuals in their sexual identity, sexual expression and sexual health needs while detained within forensic settings.

We recognised that the most fundamental problem is that we often did not even have conversations about sexuality, apart from in

relation to offending and risk. The aim of the resulting project, 'Let's Talk About Sex', has therefore been to increase service user confidence discussing sexual identity, sexual expression and sexual health needs with staff to 70% by January 2020. We have already implemented three change ideas – access to a free condom scheme for service users from local pharmacies, available to them after discharge as well, run by the sexual health charity Brook; STI screening on the ward, supported by our local sexual health clinic; and a Love, Sex and Intimacy discussion group, devised by a Psychologist elsewhere in the forensic directorate a number of years ago, but not previously run on our ward.

We are currently rolling out our fourth change idea of care plans for sexual expression, sexual identity and sexual health needs. Having started from a baseline of 30% confidence discussing these issues, we are now close to meeting our 70% target. Given concerns sometimes raised in forensic settings, it is worth noting that we have a balancing measure of number of sexual violence incidents and there has been no increase since the project started.

Our service user representative attends all core QI team meetings, which are held fortnightly for 30-45 minutes, and he has represented the views of service users in the discussions, as well as promoting the project on the ward. Moreover, he has taken responsibility within the core QI team for data collection and each week goes round knocking on all other service users' doors to invite them to fill in a card rating their

confidence talking to staff about sexual expression, sexual identity and sexual health needs from 1-10. At our ward community meeting each week, he is given the choice about whether he gives the update on the QI or a member of staff (as sometimes he does not feel in the mood). He is paid £10 per fortnight for his role.

We invited our service user representative to write this article himself, but he has been invited to feed back and disseminate his experiences through so many different channels, both presenting and in writing, that he elected to turn this invitation from us down. He did indicate that he would be willing to do it if he was paid (payment for the article in addition to his regular payment for his role) and has made similar enquiries about payment for forums that have more directly invited his input.

His enquiries can perhaps spark reflections for us all on how much we are truly inviting participation from service users at all levels of the system: On a full-time salary, I can fit writing this article into my working week and effectively be paid for doing so. When the same is not available for service users, and a burgeoning burden on ward budgets alone for service user involvement beyond the basics is unrealistic without additional funds, perhaps we need to think creatively in all parts of the system about how we can properly remunerate service users for their time and make it true co-production.

**Kate Fillingham, Clinical Psychologist;
Gbenga Olokuntoye, Matron; and Rachel Luby, Registered Mental Health Nurse,
John Howard Centre**

QNFMHS Medium and Low Aggregated Reports (2017-2019)

The reports cover the findings of the review process that occurred between September 2017 and May 2019. Each report showcases good practice examples identified during peer-review visits and they provide benchmarking graphs to enable services to monitor their performance against other services.

In devising the reports, we were reminded of all of the fantastic work being achieved by member services and the evident commitment to provide high quality care. We would like to take this opportunity to congratulate our member services for these achievements and to thank you for your continued hard work and dedication.

The reports are available on our website (<https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services>):

[QNFMHS Aggregated Report - Medium Secure \(2017-2019\)](#)

[QNFMHS Aggregated Report - Low Secure \(2017-2019\)](#)



News

Perspective On Excellence in Forensic Mental Health Services: What We Can Learn From Oncology and Other Medical Services

This paper proposes that excellence in forensic and other mental health services can be recognised by the abilities necessary to conduct randomised controlled trials (RCTs) and equivalent forms of rigorous quantitative research to continuously improve the outcomes of treatment as usual (TAU).

Forensic mental health services (FMHSs) are growing, are high cost, and increasingly provide the main access route to more intensive, organised, and sustained pathways through care and treatment. A patient newly diagnosed with a cancer can expect to be enrolled in RCTs comparing innovations with the current best TAU. The same should be provided for patients newly diagnosed with severe mental illnesses and particularly those detained and at risk of prolonged periods in a secure hospital.

For more information, please follow this link: [https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00733/full?utm_source=Email_to_authors&utm_medium=Email&utm_content=T1_11.5e1_author&utm_campaign=Email_publication&field=&journalName=Frontiers in Psychiatry&id=472231](https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00733/full?utm_source=Email_to_authors&utm_medium=Email&utm_content=T1_11.5e1_author&utm_campaign=Email_publication&field=&journalName=Frontiers%20in%20Psychiatry&id=472231)

Sending Mental Health Patients Out of Area is Counterproductive

Professor Wendy Burn, president of the Royal College of Psychiatrists, talks about a new independent research commissioned by the Royal College of Psychiatrists.

This research identifies 13 areas which are experiencing significant struggles managing levels of demand with the bed capacity available in their area. Seven of those have ongoing difficulties with having to send patients out of area to receive care and six persistently have extremely high levels of bed occupancy.

