

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	1752
Service	Adult High Secure Services
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1. Scope

1.1 Prescribed Specialised Service

1.1.2 This specification covers the provision of high secure services for adults aged 18 years and over in England and Wales and the high secure service for women in Scotland and Northern Ireland. There will be exceptional circumstances where under 18's will require admission to high secure services; a separate protocol covers this situation and is included in Appendix 5.

1.1.3 The high secure service for men in Scotland is not covered by this specification.

1.2 Description

1.2.1 This service specification describes high secure inpatient services for adults delivered within a clearly defined geographical area at multi-regional level in line with nationally agreed population catchment areas. This specification will be subject to review 3 years after publication.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

1.3.1 NHS England commissions adult secure mental health services and associated non-admitted care, including access assessment and the

High Secure Women's Outreach service (see 4.1.4) for those detained under the Mental Health Act.

1.3.2 The Secretary of State for Health has a duty under Part One, Section 4 of the National Health Service Act 2006, to provide hospital accommodation and services for persons who:

- are liable to be detained under the Mental Health Act 1983 (c20)

and

- in the opinion of the Secretary of State require treatment under conditions of high security on account of their dangerous, violent or criminal propensities.

1.3.3 Only NHS Trusts approved by the Secretary of State through a formal authorisation process can provide high secure services as detailed in Part One of the National Health Service Act 2006. Such approval must be for a specified period, may be subject to conditions and can be amended or revoked at any time.

1.3.4 There are three designated NHS Trusts authorised by the Secretary of State to provide high secure services: these are listed in Section 6.

1.3.5 The three hospitals provide the following high secure services:

- Services for people who are Deaf (Rampton Hospital)
- Male mental illness (Broadmoor, Rampton and Ashworth Hospitals)
- Personality Disorder services (Broadmoor, Rampton and Ashworth Hospitals)
- Learning Disability Services for men (Rampton Hospital only)
- Women's Service (Rampton Hospital)

1.3.6 High secure services are provided in hospitals whose physical security arrangements are equivalent to a Category B prison; they can however, treat individuals who in a prison setting would be in a Category A environment.

1.3.7 High secure hospitals are subject to the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2019, which outline requirements concerning safety, security and the management of patients. The 2019 Directions can be accessed through the following link

<https://www.gov.uk/government/publications/high-security-psychiatric-services-directions-2019-arrangements-for-safety-and-security>

- 1.3.8 The high secure hospitals must adhere to the Clinical Security Framework and will engage with the Clinical Secure Practice Forum (CSPF) and the National Oversight Group (NOG), which provides line of sight for the Secretary of State for Health.
- 1.3.9 The high secure hospitals will work collaboratively to achieve consistency in application of policies and practice for high secure mental health services to ensure there are equitable services for patients regardless of which hospital the patient resides in.
- 1.3.10 Clinical Commissioning Groups (CCGs) commission services for adults on the secure pathway who do not or no longer require high, medium or low secure care or Forensic Outreach Liaison Services all of which are commissioned by NHS England.

2 Care Pathway and Clinical Dependencies

2.1 Care Pathway

- 2.1.1 Secure services provide treatment for adults aged 18-years and over with mental disorders, these include mental illness (MI), personality disorder (PD) and neurodevelopmental disorders (NDD) including learning disabilities (LD) and autism. Further detail regarding the care pathway and service expectations is set out in Appendix 1.
- 2.1.2 Secure services also provide care and treatment for people who are
- culturally deaf (D) and audiotically deaf (deaf)
 - have an acquired brain injury
- 2.1.3 Patients in secure services are liable to be detained under the Mental Health Act and their risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings.
- 2.1.4 Patients in secure services typically have complex chronic mental disorders, which are linked to offending or seriously harmful behaviour. Some will be involved with the criminal justice system (CJS), courts and prison, and may have Ministry of Justice (MoJ) restrictions imposed.

- 2.1.5 Three levels of security currently exist across secure adult inpatient services each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the patient and others including patients, staff and the general public.
- High Secure services provide care and treatment to those adults who present a **grave risk of harm** to others and who cannot be managed in lower levels of security and who must not be able to escape from hospital
 - Medium secure services provide care and treatment to those adults who present a **serious** risk of harm to others and whose escape from hospital must be prevented
 - Low secure services provide care and treatment who present a **significant** risk of harm to others and whose escape from hospital must be impeded
- 2.1.6 All high secure patients will be detained under the Mental Health Act and the decision to admit will be based on a comprehensive psychiatric assessment and assessment of risk. Many, but not all patients admitted to high secure services will have been charged with or convicted of a violent criminal offence.
- 2.1.7 High secure services play a key role in assessing an individual's ability to participate in court proceedings and in providing advice to courts regarding disposal following sentencing.
- 2.1.8 The recognised pathways into high secure care are as a step up from medium secure care, admission directly from the criminal justice system including transfers from prison or more rarely, a step up from other services.
- 2.1.9 The core objectives of high secure services are to assess and treat mental disorder, reduce the risk of harm towards others and to support recovery and rehabilitation. The aim is for patients to safely transition to lower levels of security (e.g. medium or low secure services) or to be returned to prison. It is rare that patients are discharged from high secure services directly to community settings.
- 2.1.10 The pathway through and out of secure care must be identified early in admission though may be subject to change depending on changing needs or circumstances. The care pathway must be planned in consultation with the patient. Lengths of stay are typically between five and six years.

2.1.11 High secure care will operate within an ethos that places the patient at the centre of their care and facilitates active engagement in their recovery from mental disorder and risky behaviours.

2.1.12 Multi-disciplinary team (MDT) care will underpin delivery; the MDT will consist of appropriately trained skilled and supervised staff including psychiatrists, clinical and/or forensic psychologists, mental health nurses, occupational therapists, pharmacists, social workers and other therapists including art and speech and language therapists.

2.1.13 High secure services will ensure that patients are able to access and receive appropriate services to identify and meet physical health care needs. Appendix 1 sets out more detail about requirements for the provision of pharmacy and primary healthcare services and access to secondary healthcare services.

2.1.14 Details about the service model, acceptance and exclusion criteria and care pathway are set out in Appendix 1.

2.2 Interdependence with other Services

2.2.1 High secure services are part of a spectrum of services whose function is to meet the needs of patients with mental disorders and/or neurodevelopmental disorders including learning disability and autism that will benefit from specialist care and treatment within a secure environment.

2.2.2 Key partnerships include:

- Care Quality Commission
- NHS England
- NHS Improvement
- Medium secure and low secure services
- NHS / Independent / Third Sector providers
- Advocacy Services
- Carer Support Services
- Department of Health (DH)
- Ministry of Justice (MoJ)
- Courts
- Police
- Her Majesty's Prison and Probation Service (HMPPS)
- Multi Agency Public Protection Arrangements (MAPPA)
- Health and Justice commissioned offender health services

- Offender Personality Disorder Services
- Social Care Agencies
- Appropriate Regulators

2.2.3 The service must have Caldicott and information governance compliant protocols and structures in place to enable the appropriate sharing of clinical information with other agencies.

2.2.4 High secure services must provide training and education programmes and should participate in research/development activity which promotes the continual improvement of the service and outcomes for patients.

2.2.5 In addition, they must ensure that the patients in their service have access to participate in research activity. The service should ensure that all staff are able to participate in these activities without affecting care and treatment or business continuity.

3 Population Covered and Population Needs

3.1 Population Covered by This Specification

3.1.1 This service specification relates to adults aged 18 and over who are the commissioning responsibility of NHS England including adults from Wales and women from Scotland and Northern Ireland who require high secure services. There will be exceptional circumstances where under 18's will require admission to high secure services; a separate protocol covers this situation and is included in Appendix 5.

3.1.2 The nationally agreed population catchment areas served by each hospital are set out in Appendix 2.

3.2 Population Needs

3.2.1 Assessing the incidence and prevalence of adult mental disorders likely to require secure care is challenging. There are several factors relating to a) the population prevalence of mental disorders that require detention in hospital and b) the level of risk to the public from people with these mental disorders, which make non-secure hospital care unsafe. A comprehensive mental health service review has been undertaken in 2016-17 across England to determine the population need for secure care. This complements the Transforming Care Programme for learning disability services and autistic spectrum disorder services.

3.2.2 The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 reported that one in three adults aged 16-74 (37%) with conditions such as anxiety or depression, surveyed in England, were accessing mental health treatment, in 2014. This figure has increased from one in four (24%) since the last survey was carried out in 2007. Overall, around one in six adults (17%) surveyed in England met the criteria for a common mental disorder (CMD) in 2014. Women were more likely than men to have reported CMD symptoms. One in five women (19%) had reported CMD symptoms, compared with one in eight men (12%). Women were also more likely than men to report severe symptoms of CMD; 10% of women surveyed reported severe symptoms compared to 6% of men.

3.2.3 In terms of the Mental Health Act (1983), the CQC report monitoring use of the Mental Health Act in 2015-16 showed detention rates have continued to rise in recent years and 2014-15 saw the highest ever year-on-year rise (10%) to 58,400 detentions.

3.3 Expected Significant Future Demographic Changes

3.3.1 There are multiple factors which affect demand for high secure mental health services; these will be considered during the 5-yearly national capacity reviews which 3 hospital providers are expected to engage in.

3.4 Evidence Base

3.4.1 There are no randomised controlled trials comparing secure care with non-secure care. The criminal justice system, through the courts and prison services have within the Mental Health Act (1983) a legal framework to ensure people with a mental disorder who are a risk to the public receive evidenced based care for their mental health condition within an environment that has the level of security equivalent to a prison. Secure services primarily offer the same treatments as in the rest of mental health services but in a secure setting.

3.4.2 There are studies that follow-up patient discharged from secure hospitals which show reduced reoffending (e.g. Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis Seena Fazel, Zuzanna Fimińska, Christopher Cocks, Jeremy Coid The British Journal of Psychiatry Jan 2016, 208 (1) 17-25; DOI: 10.1192/bjp.bp.114.149997. This showed some evidence that patients discharged from secure services have

lower offending outcomes than many comparative groups. Services could consider improving interventions aimed at reducing premature mortality, particularly suicide, in discharged patients.

4 Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

4.1.1 High secure services provide a model of integrated services incorporating all elements of the service pathway and aim to deliver effective, timely, therapeutic recovery-focussed services for patients with a mental disorder assessed as presenting a serious risk of harm to others.

4.1.2 The expected outcomes of the service support the national ambitions set out in the Five Year Forward View and Building the Right Support to reduce lengths of stay, ensure admission to hospital only takes place when absolutely necessary, reduce variation in service access and availability and improve the experience of patients, their families and carers in using these services.

4.1.3 All high secure services must be recovery-orientated and outcome-focused.

4.1.4 The High Secure Women's Outreach service provides expert clinical and practical support to other services, and assists in transition, admission avoidance and discharge.

4.1.5 The core objectives are to:

- Assess and assertively treat mental disorder
- Provide a safe and therapeutic environment
- Protect others by reducing the likelihood of current and future interpersonal violence
- To maintain dignity through individualised compassionate care
- To improve health and wellbeing (including physical, mental and spiritual)

4.1.6 The Principles of care are

- Patient centred physical and mental health care pathways
- Integrated security
- Focus on recovery
- Robust evidence-based interventions/treatment
- Efficient pathway management
- Therapeutic environments

- Structured rehabilitation activities
- Effective multidisciplinary team working
- Carer involvement

4.2 NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

4.3 Indicators Include:

No.	Indicator	Data source	Domain(s)
Clinical Outcomes			
103	Proportion of patients waiting over 21 days from referral for decision to admit	SSQD	1,2,3,4,5,
106	Proportion of patients waiting over 21 days for admission following decision to admit.	SSQD	1,2,3,4,5,
107	Proportion of patients offered at least 25 hours per week of meaningful activity	SSQD	1, 2, 3, 4
108	Proportion of patients who undertake up 25 hours meaningful activity (exclude new admissions and discharges in month)	SSQD	1, 2, 3, 4
109	The number of incidents (per 100 beds), of actual physical violence from male patients to members of staff that required medical intervention/treatment	SSQD	1, 2, 3, 5
112	The number of incidents of actual physical violence from male patient to patient in period that required medical intervention/treatment	SSQD	1, 2, 3, 5
115	Number of male patients who have self - harmed and have required immediate medical intervention/treatment) during reporting period	SSQD	1, 2, 3, 5
116	Number of female patients who have self - harmed and have required immediate medical intervention/treatment) during reporting period	SSQD	1, 2, 3, 5
117	Number of patients with a learning disability who have self-harmed and have required	SSQD	1, 2, 3, 5

	immediate medical intervention/treatment) during reporting period		
121	The daily average for patients who are subject to long term segregation during the quarter	SSQD	1, 2, 3, 4, 5
125	% of staff who have received annual safeguarding vulnerable adults training	SSQD	5
126	Where discharge to medium secure is accepted, the average length time for patient to be transferred	SSQD	3, 4, 5
127	Risk Reduction - median length of stay measured in occupied bed days for people who are discharged in the quarter	SSQD	3, 4, 5
130	Total number of delayed bed nights for patients with a learning disability in period (per definition above) / OBNS x100 in period	SSQD	3, 4, 5
Patient Experience			
201	A patient experience exercise must be undertaken at least annually	SSQD	4
202	The provider has a carer strategy, which utilises the secure carers toolkit	Provider	4
Structure and Process			
301	There is a multi-disciplinary team in place as detailed in the service specification	Self-declaration	1, 2, 3, 4, 5
303	All patients have a CPA in line with the requirements of the service specification	Self-declaration	1, 2, 3, 4
304	There is a system in place whereby an external long-term segregation review is carried out at least quarterly as specified in the Code of Practice	Self-declaration	1, 2, 3, 4
305	The service adheres to the clinical guidelines as defined within the service specification	Self-declaration	1, 2, 3, 4, 5

4.3.1 Detailed definitions of indicators setting out how they will be measured are included in Schedule 6.

4.3.2 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C.

4.3.3 In addition to the above, commissioned providers are also required to collect and submit quarterly data relating to the national initiative to reduce restrictive practices. Provider data must be submitted via the NHSE Quality Surveillance Information System (QSIS) accessed through the following link <https://www.qst.england.nhs.uk/>

4.3.4 The national dashboard definitions for Reducing Restrictive Interventions can accessed via the link below.

<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/spec-dashboards/>

4.3.5 Applicable CQUIN goals are set out in Schedule 4D.

5 Applicable Service Standards

5.1 Applicable Obligatory National Standards

5.1.1 All high secure services must

- Comply with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions and Child Visiting Directions for High Secure Services 2013
- Comply with the DH High Secure Design Guide
- Operate within the terms and conditions of the High Secure Licence granted by the Secretary of State following an authorisation process
- Support NHS England in complying with the High Security Psychiatric Services National Health Service England Board Commissioning Directions (2013) relating to the requirement to prepare a national capacity assessment every 5 years. These Directions can be accessed using the following link <https://www.gov.uk/government/publications/high-security-psychiatric-services-national-health-service-commissioning-board-directions-2013>
- Provide services in line with the agreed national capacity requirements
- Adhere to the Clinical Security Framework in all matters related to security
- Support national oversight in all clinical and security matters
- Comply with relevant safeguarding legislation.

5.1.2 Robust procedures relating to the responsibilities of services and staff under the Mental Health Act and other relevant legislation must be put in place and regularly reviewed.

5.1.3 The service must deliver services, comply to and work within the requirements of:

- Mental Health Act 1983 and Code of Practice 2017
www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
www.legislation.gov.uk/ukpga/2007/12/contents

- Mental Capacity Act 2005 and Code of Practice 2007 and supplement to the Code on the Deprivation of Liberty Safeguards 2007

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice#history>

www.legislation.gov.uk/ukpga/2005/9/contents

- Criminal Justice Act 2003

www.legislation.gov.uk/ukpga/2003/44/content
[s](#)

- The Transfer and Remission of Adult Prisoners Under the Mental Health Act 1983, guide 2019

- Ministry of Justice for restricted patients

5.1.4 Services must ensure compliance against the Care Quality Commission's (CQC) "Essential Standards of Quality and Safety" (2010) www.cqc.org.uk with respect to maintaining safety and in the management of emergencies. This must include

- Provision of appropriately trained staff
- Availability of appropriate staffing capacity
- Robust on call arrangements,
- Easy access to emergency medical equipment
- Facilitation of rapid access for emergency services into the unit.

5.1.5 When rapid tranquilisation is administered there will be staff present who are compliant with Intermediate Life Support (ILS – Resuscitation Council UK) or equivalent training. The policy for Rapid Tranquilisation must be easily accessible to all staff.