The research has shown that more beds are needed and that is why we are calling for additional beds across these areas, aligned with workforce and service delivery plans so they are properly staffed and resourced.

To read the full article, please follow this link: <https://www.hsj.co.uk/mental-health/sending-mental-health-patients-out-of-area-is-counterproductive/7026312.article>

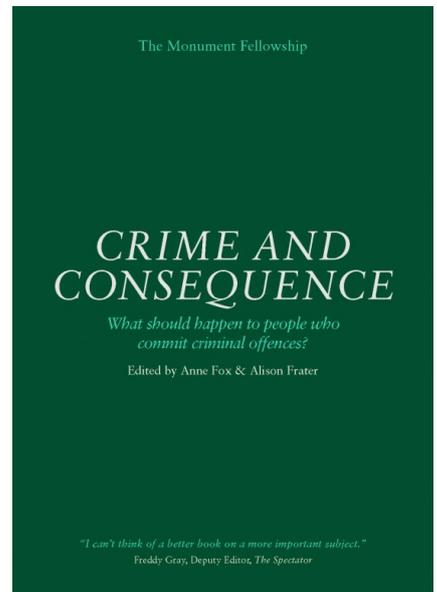


Crime and Consequence: What Should Happen to People Who Commit Criminal Offences?

A collection of essays and creative reflections on one of the most important questions for our society - what should happen to people who commit criminal offences.

Contributors include academics, business leaders, artists, criminal justice professionals, charity leaders and prisoners themselves. They explore how our society can respond to crime to tackle the causes and consequences.

This collection is the third in a series of books curated by The Monument Fellowship; eight organisations funded by The Monument Trust to work together to make a sustained, cumulative and transformative change to the journey of individuals through our justice system. The members of the fellowship are: The Centre for Justice Innovation, Clinks, the Diagrama Foundation UK, Khulisa UK, Koestler Arts, Lemos and Crane: The Good Prison, The National Criminal Justice Arts Alliance and Restorative Solutions CIC.



For more information, please follow this link: <https://www.clinks.org/publication/crime-and-consequence>

Sexual Safety Collaborative

The Sexual Safety Collaborative is part of a wider Mental Health Safety Improvement Programme (MHSIP) which was established by NHS Improvement (NHSI), in partnership with the Care Quality Commission (CQC), in response to a request made by the Secretary of State.

The Sexual Safety Collaborative has been established in response to the CQC report on Sexual Safety on Mental Health Wards and aims to meet a number of objectives:

- Produce a set of standards around sexual safety during the mental health and learning disability inpatient pathways (including a strategy to measure and support quality improvement)
- Run a national quality improvement (QI) collaborative to support inpatient mental health teams in every mental health trust in England to use QI to improve sexual safety on their wards.
- Produce a library of resources, building on best practice to support the work of mental health trusts to improve sexual safety.

The standards for sexual safety are currently in the process of being published. For more information, please follow this link: <https://www.rcpsych.ac.uk/improving-care/nccmh/sexual-safety-collaborative>

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Workplace Trauma Support

We know that providing the right dose of support, at the right time, and from the right person is key in preventing serious outcomes following exposure to trauma. Staff in secure services are often directly exposed to incidents of violence and aggression and indirectly exposed to service user's trauma. Working with complexity and trauma can be highly rewarding yet challenging and frightening. At Guild Lodge, we have been focusing on supporting staff wellbeing following critical incidents in the workplace, striving towards a cultural change where asking for help and offering support is normal practice.

A critical incident is considered to be an event or situation that overwhelms an individual's coping abilities. Most people are affected in some way when they are exposed to a traumatic event e.g. physical, psychological, emotional, and behavioural reactions; vicarious trauma; burnout; and compassion fatigue. For many, their reactions do not last long and are not too distressing. For some people however, reactions can be more distressing and longer lasting. Unfortunately, stigma still exists in mental health workforces and many staff are reluctant to talk about their mental health or trauma experiences.

The Workplace Trauma Support model was developed from positive practices and models used within LSCFT and from models/approaches used in other organisations, which have been creative in how they provide support to individuals after traumatic experiences. The model incorporates elements of the psychological first aid (PFA; Brymer et al., 2006), trauma risk management (TRiM; Whybrow, Jones & Greenberg, 2015), and critical incident stress management (CISM; Everly & Mitchell, 1999) models.

Key points of the Workplace Trauma Support model:

- Being careful not to pathologise trauma responses.

- Not assuming that trauma exposure will automatically lead to longer-term mental health problems.
- Reduce initial distress and promote adaptive functioning and coping, supporting people in their natural processing of trauma.
- Based on the principle of teamwork and the knowledge that people are more likely to engage with people they know than a trained professional they do not know.
- Supporting each other to meet our basic needs of feeling safe in the workplace.
- Changing the culture to make sure everyone always gets support.