5.1.6 NICE Guidance for the treatment of the following should be adhered to:

- CG136 Service User Experience in Adult MH Services
- CG82 Schizophrenia
- CG38 Bipolar disorder
- CG90 Depression in adults
- CG120 Psychosis with coexisting substance misuse
- CG77 Antisocial personality disorder
- CG78 Borderline personality disorder
- CG51 Drug misuse: psychosocial interventions

- CG25 Violence (short-term management)
-

- CG133 Self-harm (longer term management)
- CG142 Autism in adults

5.2 Other Applicable National Standards to be met by Commissioned Providers

- 5.2.1 Robust procedures relating to the responsibilities of provider organisations, services and clinicians under the Mental Health Act 1983 must be put in place and regularly reviewed.
- 5.2.2 Any medical treatment provided to patients must comply with Part 4 of the MHA and, where relevant, the Mental Capacity Act 2005 and the common law.
- 5.2.3 Services must comply with the requirement to liaise with the bodies responsible for providing after-care services to patients under section 117 of the MHA.
- 5.2.4 High secure services must operate within an ethos that places the patient at the centre of their care and facilitates active engagement in their recovery from mental health difficulties and risk behaviours.
- 5.2.5 Providers must promote equality of access, experience and outcomes across ethnic groups, faiths, gender, disabilities, sexual orientation and socio-economic status.
- 5.2.6 Due to the nature of secure services, it will be necessary for certain blanket restrictions, as described in the MHA Code of Practice, to apply in order to maintain the overall security of the service and to manage high levels of risk to other patients, staff and members of the public.
- All blanket restrictions must be a necessary and proportionate response to risk and must be authorised and monitored through the provider organisation's operational and governance procedures.
 - All blanket restrictions must be recorded in writing and be subject to review and evidence consideration of the impact of that restriction on each patient.
- 5.2.7 CPA meetings must be held within the first three months of admission and then every six months.
- 5.2.8 Care and Treatment Reviews (CTR) must be held in accordance with national policy which can be accessed via the following link

<https://www.england.nhs.uk/publication/care-and-treatment-reviews-policy-and-guidance/>

5.3 Other Applicable Local Standards

- 5.3.1 High secure service providers will comply with the Clinical Security Framework and engage with the National Oversight Group (NOG) providing line of sight to the Secretary of State.
- 5.3.2 The three high secure hospitals are expected to work collaboratively to achieve consistency in the design and application of policies and practice for high secure services and actively contribute to and participate in the Clinical Security Practice Forum (CSPF) which is a formal sub group of NHS England's Adult Secure Clinical Reference Group and the National Oversight Group.

6 Designated Providers

6.1 The providers listed below are authorised by the Secretary of State to provide high secure services for adults

- West London NHS Foundation Trust – Broadmoor Hospital
- Nottinghamshire Healthcare NHS Foundation Trust – Rampton Hospital
- Mersey Care NHS Foundation Trust – Ashworth Hospital

7 Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

CMD: Common Mental Disorders

CJS: Criminal Justice System

CPA: Care Programme

Approach CQC: Care Quality

Commission

CQUIN: Commissioning Quality and

Innovation CSPF: Clinical Security Practice Forum

CTR: Care and Treatment Reviews

DHSC: Department of Health and Social Care

HMPPS: Her Majesty's Prison and Probation Service

LD: Learning Disability

MAPPA: Multi Agency Public Protection

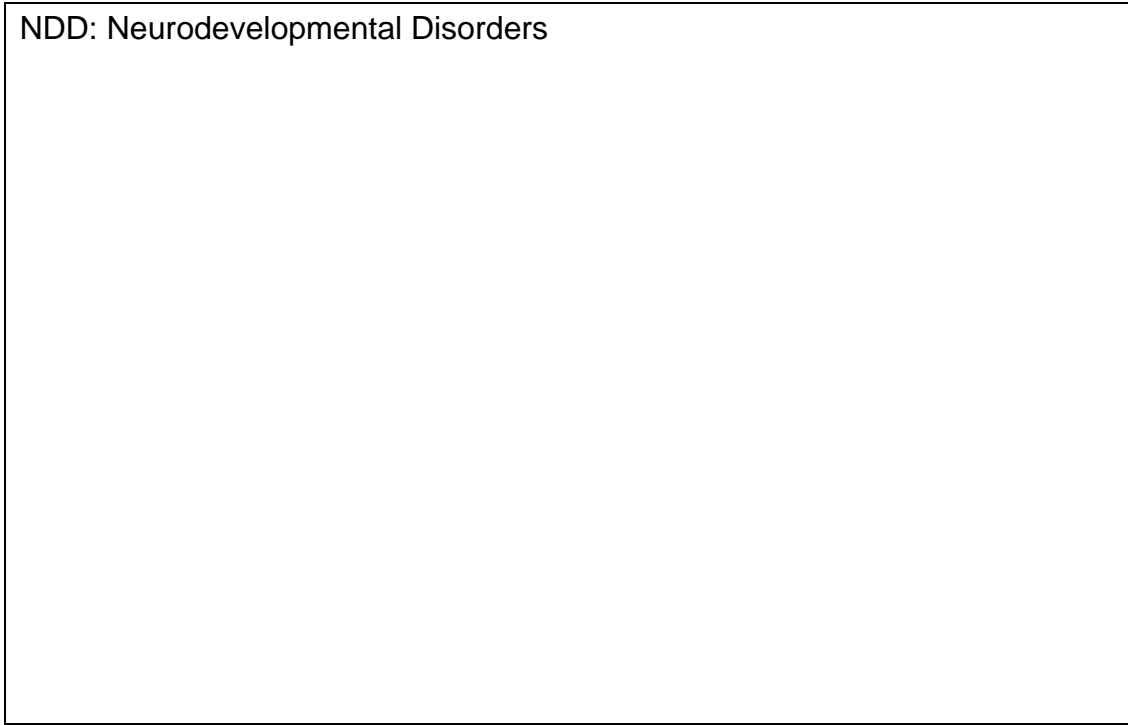
Arrangements MDT: Multi-disciplinary Team

MHA: Mental Health

Act MI: Mental Illness

MoJ: Ministry of Justice

NDD: Neurodevelopmental Disorders



NICE: National Institute of Care Excellence
NOG: National Oversight Group
PD: Personality Disorder
SSQD: Specialised Services Quality Dashboard

Date published

APPENDIX 1

ACCEPTANCE AND EXCLUSION CRITERIA, CARE PATHWAY AND ADDITIONAL SERVICE COMPONENTS

1. Introduction

- 1.1 High secure hospitals provide comprehensive evidence-based care and treatment delivered by a range of practitioners expert in the field of forensic mental health.
- 1.2 A range of specialist treatment programmes will be available to patients delivered either individually or within groups. The aim is for the patient to safely transition to levels of lesser security or return to prison if subject to a prison transfer under the Mental Health Act. It is rare for patients to be discharged directly to the community from high secure services.
- 1.3 The recognised pathways into high secure services are as a step up from medium secure care, admission directly from the criminal justice system and more rarely as a step up from other services.
- 1.4 The pathway through and out of secure care should be identified early on in the admission process although these plans may be subject to change depending on the patients changing needs or circumstances.
- 1.5 High secure services will operate within an ethos that places the patient at the centre of their care and facilitates their active engagement in recovery from mental health issues and reduction in risk behaviours.
- 1.6 High secure services will promote equality of access, experience and outcomes across ethnic groups, faiths, gender, disabilities, sexual orientation and socioeconomic status.
- 1.7 Multidisciplinary team (MDT) working and care will underpin service delivery. The MDT will include appropriately trained and supervised staff including psychiatrists, clinical and/or forensic psychologists, mental health nursing staff, occupational therapists and social workers supported by other therapists including, for example, pharmacists, art therapists and speech and language therapists.
- 1.8 The Care Programme Approach (CPA) will be implemented for all patients and will form the basis of all care planning and treatment options, dynamically supporting the transition through the high secure services pathway to discharge.

- 1.9 Care and Treatment Reviews (CTR) have been developed as part of NHS England's commitment to transforming services for people with learning disabilities (LD) and/or Autism who display behaviour that challenges. All high secure services must support commissioners to host CTRs for patients with LD and/or autism. This is in addition to the CPA process. Guidance on the national CTR process and approach can be accessed using the following link
www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf
- 1.10 Robust procedures relating to the responsibility of the hospitals, services and clinicians under the Mental Health Act 1983 will be put in place and regularly reviewed.
- 1.11 Any medical treatment provided to patients must comply with part 4 of the Mental Health Act and where relevant the Mental Capacity Act 2005.
- 1.12 The maintenance of security is crucial to the provision of effective therapeutic interventions in all adult secure services. A key principle underpinning delivery of secure care is that patients should be managed in the least restrictive environment possible to facilitate their safe recovery whilst also maintaining safety. Least restrictive refers to therapeutic use of the minimum levels of physical, procedural and relational security measures necessary to provide a safe and recovery focused environment.
- 1.13 Due to the nature of high secure services and in order to maintain the overall security of the service, to manage high levels of risk to other patients, staff and members of the public it will be necessary for certain blanket restrictions as described in the Mental Health Act Code of Practice to apply.
- 1.14 Any blanket restrictions must be a necessary and proportionate response to the respective risks. The impact of a blanket restriction on each patient should be considered by the patient's MDT and the organisational governance structures. All blanket restriction must be recorded in writing and be subject to a defined review.
- 1.15 Blanket restrictions must be authorised and monitored through the respective provider organisations' operational and governance procedures.

2. Acceptance criteria

- 2.1 The patient must be suffering from a mental disorder (including mental illness, neuro-developmental disorder and personality disorder) as defined within the Mental Health Act 1983 which is of a nature and/or degree warranting detention in hospital for medical treatment and that appropriate treatment is available.

- 2.2 The patient must be assessed as presenting a grave risk of harm to others, appropriate management of the risk requires in-patient care, specialist risk management procedures and treatment interventions that cannot be provided safely in lower levels of security.
- 2.3 Patients suitable for transfer from prisons under the Mental Health Act will generally be charged with or have been convicted of a specified violent or sexual offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence such as arson.
- 2.4 On occasion patients will be accepted without criminal charges pending where there is clear evidence of grave risk of harm to others. In such cases, there will generally be a pattern of assaults and escalating threats which may, in the light of an access assessment constitute grounds for admission.
- 2.5 Patients directed to conditions of high security by the Ministry of Justice even if they have not been assessed to be a grave risk of harm to others by the individual hospital.

3. Exclusion criteria

- 3.1 People who do not present a grave risk of harm to others should not be admitted to high secure services and should be referred to medium or low secure services.
- 3.2 People with a severe learning disability and who present with dangerous behaviours will in most cases, require bespoke packages of care in non-high secure settings.
- 3.3 People who present with severe self-harm should only be admitted to high secure services if their risk to others clearly necessitates it.

4. Response times

- 4.1 Routine cases:
- 4.1.1 A decision regarding admission to high secure services will be made within 21 days of referral receipt and the patient will be admitted within a further 21 days.
- 4.1.2 Where this applies to those referrals, assessments and admissions from prisons and Immigration Removal Centres (IRC) the timescales set out in the current national policy guidance for transfers and remissions take precedence.

4.2 Urgent cases

- 4.2.1 The urgency of a referral (including where life is at imminent risk and where the patient cannot be contained and/or treated in the short-term in their current environment) is determined by the receiving high secure service and urgent cases will be prioritised. A decision regarding admission and subsequent admission will be made in **9** days.
- 4.2.2 Where a decision to reject a referral has been made by the Admissions Panel the referrer can request a review of their decision using the hospitals appeals system.

5. Care pathways

- 5.1 All patients will be treated and managed according to a care pathway and this will be planned in consultation with the patient.
- 5.2 The care pathway whilst not prescriptive describes the patients anticipated transition into, through and out of high secure care. The indicators and criteria which are used for assessing progression and transition through the pathway will include:
- Nature and degree of mental disorder and its relationship to risk
 - Level of risk to others
 - Level of care and supervision required
 - Need for input from specialist services or staff
 - Need for offence/risk behaviour related work
 - Level of engagement with treatment/care plan
 - Level of engagement in structured and meaningful activities
 - Level of misuse of drugs or alcohol
- 5.3 The high secure care pathway has 5 elements:
- i. Referral and assessment
 - ii. Pre-admission management
 - iii. Admission assessment
 - iv. Care, treatment and recovery
 - v. Discharge/transfer

Referral and Assessment

- 5.3.1 Each hospital has a defined catchment area for the regional services (see Appendix 2) and will accept referrals from that area unless a referral is made

to a specialist or national service provided in a specific high secure hospital (i.e. national deaf service, women's services and national learning disability service).

- 5.3.2 A patient's catchment area will be determined by NHSE's "Who Pays? Determining responsibility for payments to providers 2013, Rules and Guidance for Commissioners".
- 5.3.3 There will be occasions when referrals are accepted from outside a particular hospitals' catchment area by arrangement with the other high secure hospitals and with written NHSE commissioner support.
- 5.3.4 If the accepting high secure service is nearing or at capacity, the November 2014 NHSE guidelines ratified by the Clinical Secure Practice Forum should be followed see Appendix 3.
- 5.3.5 It is important to note that each referral is unique, the receiving high secure hospital will determine the urgency of the referral on receipt. Discussion between the referrer, assessing clinician and commissioner case manager is required to inform the determination decision.
- 5.3.6 The normal referral and assessment process for admission to high secure services is set out below. The Secretary of State may on occasion 'direct' an individual for admission for high secure care.
- 5.3.7 The referrer must be a consultant psychiatrist or the patient's Responsible Clinician. The referring clinician must seek an opinion from the patients catchment area medium secure Access Assessment Service before submitting a referral to a high secure service.
- 5.3.8 If a patient is detained in an independent medium secure unit, there must be evidence of a discussion prior to referral with the catchment area medium secure Access Assessment Service.
- 5.3.9 Self-referrals will not be considered.
- 5.3.10 The referring clinician must confirm that the patient and/or their legal representative have been informed of the referral including the nature and reason why admission to high secure care is being sought unless there is a good reason not to.
- 5.3.11 The patient and/or their legal representative must be made aware of the admissions procedure and advised to contact the relevant high secure hospital's referrals co-ordinator if they wish to make representations to the Admissions Panel considering the referral.

5.3.12 Assessments for high secure care will generally be carried out face to face and by a suitably qualified clinician under the supervision of a consultant psychiatrist.

5.3.13 The assessing clinician will provide a written report to the high secure hospital Admissions Panel containing details of

- Patient demographics
- Current clinical presentation
- Current risk issues
- Identified care and treatment needs
- Clear recommendation of the least restrictive care environment
- Proposed care and treatment plan
- Recommendations to the Admissions Panel

5.3.14 High Secure Hospital Admissions Panel

- The Admissions Panel will be chaired by a consultant psychiatrist or high secure services Clinical Director and will have multidisciplinary membership.
- The Admissions Panel will make arrangements to meet weekly if required. The Panel will decide if the patient meets criteria for admission to high secure care.
- Each hospital will operate an appeals system to consider referrals that have been rejected by Admission Panel if required.

Assessment for specialist high secure services

5.3.15 The processes for referral and assessment for patients requiring specialist high secure services are broadly similar to the process set out above for routine and urgent cases.

5.3.16 A number of additional measures are required to ensure referrals and assessments are managed and facilitated effectively for particular patient groups. More information is set out below against each service specialism

Deaf Services – Rampton Hospital

The process for referrals and assessment is set out above in addition

- All referrals for people who are audiological or culturally Deaf must be made to Rampton Hospital.
- The current placements most recent language and communications assessment will be used to inform the approach to and tools for communication with the patient.

- Staff from Rampton will conduct a brief communications analysis during the initial assessment for admission.
- If accepted for admission formal communications assessments are undertaken by Speech and Language Therapists and Deaf Support Workers at Rampton.
- Video recordings of the patient and audiometry tests will be completed to inform the decision about the most appropriate ward placement.
- If accepted appropriate needs-led communications requirements will be identified alongside other needs that will support the transition to high secure services.

Women's Services – Rampton Hospital

- All referrals for women must be made to Rampton Hospital who will identify the most appropriate clinical team from the women's service to undertake the assessment.

Learning Disability Services – Rampton Hospital

The process for referral and assessment is set out above in addition

- All referrals for people with learning disability must be made to Rampton Hospital
- Referral information must include evidence supporting Learning Disability diagnosis from a suitably qualified specialist psychiatrist or psychologist in addition to evidence of both reduced intellectual functioning and problems with adaptive living skills arising before the age of 18
- The most recent CTR outcome must be used to provide evidence of the need for admission to a secure service
- If accepted appropriate needs-led communications requirements will be identified alongside other needs that will support the transition to high secure services.

Pre-Admission Management

5.3.17 The high secure provider will maintain and manage a planned admissions list for all patients assessed and accepted for admission.

5.3.18 If an admission is not achieved within the agreed timescale and it is still required, the provider will inform the high secure commissioner setting out the reasons for the delay with a plan including timescales to complete the admission.