The Model

1. **Pre-incident awareness training:** This is information about what to expect following a critical incident, such as, physical and emotional reactions, what the impact of a critical incident might be, and how to access support.
2. **Demobilising:** This will ideally be carried out by a manager not involved, or affected, by the critical incident. It will usually involve a meeting of all affected. It is a way of grounding and enabling staff to become more emotionally regulated, ensuring that their immediate needs are met. The manager (demobiliser) will discuss with the crisis facilitator (see on the next page) about those involved in the incident and consider who needs support and decide whether a proactive

approach is required or keeping a watchful eye is sufficient.

- 3. Defusing:** This will be provided by crisis facilitators (ward-based staff). Their aim is to intervene before critical incident stress processes have become established. Support will be provided in an informal manner and will be responsive to staff and the situation.
- 4. Individual crisis support:** If indicated and required, more specific management and psychological interventions following on from the above and may take a variety of forms, ranging from ongoing supportive interventions in the workplace or more formal therapeutic interventions that can be accessed through occupational health, GP, or as needed from specialist services, such as the LSCFT Traumatic Stress Service.

The impact and feedback from staff of this model has been increased feelings of value and support. We have successfully trained 48% of managers (ward managers, team leaders, senior management) in demobilising (on the day support) and 31 staff trained (nurses, psychology, OT, HCAs, temporary staffing, admin) in defusing (crisis facilitators), and we deliver supervision sessions to support the implementation of the model. However, there have been challenges to implementation including lack of confidence in using the role and poor attendance to supervision due to low staffing levels across site. We have attempted to

overcome these barriers through raising awareness of the model via a launch event, brightly coloured lanyards for those trained in the role, and a range of visual resources to promote and support staff utilising the role. We are continuing to challenge the culture through open dialogues, role modelling, and creating psychological safety for staff to share their experiences with each other.



WORKPLACE TRAUMA SUPPORT

A **critical incident** is a situation that has 'sufficient emotional power to overcome the usual coping abilities of people working in environments where some degree of exposure is expected'.

Critical incidents may trigger a wide range of physical and psychological symptoms.

Guild Lodge is offering Pre-incident Training to all LCFT staff and Immediate Personal Support to all wards.

Immediate Personal Support aims to offer informal support via trained peers and managers after a critical incident.

IMMEDIATE PERSONAL SUPPORT INVOLVES:

Demobilisation – provided by Team Leaders, Managers, and Matrons, also known as Demobilisers.

Defusion – provided by peers on your ward, also known as Crisis Facilitators.

Monthly reflective safe space – provided to all trained Demobilisers and Crisis Facilitators.

WHAT WILL THIS LOOK LIKE?

Following a critical incident, all staff will have the opportunity to access appropriate support before the end of the shift supported by a demobiliser. Crisis Facilitators will be available for further support, if needed.



Dr Claire Purtill, Senior Clinical Psychologist; David Keane, Senior Psychotherapist; Laura Room, Assistant Psychologist; Rhiannon Houghton, Associate Practitioner; and Dr Hein Ten-Cate, Consultant Clinical Psychologist, Guild Lodge

Northumberland, Tyne and Wear NHS Foundation Trust

Carer Involvement at the Bamburgh Clinic

The Bamburgh Clinic in Newcastle upon Tyne is a 40-bedded medium secure mental health unit including one personality disorder ward and is part of

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Collaborating and coproducing with service users and carers towards recovery is at the heart of everything we do. We are always looking for ways to further improve family involvement in secure care. We know that supporting family relationships and enabling families to get a deeper understanding of pathways and recovery can be a huge protective factor for our service users, especially when they

transition back to community-based life. This initiative also supports the principles of the New Care Model; repatriating service users to their home areas and ensuring a well supported and timely discharge. Carers of those in secure care are present daily on the wards and staff facilitate home leaves whenever this is a positive and possible step. However, there can always be other meaningful and powerful ways of embedding positive family contact.



When we asked carers what we could improve, the feedback was that dedicated events for socialising would be appreciated. The Bamburgh Clinic holds quarterly events that focus on providing a space to relax and socialise. The first was held in December 2017 and watching families laughing, playing pool and forming quiz teams was so encouraging. Since then, these events have included high tea, summer fayres, therapy animals and fundraising amongst other things. The focus is always about families spending time together outside of a typical family visit (which may be the only other face-to-face contact for some restricted service users). It also creates supportive links between carers and helps carers to understand the running of the service, roles of staff disciplines and care pathways. It breaks down barriers and promotes mutual expectations and understanding of necessary restrictions and how they keep everyone safe.