5.3.19 In the pre-admission phase the high secure service will:

- Provide the referrer and patient with information about the high secure service
- Complete a pre-admission nursing assessment (unless urgency does not allow)
- Consider involvement of carers at earliest opportunity considering General Data Protection Regulations (GDPR)
- Identify initial therapeutic targets
- Identify relevant physical health care records to inform care and treatment needs
- Ensure that an initial care plan including the least restrictive management of risk is in place for the day of admission to the high secure hospital.

5.3.20 Patient care plans will be individualised, gender sensitive, recovery orientated, and address needs related to mental and physical health and management of risk.

5.3.21 The high secure service will ensure care is provided with the purpose of meeting the patient's needs, goals and desired outcomes

Admission Assessment

5.3.22 Multidisciplinary assessment and care planning is a continuous process. The first 6 months of the admission will primarily focus on orientating the patient to the service, completing initial assessments, meeting initial physical and mental health care needs, assessing and managing risk, building therapeutic relationships and commencing the appropriate care and treatment.

5.3.23 The assessment process usually comprises three phases:

Phase 1: first week

During the first week the following activities will take place:

- Patient orientated to the ward and provided with an admission brochure (containing useful information about e.g. access to and managing their property, provision of and access to advocacy, contact with family)
- Allocation of Named Nurse
- MHA S132 rights explained
- Mental state examination
- Physical examination
- Routine bloods and ECG conducted
- Blood Borne Virus screening completed if indicated

- Treatment commenced, if indicated
- Demographic information checked for accuracy
- If patient consents, next of kin contacted and provided with information about the service and ward
- MDT meeting held to discuss care
- MDT care plan agreed and written
- Initial risk assessment and management plan completed
- Written care plan shared with patient
- HONOS completed
- Emergency Leave of Absence protocol agreed by MDT
- High Risk Patient Register completed if applicable
- Consideration of safeguarding issues made (and recorded if required)

Phase 2: first six months

During the first six months of admission the following activities will take place

- Build a collaborative therapeutic relationship
- Commence psychological assessment including cognitive/psychological functioning, personality assessment (where indicated), in depth formulation of risk, offence recovery goals and recommended psychological care plan
- Commence drug and alcohol assessment where indicated
- Nursing assessment
- Social background report by Social Worker to include safeguarding (adult and child) issues, contact with carer, liaison with probation, housing and Multi Agency Public Protection Arrangements (MAPPA), if subject to MAPPA.
- Agree initial Occupational Therapy (OT) engagement plan and complete baseline assessment using a validated tool
- Commence standard literacy/numeracy assessment including English for Speakers of Other Languages (ESOL) when required.
- Complete HCR-20
- Completion of comprehensive physical health assessment
- Complete Court reports as required
- Comprehensive psychiatric assessment including diagnosis, treatment needs and recommendations for care pathway
- Conduct other relevant assessments e.g. dietician, speech and language
- Complete collaborative risk assessment with patient
- Commence appropriate treatment including medication
- Social worker in contact with victim liaison officer where applicable.

Phase 3: Three-month CPA

It is important that the medium secure Access Assessment Service attend the first CPA to enable the originating service to provide input into the patient's care pathway. The high secure hospital service must provide the medium secure Access Assessment Service with timely and sufficient notice of the CPA.

The CPA meeting will be used to:

- Review reports from each discipline
- Review HCR 20
- Review HONOS
- Review high risk status.
- Determine need for patient to remain in high secure care
- Formulate and agree the care plan in conjunction with catchment area secure service and patient with type of and timescales for required treatments and therapeutic interventions

In the Learning Disabilities service in addition to CPA, Care and Treatment reviews (CTRs) will also be convened. The CTR involves an independent panel of people including an expert by experience, a clinical expert and the relevant commissioner.

Care, Assertive Treatment and Recovery

5.3.24 The care, treatment and recovery phase will vary in duration for each patient and will be individualised to meet their needs.

5.3.25 Each patient's care will be coordinated through the CPA and /or CTR process and will be co-produced between the patient and clinical team.

5.3.26 Active treatment will often begin on admission and assessment wards and a focus on promoting stability and recovery may also begin from the outset, depending on the patient's presentation.

5.3.27 The three hospitals will offer a diverse range of therapeutic interventions dependent on patient need.

5.3.28 The patients' day will be actively managed and will provide structured therapeutic activities including psychological therapies, occupational therapy activities, sports and leisure activities and rehabilitative activities (e.g. gardening).

5.3.29 Activities will be available 7 days a week.

- 5.3.30 Every patient will have an individual programme reflecting the objectives of their overall treatment plan which has been agreed with their clinical team; the programme will provide a balance of therapeutic work as well as leisure and rest activities.
- 5.3.31 The programme will cover therapy and care delivered on wards and the use of off-ward therapy areas. A work ethos will be established to enable patients to develop occupational skills to assist in normalisation, build self-esteem, reduce negative symptoms and develop important life skills through positive reinforcement.
- 5.3.32 A minimum of 25 hours of personally meaningful therapeutic activity per patient per week will be provided.
- 5.3.33 Medication generally plays an important role in the care and treatment of patients who suffer from serious mental disorder. However, it is recognised that many of these medications can also cause side-effects. Patients must be able to exercise fully informed choice whenever possible in all decisions related to medication and, in instances where a patient is incapacitous or refusing medication, a Second Opinion Appointed Doctor will be requested.
- 5.3.34 Each patient's therapy programme will be tailored to reflect their individual needs as assessed in CPA and/or CTR meetings and articulated in the care plan. Therapies will be available on an individual or group basis subject to the patient's needs and provided by suitably qualified and experienced clinicians. Interventions will be accessible to patients on wards as well as off their ward of residence.
- 5.3.35 Psychological therapy includes different therapeutic approaches (e.g. DBT, CAT, Schema, Cognitive-Behavioural), problem-solving, personal and mental health management, index offence-related work, relapse prevention and restorative work and, finally, preparation for transfer. All the programmes must be designed to promote engagement and support motivation and be informed by the principles of secure recovery.

Discharge Pathway

- 5.3.36 The patient's transition from high secure services (including back to prison for patients who can be remitted) will be considered throughout their pathway and will occur at the appropriate juncture and in a timely fashion.
- 5.3.37 Prior to any First Tier Tribunal when discharge against clinical advice is understood to be a significant possibility, the Clinical Team will hold a Section 117 meeting and invite the accepting clinical team from the patient's home area, the patient's carers (with the patient's consent), the MAPPA

representative and Victim Liaison, (as appropriate) to consider a contingency discharge plan.

- 5.3.38 Transfer and discharge will be managed by the high secure clinical team in consultation with the receiving unit's team and the medium secure access assessment area's service. The high secure service will ensure that all relevant parties are informed and involved as early as possible in the transfer process.
- 5.3.39 For patients where discharge is planned to be to medium secure services (as opposed to transfer to the criminal justice system) strategic care planning for this transition will start early in their high secure care pathway.
- 5.3.40 Patients will generally move to medium secure on a trial leave basis usually for a period of six months, but this may be extended. The term 'trial leave' reflects that if, for any reason, there are difficulties during leave the patient can be returned to high secure care swiftly.
- 5.3.41 The high secure clinical team will maintain contact with the patient during the period of trial leave and an agreement will be reached regarding frequency of contact.
- 5.3.42 During the period of trial leave the Responsible Clinician from the high secure service will continue to maintain oversight of the patients care and progress.

Components of transfer arrangements

- 5.3.43 Prior to discharge, remission to prison or transfer to another hospital a S.117/CPA meeting will be held.
- 5.3.44 Where the patient is being remitted to prison, all discharge arrangements including the S117 meeting will be undertaken jointly with the appropriate prison mental health team. Pre-discharge planning arrangements will ensure appropriate provision is made with the receiving establishment.
- 5.3.45 The high secure service will share information as appropriate and in accordance with Information Governance arrangements and Caldicott principles. Information will include:
- Discharge summary
 - The most recent CPA review documentation
 - The most recent risk assessment and management plan
 - Record of all current medication and physical healthcare needs
- 5.3.46 At discharge/transfer the high secure service will ensure the individual's belongings (including money) are transferred.

- 5.3.47 The high secure service will ensure appropriate patient transport arrangements are in place for patients being transferred or remitted to prison. These arrangements will vary depending on the destination of the patient and, for patients being remitted their prison category status.
- 5.3.48 Where applicable, the high secure service will ensure the appropriate reports are received by the Ministry of Justice without unnecessary delay.
- 5.3.49 Immediately prior to discharge each patient will be assessed by an appropriately qualified member of clinical staff in the patient's current placement to ensure that the agreed discharge criteria are met.
- 5.3.50 The high secure service will formally transfer the patient and for those patients who have been subject to Trial Leave arrangements, formally transfer at the end the Trial Leave arrangements.