These events can hold their own challenges to arrange as staff must be sensitive to family dynamics and inter-ward and inter-service user dynamics. When feeding back about such events, service users have requested a planning committee so they can be more formally involved in the whole process which is now being put in place.



Wherever possible, carers are involved and their feedback is used as a benchmark. Service users, carers and staff have been part of in-house research and have given data regarding their experience and understanding of post incident support and debrief which subsequently informed a research article and an awareness training package for service users, carers and staff. Peer support workers have also shared their own personal experience as carers and this is included in Carers Awareness Training with clinical staff from all backgrounds and bands. Advice and guidance is given by those who have experienced being carers in how to involve families in care planning and care pathways. The more contact between carers and staff, the more the confidence grows from both sides.

A quarterly newsletter ('Keeping in Touch') has been sent out to carers for the past two years. Produced by a group of service users and staff, the purpose of the newsletter is to give a window into clinic life; from events, celebrations and achievements to challenges and changes. The newsletter goes out to relatives and friends of service users on the clinic, including those who do not receive much information due to consent restrictions. As there is nothing confidential in the newsletter it is another step towards inclusivity and understanding. It's even been translated into another language!

In the early days of the newsletter we found that using the newsletter group time to plan and having staff format the content electronically afterwards was not working well. It was time consuming and ignored the considerable IT skills of some service users. After conversations with IT staff we got an encrypted memory stick for the purpose of working on an electronic template on both service user and staff computers. This has been a much more successful, strength-based approach.

Each newsletter we send out includes a secure email address set up specifically for carers wanting to give feedback on events etc, to link them in with staff outside of their relative's immediate care team. The newsletter invites carers to contribute and hopefully in future a carer will write for the newsletter, either remotely or in the group.

There are regular upcoming information evenings organised for carers, the next two topics are Wellness and Recovery Action Plans (WRAP) Awareness and Antipsychotic Medication. These topic choices reflect conversations with carers. Carers frequently request information about medication and speak to staff about the pressures they are under. WRAP awareness gives an insight into a tool used by service users but is also a tool

they can also use themselves. Previous information evenings included training on co-production as well as understanding care pathways and these sessions have also made Recovery College material more accessible to carers.

Helen Goudie, Clinical Manager, and Nadia Burman, Clinical Team Lead, St Nicholas Hospital

Avon & Wiltshire Mental Health Partnership Trust

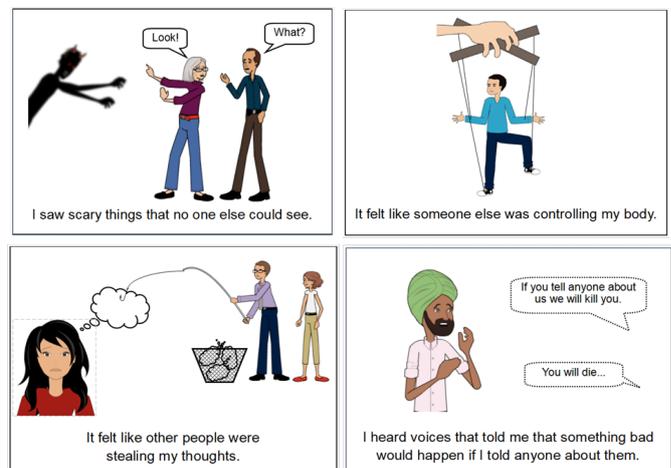
The Development of the 'Understanding Psychosis Accessible Workbook'

Many of the service users in secure hospitals have been admitted because they have a diagnosis of schizophrenia or another psychotic illness. NICE guidelines (2014) recommend that psycho-education and relapse prevention planning should be part of the treatment provided to adults who experience psychosis, and there is good evidence that psycho-education can lead to significant improvements in concordance with medication, reduced rates of relapse and readmission (e.g. Xia et al., 2011). However, there is a lack of psycho-educational materials about psychosis which are suitable for people who have learning disabilities, or who have other difficulties with reading or understanding written materials.

To try to address this need, we have developed an accessible psycho-educational workbook about psychosis, which is structured to help service users develop a relapse prevention plan. A workbook design was chosen to allow service users to work through it at their own pace, with help from a member of staff, and to provide service users with a resource that they, their families, carers and community teams can refer to in the future.

The workbook includes detailed but simple information about psychosis, illustrated with cartoons specifically developed for this project (using © Pixton). The content of the

workbook was developed in collaboration with service users, and includes information about issues such as the causes of psychosis, how to identify early warning signs, and illicit drugs and psychosis. There is a 'story of recovery' describing how an individual recovered from psychosis, and tips for managing distressing psychotic symptoms, with ideas provided by service users from within secure services. The workbook also includes three sets of illustrated sorting cards to help service users identify and discuss the symptoms they experience when unwell, potential triggers for psychosis and early warning signs.



We have been evaluating the workbook with over 30 service users and clinicians from a range of settings, including mainstream and learning disability secure services, early intervention and community learning disabilities teams. The workbook has also been used successfully as a psycho-educational resource for carers, and when working with service users together with interpreters. Overall, the feedback has been very positive.

Comments from service users have included:

'I think the book really helps me.'

'I would recommend people to make a staying well plan because it will help them.'

'I liked the card activities it made me understand what psychosis was.'

Comments from clinicians have included:

'We find it a fantastic resource.'

'Extremely helpful pack- it gives us a structure and intervention when people are admitted... with psychotic presentations. Also good at promoting service users' insight.'

'This has been an excellent resource that has had a positive impact on a hard to treat patient. Very useful resource. Accessible and interesting way of helping a service user understand their experiences.'

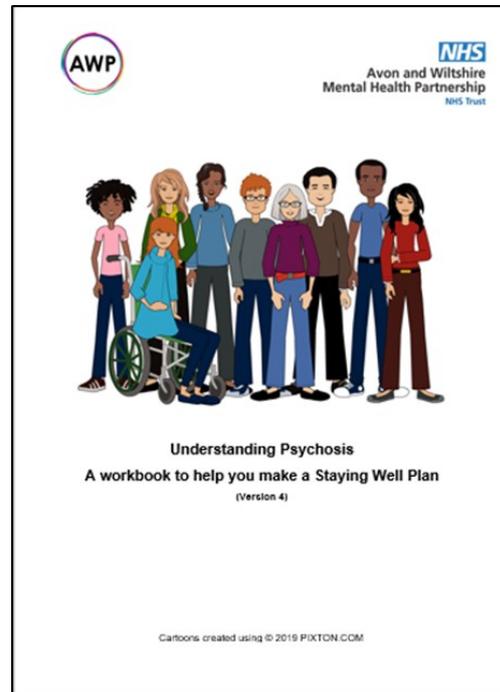
Comments from carers have included:

'I now understand that anyone can get psychosis, it has helped me to understand their behaviour.'

'It should have been given to us years ago!!'

We have been using the feedback from the evaluation to improve the workbook further, and hope to be able to provide the materials free of charge to any clinicians who might find them helpful, from January 2020 onwards. We also hope to be able to publish the full results of the evaluation in the

future. If you would like a copy of the workbook, please get in touch (awp.UPworkbook@nhs.net).



Dr Amy Canning, Clinical Psychologist, Dr Hannah Toogood, Consultant Learning Disabilities Psychiatrist, Lori Appleyard-Ewings and Abigail Croker, Assistant Psychologists, Jasmin Hernon, Speech and Language Therapist, Mike Richardson, Senior Learning Disabilities Nurse, and Steve Slater, Specialist Community Forensic Nurse, Fromside

University of Oxford and National Institute of Health Research

Research Working Group for the Adult Secure Clinical Reference Group

Research in healthcare aims to answer those questions that are the most pressing for the people who use health services. There are almost as many questions as there are service users, all of them in competition for limited resources. How are such questions developed and how are decisions made

about which ones will get that all important funding?

The National Institute for Health Research (NIHR) is the research arm of the NHS. It was set up ten years ago to ensure that research is coordinated in a way that is responsive to the needs of the people who use the health system. NIHR works with partner organisations to review what priorities for research they have identified, in order to develop a strategic approach to commissioning further work. As part of this approach, NIHR annually solicits suggestions from the Clinical Reference Groups (CRG)

that advise NHS England's Specialist Commissioning.

NIHR considers these submissions and weighs up the various merits of the different proposals. As well as assessing the importance of the issues at stake, they also consider them within the context of their existing programmes of work. Is someone already working on this area? Does this sound like a question that research will be able to answer? Is now the right time to be looking at this? Based on the overall assessment of all proposals from across the CRGs, NIHR choose those that appear most promising. These then go forward to inform funding calls via NIHR and charity partners, which invite research teams to propose ways to answer the questions posed.

Mental health has historically fared poorly in this process compared to other medical specialties. This may be due partly to the fact that interventions in mental health often rely on complex, system level approaches, which can be harder to formulate into the precise format required by research proposals.

This year the Adult Secure (AS) CRG has developed a new approach to ensure that its priorities are well thought through and clearly articulated in a format that would appeal to funders. Inspired by work that was completed in the Perinatal Mental Health CRG, the AS CRG decided to establish a dedicated research working group. The initial focus is to facilitate the process of submitting research priorities to NIHR, but there are potentially other opportunities throughout the year that could also be supported.