6. ADDITIONAL SERVICE COMPONENTS

6.1 CPA meetings

- 6.1.1 The frequency of CPA review meetings will be based on the needs of each patient to promote a patient-centred, recovery and outcomes based approach to care planning and review. However, as a minimum CPA reviews will be held 6-monthly and the high secure service will support patients to prepare for CPA meetings.
- 6.1.2 For patients in high secure services the medium secure Access Assessment Service from their home area provides a vital link across the pathway and should be asked by the high secure service to review the patient at least annually and contribute to and participate in discussions about discharge planning through appropriate meetings.
- 6.1.3 Patients meeting the criteria for Care and Treatment Reviews will have these annually.
- 6.1.4 Patients who are Deaf will:
- Have access to continuing communication assessment and development e.g. appropriate language lessons (British Sign Language BSL)
 - Have access to sign language interpreters and communication support workers
 - Be cared for in a ward environment with an appropriate therapeutic milieu and have an individual care plan conducive to their specific treatment and rehabilitation needs.

7. Pharmacy Services

7.1 The treatment of mental disorders with medication is fundamental in either directly treating the condition or allowing patients to access other therapeutic interventions. The high secure pharmacy service should:

- Comprehensively deliver the requirements for medicines management in accordance with the Care Quality Commission (CQC)
- Ensure compliance with the relevant legislation and best practice in relation to the procurement, supply, storage and prescription of medication including controlled drugs
- Operate within clear accountability arrangements in relation to controlled drugs
- Provide other health professionals in high secure services with education and training to enable the safe use of medicines by competent staff.
- Support patients with their treatment and concordance
- Regularly review the medication regimen of the service and each patient for appropriateness and safety
- Contribute to and assist with the monitoring and review of compliance with Mental Health Act legislation.
- Support effective admission and discharge processes regarding the reconciliation of medicines processes.

8. Leave of Absence: Trial Leave and Section 17 Leave

8.1 The three high secure hospitals will work together to ensure there is equity in access to leave of absence and consistent procedures and practice across the high secure system.

8.2 The high secure service will seek Ministry of Justice permission for leave of absence for individual patients as required.

8.3 The high secure service will ensure that the process of granting leave of absences or pre-discharge Trial Leave considers the safety and welfare of the individual, staff, carers, the family, the general public and possible victim issues.

8.4 The three high secure hospitals will use a standard Leave of Absence form (LAPA: Leave of Absence Planning and Authority process), detailing the purpose, risks and associated management plans for the period of leave. This plan will specify the staff and non-staff resources required to safely manage the patient and the risks associated with the leave and the place being visited.

8.5 All programmes of Trial Leave will be subject to an agreed Care Plan specifying purpose, objectives, restrictions and use of staff and non-staff resources.

8.6 The high secure service will maintain links with the patient whilst they are on Trial Leave (usually six months) and where Trial Leave is unsuccessful, the high secure hospital will readmit the individual into the appropriate place on the care pathway.

9. Therapeutic and Enhanced Observations

9.1 Therapeutic and enhanced observations should only be considered within a framework of support and engagement between patients and staff to minimise the need for their prolonged use. They should be utilised in line with principles of least restriction.

9.2 The three high secure hospitals will work together to operate a consistent approach to enhanced observation and this will be assured through:

- Agreement and implementation of high secure system-wide operational policy for Engagement and Enhanced Observations.
- Operational policies and procedures that support the core values of engagement, collaboration and negotiation to minimise risk to the patient and others.
- The maintenance of environmental and procedural safety to uphold dignity, respect and care for the individual that reflects their immediate needs and the needs of others.
- Undertaking regular reviews of the continuing need for the observation with observations reduced to the minimum level at the earliest opportunity whilst maintaining safety.
- Review and amendment of the patient's Care Plan where appropriate, detailing each area of need (including levels of observation and escorts if required), how and when it will be met and by whom.
- Delivering proportionate therapeutic and enhanced observations, as may be required when a patient displays overt physically aggressive behaviour towards others or is an active risk to themselves.

10. Medical Emergencies

10.1 High secure services must ensure they have effective policies, processes and procedures in place to manage medical emergencies.

10.2 This includes having appropriately trained staff, robust arrangements for transfer of patients to the local accident and emergency department and for supporting the effective management of risk.

11. Primary Healthcare

11.1 All patients will have access to the full range of primary health services, including health promotion, dentistry and optometry and in particular have access to:

- Information about the primary health service including access hours and service details
- Comprehensive primary health services within the same timescales and same range as the general population according to the Department of Health guidelines and in line with good clinical practice.
- Primary Care Practice staff that hold appropriate professional or vocational qualifications and who receive professional support
- Appropriate age and gender specific screening in line with the Department of Health guidance.
- A general health assessment and health checks on an annual basis.
- Immunisations will be provided in line with national guidance.

11.2 Due to the specific needs of the patient population support will be given for smoking cessation and weight management.

12. Secondary Healthcare

12.1 When on the recommendation of the primary care clinical staff a patient needs secondary healthcare services the high secure service will:

- Have appropriate arrangements to enable access to secondary healthcare services including the safe conveyance of patients to and from secondary healthcare settings.
- Adhere to Ministry of Justice requirements with respect to leave permissions for the patient.
- Make the necessary arrangements in accordance with the agreed protocol to meet the appropriate national physical health waiting times for treatment targets within the scope of the individual's legal status and in accordance with good clinical practice.

12.2 Due to the nature of the patient population, it may be necessary to provide some services which would ordinarily be provided within a secondary care setting within the high secure hospital. In these circumstances appropriate

operational, policies, procedures and processes must be in place alongside appropriately qualified clinical staff able to deliver the care required.

13. Patient Involvement

13.1 The three high secure hospitals will work together to ensure a consistent approach to information sharing and patient involvement.

13.2 In keeping with the recovery model, patients will be encouraged to take as much responsibility as possible for their own wellbeing and progress.

13.3 Services will encourage and support patients to be involved in all decisions about their care. This includes being fully involved in multidisciplinary meetings, care programme approach review meetings and other meetings relating to their care and treatment.

13.4 High secure services will have an involvement strategy, implementation plan and systems that support patients to be involved in their care and treatment, pathway plans and decision-making at all levels of the organisation. This includes patient representation in organisational governance structures and involvement in policy-making and service development.

13.5 All information about the high secure service, treatment and care plans will be in a format that patients can access and understand considering their individual communication needs. Plain language will be used in all documentation.

14. Carer Engagement and Involvement

14.1 High secure services will have a carer engagement and involvement strategy and system that support carers to be involved in the care, treatment and recovery pathways plans of patients; this will be subject to agreement by the individual patient concerned.

14.2 The strategy will define how the needs of carers will be addressed and supported and will be in line with the Secure Carers' Toolkit which can be accessed via the following link:

www.england.nhs.uk/securecarerstoolkit/

15. Long Term Segregation (LTS)

15.1 Long Term Segregation (LTS) is used by high secure services to manage and reduce violence and aggression from individual patients towards others. It is only implemented where all other less restrictive strategies have been unsuccessful.

15.2 The high secure hospitals will use the jointly developed and adopted best practice guidance for patients being managed in LTS. The guidance is included in Appendix 4.

15.3 Patients subject to LTS must have these arrangements reviewed in line with MHA Code of Practice requirements.

16. Night Time Confinement (NTC)

16.1 The High Security Psychiatric Services (Arrangements for Safety and Security) Directions permit high secure hospitals to confine patients in their rooms at night subject to certain conditions.

16.2 High secure services using NTC must have appropriate operational policies and procedures to support any patient who may be subject to these arrangements including a process to review its continued use.

17. New Technology

17.1 All three high secure services will be jointly involved in developing and using new technology aimed at improving patient experience, care, safety and security.

17.2 All technological innovations must fall within the scope of and be permissible under the High Security Psychiatric Services (Arrangements for Safety and Security) Directions and the Clinical Security Framework.

18. Safeguarding Adults and Children

18.1 All high secure services will have appropriate adult and child safeguarding arrangements, operational policies, systems and processes that comply with the requirements of the Care Act 2014

19. Advocacy

19.1 An independent Advocacy service including IMHA must be provided for patients in the service and commissioned independently to ensure individual rights are safeguarded. This will be underpinned by a robust engagement protocol agreed between the hospital and advocacy service.