As well as relevant members of the CRG, the working group sought to involve a range of additional academic expertise, including those with a range of professional backgrounds and those with experience of using services. The working group met for the first time at the end of July. A wide-ranging discussion started to generate an

extensive long list of interesting research questions. Input was also sought from a range of other stakeholders, such as high secure services, provider collaboratives and the women's blended service pilots.

Several clear themes started to emerge from the extensive list of possible questions. These coalesced in to seven categories, namely:

- Involvement and experience
- Outcomes
- Pathways
- Risk assessment
- Tackling inequalities
- Treatment options
- Workforce and infrastructure

These were then taken back to the next meeting of the CRG for further discussion and consideration. The next steps will be to work closely with colleagues from the NIHR's research design service to further hone the questions. Guided by input from the CRG around the areas to focus on, the challenge will be to formulate precise questions in the PICO format. This classic approach breaks down a research question to its fundamental components:

Population – who will be participating in the research?

Intervention – what will be done differently?

Comparison – what will the intervention be compared to?

Outcome – how will we know if it is better?

It will be exciting to see how further discussions develop!

Howard Ryland, NIHR Doctoral Research Fellow, Department of Psychiatry, University of Oxford

Physical Security, 03 March 2020

We have now opened the booking for our next special interest day.

For further information please visit our website: <https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services>

Birmingham and Solihull Mental Health NHS Foundation Trust

Recognising and Celebrating Difference in Secure Services

Inclusion is at the forefront of the work we do at the Tamarind Centre and we are continually looking for innovative ideas and opportunities to engage our service users (SU) and ensure that we are meeting the needs of the diverse population we serve. We have had quite a few exciting things take place this year.

LGBTQ+ May - Although nationally celebrated in June, we held our celebrations in May as has been a tradition for the last 5 years. The month included our team psychologists facilitating discussions on the wards about the importance of equality and diversity, challenges people from the LGBTQ+ community may face and expression of self-identity. There was a theatre production by Women in Theatre and to top things off, a newsletter was co-produced with our SUs. This also featured personal stories written by SUs on their experiences.

Black History Month - BHM celebrations were fantastic. Our sports hall was transformed into a festive sight with African print table cloths, national flags and posters featuring some of the influential and inspiring black people to date. There was a real sense of community as SU, staff and families and carers came together to enjoy a live reggae band and drummers, delicious Caribbean food and a quiz. SU fed back at the LGBTQ+ May events that they enjoyed having discussions about current affairs and the film afternoon that was held with staff. As such, we have continued BHM celebrations with two film afternoons this month. This was well received by our SU who enjoyed the opportunity to socialise and chat with staff while enjoying the movie.

New initiatives

There are several new projects in the pipelines.

1. The Elders project - In recognition of the over-representation of black men in services and the difficulties this group faces

following discharge into the community, secure services is involved in a new project called the Elders Project. The aim is to offer a proactive approach to supporting African and Caribbean service users throughout their recovery, with a particular focus on the period of transition and discharge. The Tamarind Centre is the initial pilot site, after which, it is hoped that it will be rolled out across our other secure sites. The project involves recruiting Elders from the community from various backgrounds including sport, faith and music and matching them with SU who are interested in taking part. We are currently in the process of planning training for the Elders.

2. Translation apps pilot - Some of the observed challenges in our work with non-English speakers include the discomfort SU can feel using interpreters, and the lack of language skills or confidence to communicate their needs. This can be an isolating experience and can lead to reduced engagement with the team. One of the ways we are trying to address the barriers is through piloting translation apps on tablets. This will enable service users to speak directly to the tablet in their native language, and the English translation produced via speech and text for the professional. Of course, there are likely to be difficulties with less common dialects as these may not be available via the apps, however, this is a good start. We envisage benefits for our service users such as a greater sense of independence, increased participation and involvement in care and treatment and increased trust in the therapeutic relationship as a result of feeling more understood. As professionals, through increased dialogue, this will be a great way for us to develop our cultural awareness.

3. Practitioner guides for working with people from different cultural backgrounds - While still in the early stages, we are developing a series of practitioner guides for working with various cultures. This has been an excellent opportunity to collaborate with people from the Somali background - the first of our series - with lived experience and who have also been in secure services. The purpose of these guides will be to increase staffs' knowledge and competence about the more nuanced aspects of the communities we serve, highlight important cultural

celebrations and practices and to offer practical tips to enhance our ways of working.

Stay tuned, definitely more things to come!

For more information, contact:
Kimberly.shamku@nhs.net

Dr Kimberly Sham Ku, Senior Forensic Psychologist, and Dawn Sutherland, Advanced Nurse Practitioner, Tamarind Centre

Birmingham and Solihull Mental Health NHS Foundation Trust

Forensic Intensive Recovery Support Team (FIRST) - Developing a Community Recovery Focused Transitions Group

Why transition matters?

NICE (2016) highlights the importance of an effective transition from hospital to the community for an individual and their families. Between 2003-2013, 2,368 mental health patients died by suicide in the first three months after being discharged from hospital in England alone (University of Manchester, 2014). A lack of integration and collaborative working between mental health services, practitioners and service users within the community was noted to be a key issue affecting transition (NICE, 2016). The consequence of poor integration can lead to inadequate and fragmented support for people using mental health services with reportedly a negative impact on specific recovery goals (Parkes et al., 2015).

The Forensic Intensive Recovery Support Team (FIRST) supports individuals in their secure care pathway, within the community and those transitioning to a less restrictive environment, by providing individualised care that manages risk, supports wellbeing and encourages recovery. FIRST is part of REACH OUT, a model of care which seeks to work collaboratively with service users, their families and other professionals to avoid re-admissions and delays in treatment. REACH OUT incorporates BSMHFT, St Andrews Healthcare and Midlands Partnership NHS Foundation Trust.

Working with individuals transitioning from secure care to the community, FIRST recognised how important a stable and comfortable transition period can be. Subsequently, the team sought to support our service users develop greater confidence for community living. A group setting was thought to help share learning and normalise transitional anxieties.

Service user feedback - focus groups

Focus groups were undertaken with a total of 16 service users and staff across two secure sites and two supported accommodation placements. Various topics were identified (Figure 1) which informed the content and structure of the group programme, reinforcing the importance of a multi-disciplinary approach to facilitation.

Group structure and content



Figure 1: Outline of topics covered

Following feedback, the core team consisting of occupational therapy and psychology colleagues developed a total of 20-weekly sessions, split into 4 modules (Table 1).

1) Practical Living	2) Keeping Myself Safe	3) Health and Wellbeing	4) Healthy Relationships
<ul style="list-style-type: none"> •Hopes and Expectations* •Budgeting •Transport •Work / Life Balance •Benefits •Accommodation 	<ul style="list-style-type: none"> •Fire Safety •Technology •Online Safety (Banking) •Personal Safety 	<ul style="list-style-type: none"> •Hopes and Expectations* •Physical Health •Substance Use •Mental Health •Healthy Living 	<ul style="list-style-type: none"> •Disclosure •Relationships •OnLine Safety (Dating, Social Media) •Problem solving

Table 1: Outline of modules covered within the Transitions Group. Note: *led by experts by experience

Sessions were designed to be less didactic and more interactive in nature. This has been an opportunity to work with the expertise of both internal MDT colleagues and external agencies (e.g., fire service). We have also had an excellent session co-facilitated by people with lived experience. Service users can attend all sessions or can be referred for specific modules. Selection of modules is made collaboratively between the service user and their team.

The group is held at a local library in the community which is easily accessible by public transport. Furthermore, the mixed-gendered nature of the group coincides with the relational topics covered and enables service users to develop their interpersonal skills.

Who is it for?

The transitions group is open to service users approaching discharge or who have recently moved into the community from BSMHFT and our partnership sites. The group-based nature encourages learning from others who are at the same or different stages of their transition, and creates an opportunity to develop social support.

So far

The first cycle of this group began in

September 2019 and is currently underway. Attendance is high and the layout and modular format has received positive feedback. Service users have completed pre/post confidence and knowledge measures each session and a collective increase has been found for the modules so far. Due to the high attendance (and high demand waiting list), the capacity for each group has been extended and we hope that the interest generated continues.

There have been some challenges such as co-ordinating travel, ensuring responsiveness to diverse cognitive abilities and securing a location that was accessible to all secure sites. We have, however, been able to overcome these and they have been learning lessons that will undoubtedly inform future groups.

We are in the process of evaluating the group with a plan to incorporate service users' perspectives. We hope that the group will continue to be a success and it is planned to be rolled out again in the New Year.

**Ross Taylor, Assistant Psychologist;
Laura McCarron, Assistant Psychologist;
and Dr Kimberly Sham Ku, Senior Forensic Psychologist, Ardenleigh Hospital**

Elysium Healthcare

Supporting Research and Quality Improvement: The Chadwick Lodge Experience

Clinicians are finding it increasingly difficult to allocate time for research activities within under-funded mental health services. Secure services are also vulnerable to such pressures, though in many ways, secure units are ideal places for clinical research, as such units are generally better resourced and the longer durations of stay offer opportunities for asking more longitudinal research questions. Within secure services, the independent sector beds have so far been spread around the country but the recent formation of local forensic clinical

networks offers opportunities to better embed the independent sector within existing NHS structures, thus enhancing opportunities for research and quality improvement projects.

Chadwick Lodge is a 112-bedded secure hospital in Milton Keynes owned by Elysium Healthcare, with male and female beds across medium, low secure and locked rehabilitation, with a specialist interest in personality disorder. The location of Chadwick Lodge is advantageous for the development of links with both London and the Midlands, as well as Oxford and Cambridge.