19.2 Advocacy services will work towards the self- advocacy model and will support patients as necessary and specifically in relation to CPA and/or CTR meetings and transition planning.

19.3 The high secure service will provide appropriate accommodation and facilities to enable the provision of advocacy services.

20. Governance and Oversight

20.1 High secure services will actively participate in, contribute to and collaborate with the governance arrangements as part of the Secretary of State's Line of Sight arrangements. These arrangements include the National Oversight Group (NOG) and the Clinical Secure Practice Forum (CSPF).

20.2 High secure services will have protocols in place to enable the appropriate sharing of clinical information with other agencies which are underpinned by Caldicott principles and information governance structures.

21. Training, education and research

21.1 Training, education and research/development activities and programmes in and for high secure services will reflect strategic service priorities and clinical needs. Outcomes of these activities and programmes will be targeted towards positively influencing and benefitting health outcomes for patients and to service development.

21.2 Each high secure service will ensure that staff and patients are able to participate in training, education and research activities without affecting care and treatment or business continuity.

21.3 Training, education and research activities undertaken by high secure services will comply with national research and ethics guidance.

22. Addressing the needs of specific patient groups

Patients who are culturally deaf (D) and audiological deaf (deaf)

22.1 Rampton Hospital provides services to D/deaf patients who require high secure care.

22.2 The service for men is designated as the National High Secure Deaf Service and provides comprehensive multi-disciplinary team assessment, treatment and rehabilitation irrespective of diagnoses or treatment pathways.

22.3 The service will provide specialist deaf staff and all therapies will be delivered using British Sign Language (modified as appropriate).

22.4 Rampton Hospital provides the in-reach service to deaf men at HMP Moorlands and active clinical support to the high secure women's service also in Rampton.

Patients with Personality Disorder

22.5 All admissions to high secure services of men who with personality disorder must be in accordance with the catchment areas. There will be a small number of patients admitted to high secure out of their catchment area as a result of their specific individual clinical needs, legal reasons, national requirements or for reasons related to the safety of others.

Patients with Learning Disabilities

22.6 Rampton Hospital provides a national service for men with learning disability from England and Wales.

Services for Women

22.7 Rampton Hospital provides the national high secure service for women from England and Wales (and with Commissioner approval, referrals from Scotland and Northern Ireland).

22.8 The service has specialist clinical streams for different diagnostic groups and works closely with the women's Offender Personality Disorder (OPD) pathway.

Offender Personality Disorder (OPD) Pathway Midlands & East, South and London Complex Case Group

22.9 High secure services will actively participate in the Offender Personality Disorder (OPD) Pathway Midlands & East, South and London Complex Case Group developed to support the progression of complex cases along the Offender Personality Disorder pathway.

22.10 The Group will provide a forum for professionals to discuss and agree routes of intervention for patients on the pathway, particularly those who present with particularly challenging behaviour or needs and/or are not making progress through their pathway.

Trans Patients

22.11 High secure services will manage referrals and admissions in line with the NHS England Interim Guidance for the Management of Trans Patients in Adult Secure Services (2018).

22.12 Patients in inpatient settings who are considering their gender identity and have mental health issues or a diagnosed mental health condition have the legal right to access a Gender Identity Clinic (GIC).

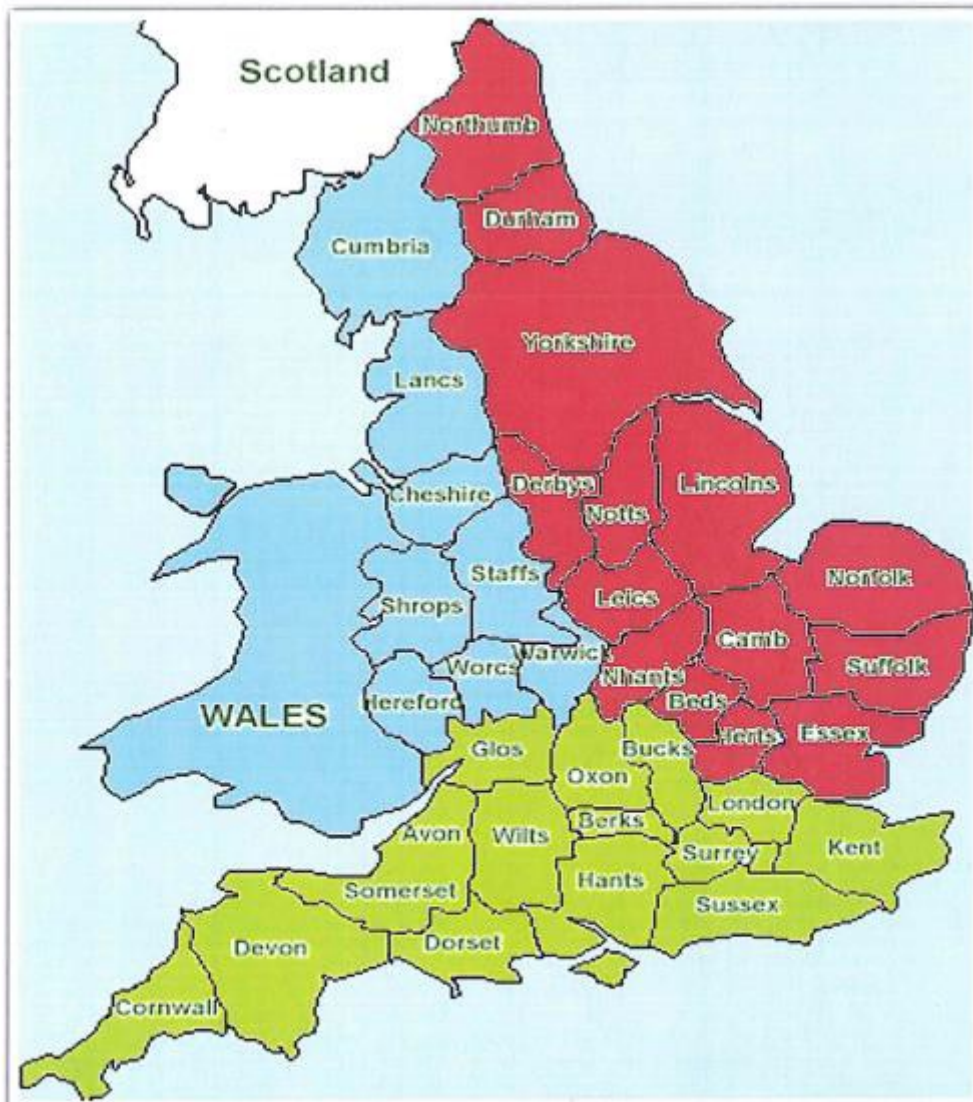
22.13 Until a diagnosis has been given by a GIC, a formal diagnosis cannot be given even if the patient states that they have Gender Dysphoria or Gender Incongruence.

22.14 The placement of patients in secure services who are considering their gender identity must be informed by a comprehensive risk assessment that addresses the impact and appropriateness of placement in male or female services. This assessment must identify any risks to/from the patient to/from other patients and consider the patient's wishes.

22.15 Risk assessments must consider and identify any additional safeguarding arrangements required for the patient themselves or for other patients.

APPENDIX 2

High Secure Hospital Catchment Areas



	Broadmoor Hospital
	Ashworth Hospital
	Rampton Hospital

APPENDIX 3

Effective Use of High Secure Hospitals in England (Nov 2014)

It is essential that the High Secure Hospital (HSH) Estate is used as efficiently as possible to ensure the timely admission of patients.

In order to ensure the most efficient use of the three High Secure Hospitals, the Ministry of Justice and Commissioners must work collaboratively with the Hospitals to maximize throughput.

Agreed principles:

1. When any service in any High Secure Hospital (HSH) is reaching capacity that service must try to identify any patients in their service whose discharge process could be expedited through a more closely managed process and/or concerted effort by the service in conjunction with the Ministry of Justice and Commissioners. All efforts must then be made to minimize any unnecessary delays in the discharge process.
2. When any service reaches capacity and there is no prospect of an imminent discharge they should identify potential capacity within the Hospital to facilitate an admission. For example, the possibility of a male mentally ill patient being admitted to a male PD bed within their catchment area HSH. How they would provide the necessary expert input and continuity of care would be locally agreed.

This would mean, for example, that an LD patient at Rampton Hospital may need to be placed in a bed in the male mental illness or male PD service at Rampton Hospital¹.