Within Elysium Healthcare, a research governance framework has been created with the formation of a research steering group chaired by the Group Medical Director.

Chadwick Lodge has developed multidisciplinary academic links with various universities like King's College, London, University of Northampton, Bedfordshire and Hertfordshire. This enables a steady flow of students doing their clinical and research placements in Chadwick Lodge. The regular arrival of students and discussion of their projects in the unit CPD programme along with other measures like making them feel welcome in unit handover meetings has helped to develop a culture where research is encouraged and facilitated. Clinically important projects like evaluation of the unit fitness programme called Mission Fit as well as assessment of organisational cultural competence have been facilitated through student projects and presented at conferences like the Quality Network conference of The Royal College of Psychiatrists.

Chadwick Lodge has further developed a formal research partnership with the Division of Psychology and Life Sciences at Brunel University. As part of this partnership, two PhD students will be doing most of their data collection for a project exploring cognitive and affective measures for patients within secure settings and the link between these characteristics and clinical outcome, including length of stay. This has long-term benefits for patients and clinicians at Chadwick Lodge not only in developing a more evidence-based way to predict length of stay for secure patients but also more immediate benefits like the results of the cognitive and affective testing being available to clinicians whose patients are eligible to take part in the study.

Another important project, is Chadwick Lodge's participation in the world's first randomised controlled trial of Clozapine in the treatment of borderline personality disorder, run from Imperial College, London. Elysium Healthcare is one of seven national partners for this trial, with Chadwick Lodge chosen due to its special interest in

personality disorder. Chadwick Lodge contributed the very first patient to this important trial, which has important clinical practice implications for secure patients, a number of whom do very well on Clozapine within in-patient services but relapse due to reluctance of community psychiatrists to prescribe Clozapine.

Chadwick Lodge is also exploring other projects with the Institute of Psychiatry, Psychology and Neurosciences, King's College, London, like assessment of trust in borderline personality disorder. Again, the benefit to clinicians and patients would be an objective evaluation of their ability to trust, crucial to their prognosis. Development of a culture of research has undoubted benefits for patient care. It helps to develop a culture of innovation, one of the core values of Elysium Healthcare. In our experience, patients like meeting researchers who are new faces to the unit, with a lot of knowledge and time on their hands. Staff also value having students and researchers around, not only to be challenged and questioned on their practice, but also because some of their workload can be eased by students and researchers doing some of the hands-on clinical work, for example, completing the risk assessment tool for a particular patient under supervision!

The most important factor in supporting research and quality improvement is the attitude of the senior management team of the hospital and the organisation. The words of Francis Bacon, the noted English philosopher and statesman, continue to be relevant here and helps to facilitate the spirit of enquiry and innovation - *"If a man will begin with certainties, he shall end in doubts, but if he will be content to begin with doubts, he shall end in certainties."*

Dr Piyal Sen, Medical Director and Consultant Forensic Psychiatrist, Chadwick Lodge & Eaglestone View



Useful Links



Care Quality Commission
www.cqc.org.uk

Centre for Mental Health
www.centreformentalhealth.org.uk

Department of Health
www.doh.gov.uk

Health and Social Care Advisory Service
www.hascas.org.uk

Institute of Psychiatry
www.iop.kcl.ac.uk

Ministry of Justice
www.gov.uk/government/organisations/ministry-of-justice

National Forensic Mental Health R&D Programme
www.nfmhp.org.uk

National Institute for Health and Care Excellence
www.nice.org.uk

NHS England
www.england.nhs.uk

Offender Health Research Network
www.ohrn.nhs.uk

Revolving Doors
www.revolving-doors.org.uk

Royal College of Psychiatrists' College Centre for Quality Improvement
<https://www.rcpsych.ac.uk/improving-care/ccqi>

Royal College of Psychiatrists' Training
<https://www.rcpsych.ac.uk/training>

See Think Act (2nd Edition)
<https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services/see-think-act>

Contact the Network

Megan Georgiou, Programme Manager
Megan.Georgiou@rcpsych.ac.uk
020 3701 2701

Jem Jethwa, Deputy Programme Manager
Jemini.Jethwa@rcpsych.ac.uk
020 3701 2671

Kelly Rodriguez, Project Officer
Kelly.Rodriguez@rcpsych.ac.uk
020 3701 2684

Twitter
Follow us: @rcpsych @ccqi_
And use #qnfms for up-to-date information

QNFMS Knowledge Hub Group
www.khub.net/group/quality-network-for-forensic-mental-health-services-discussion-forum

Royal College of Psychiatrists' Centre for Quality for Improvement
21 Prescott Street, London, E1 8BB



www.qnfms.co.uk