3. If the internal capacity of a HSH has been exhausted, and a patient is therefore unable to access a bed within an agreed and reasonable timeframe (see paragraph 7), decisions in relation to finding an alternative HSH will need to be made on a case by case basis.
4. The HSH will liaise with one of the other HSHs to seek an alternative placement. The following issues should be considered:
 - Clinical needs of the patient
 - Patient choice
 - Location of family and friends
 - Current location

Commissioners and the Ministry of Justice will need to be involved in these discussions.

5. The view that the patient requires high secure conditions will not be contested by the other HSHs following the admission panel decision. If the admission panel is yet to convene and an alternative HSH has been identified, then consideration should be given to including a member of

¹ Such an arrangement would of course never be appropriate if it resulted in a mixed sex ward,

i.e. at Rampton Hospital.

the alternative HSH on the panel. The guiding principle should be to avoid multiple assessments. The nursing assessment should be conducted by the receiving HSH.

6. If it is agreed that a patient is admitted to a Hospital other than their catchment area HSH, the catchment area HSH must make arrangements to attend the CPA Meetings and agree an appropriate care pathway. That care pathway will of course be influenced by the factors which led to the choice of admission location, but repatriation to the catchment area HSH should be given due priority as soon as capacity allows.
7. The above arrangements should be in place as promptly as possible. However, it is noted that a 'reasonable' timeframe may be impacted upon by a variety of factors, e.g. clinical acuity, medicolegal considerations, and may vary significantly between cases (e.g. it may be appropriate for individuals with chronic personality disorders, post-sentence, causing little in the way of acute day to day distress to wait longer for a placement than a behaviourally disturbed individual suffering from an acute psychosis pre-trial).

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Acknowledgements

Acknowledgement for their review and contribution goes to Dr Kevin Huckshorn and Dr Sharon Shalev.

Acknowledgement and thanks goes to patients from each of the high secure hospitals for their involvement and insight.

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INTRODUCTION

Within High Secure Hospitals; Long Term Segregation is a process to manage and reduce the risk of violence and aggression from patients towards others and it is implemented where all other less restrictive strategies have been unsuccessful.

The consequences of being in LTS for patients may result in increased isolation, increased psychological distress and social anxiety, and may indirectly contribute and maintain anxieties about reintegrating back into ward routines and associating with other patients.

Patients spending time in conditions of Long term Segregation (LTS) and seclusion is a recognised form, of restrictive practice and is defined in the Code of practice (DH 2015). Patients in high secure psychiatric hospitals have a range of complex needs requiring medical, psychological and/or social intervention (Harty et al., 2003¹). Due to the complex and dynamic challenges presented by clients in high secure settings there is potential for an increased emphasis on risk aversion management than on positive risk management (Qurashi et al., 2010²). There is a risk that staff members may therefore focus on the negative characteristics of the clients that are more likely to be associated with perpetration of violence (Glover, 2005³). As a result staff may be more inclined to utilise restrictive measures due to the anticipation of violent behaviour and this may reduce their perceived ability or responsibility to manage challenging behaviours effectively (Sivak, 2012⁴).

A steering group of experts from the Three High Secure Hospitals worked in collaboration to better understand the use of LTS within the high secure environment and to develop best practice guidelines in this area.

The ultimate aim of the development of Best Practice Guidelines is to minimise the frequency and duration of Long Term Segregation and to ensure that those patients subject to its use receive the best care and treatment they can, in a safe and therapeutic environment.

The work of Huckshorn (2005⁵) Six core strategies has been valued by the steering group and informed the Best Practice guidelines.

Section one - Organisational Framework

1.1 Organisational Commitment

High Secure Services are committed to providing high quality, safe and compassionate care to all patients in the least restrictive environment. This care will be individually tailored and strength-based to maximise positive experiences and opportunities. The approach used is to be collaborative at every stage to promote wellbeing, safety and recovery.

¹ Harty M, et al. (2003). Inverse care for mentally ill prisoners: Unmet needs in forensic mental health services. *The Journal of Forensic Psychiatry and Psychology* 14: 600–14.

² Qurashi I, et al. (2010), 'Reduction in the use of seclusion in a high secure hospital: A retrospective analysis,' in *Journal of Psychiatric Intensive Care, Vol. 6(2), 109-115*.

³ Glover R (2005) Special section on seclusion and restraint: commentary: reducing the use of seclusion and restraint: a NASMHPD priority. *Psychiatric Services*; 56: 1141-1142.

⁴ Sivak, K. (2012) Implementation of comfort rooms to reduce seclusion, restraint use, and acting-out behaviours. *Journal of Psychosocial Nursing & Mental Health Services*, 50, 24–34.

⁵ Huckshorn KA (2005), *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* (Alexandria [VA], NASMHPD)

Long Term Segregation (LTS) as defined in the Mental Health Act Code of Practice (2015)⁶ is a highly restrictive intervention which is only to be used when a patient is considered to present with chronically high risk behaviours/potential of serious harm to other people that cannot be managed in a less restrictive manner. The clinical criteria for this risk relates to high risk of significant harm to others by aggressive behaviour which cannot be managed by any other means. High Secure Services are fully committed to preventing and reducing Long Term Segregation across services for the benefit of all patients and staff.

Key Principles:

1. Patients nursed in LTS should expect their human, legal and personal rights and dignity to be maintained at all times.
2. Organisations should adhere to the standards and guidelines set out in this document.
3. People in LTS should receive the same access to high quality care as other patients that reflects their individual, psychosocial and physical health needs and is based on principles of recovery and trauma informed care.
4. LTS has well established negative physiological and psychological consequences and therefore is always regarded a temporary measure and a strategy of last resort after all other options have been considered and attempted.
5. In a small number of exceptional cases LTS may be considered as a suitable option to reduce repeated assaults and episodes of seclusion and to support a break in this cycle. However, in such cases a robust exit strategy with clear objectives is essential to ensure it is used for the minimum amount of time possible to achieve this outcome.
6. LTS is a complex process which has a number of contributing and maintaining factors which relate to: the individual; the system; the environment and risk management. Appropriate attention to these factors is essential when planning care for individuals in LTS.
7. The Care of patients in LTS requires rigorous monitoring and regular external scrutiny and review by the organisation.
8. All clinical staff working with patients in LTS require an awareness of the issues which may impact on the care of patients in LTS.
9. Patients in LTS require high intensity care to reduce their risk and mitigate against the negative impacts of LTS.
10. Patients in LTS require opportunities and the support to reduce their risk and improve their psychological health and be hopeful about progress in the future.

⁶ DH; The Code of Practice. Mental Health (2015)

1.2 Standards of Care For LTS patients

All patients in LTS should be provided with the following Standards of care:

- **be treated with dignity and respect**
- **receive compassionate trauma informed care**
- **have hope of change for the future which is shared by those involved in their care**

Physical Environment and Hygiene:

The person is to be nursed in a clean, safe and positive environment with the least restrictive principles

- Rooms used for patient's in segregation to have as minimum standards: toilet, sink, appropriate bed and bedding, clock visible, information about legal rights and complaints displayed, access to reading materials/TV/ Radio (unless there are specific safety reasons not to have any of the above)
- Rooms and bedding cleaned daily (this should be offered even if declined)
- Access to shower facilities daily
- Privacy must be ensured where possible within the parameters of clinical need and the security directions i.e. gender specific observations
- Every attempt must be made to assist the person with their appearance e.g. haircuts, shaving, clothing
- Appropriate Room temperature and access to fluids should be ensured at all times and be given special consideration in hot weather
- All patients should have a have a means of raising alarm at times of emergency
- Good Access to artificial and natural light and windows
- Sensory deprivation needs to be addressed by the team using a range of visual, auditory and tactile activities to improve functioning
- Access to additional personal possessions to be considered

Psychosocial and Therapeutic Requirements:

- To have access to fresh air via an outside environment on a daily basis
- To have a structured plan for each day. The plan would include meaningful activities which are easily achievable, high success, for a short time-frame. The activities would be individualised to provide internal and/ or external reward.
- To have appropriate treatment and therapy to improve functioning, improve mental health and reduce risk at the intensity consistent with the persons functioning.
- To have high levels of social contact through protected time with staff in addition to meeting basic needs
- To have daily access to meaningful activity both within and outside the room (risk level permitting)
- Access to phone calls to family, carers, other support networks (at least daily)
- To have access to family/ carer / external visitors
- To have spiritual, cultural and diversity needs accommodated

Physical and Dental Health:

- To have regular health and dental checks and essential and preventative physical/medical care. Physical health checks (minimum level: monthly). However a visual health check should be undertaken regularly during observation throughout the day.

Monitoring and Governance:

- To have a plan which clearly articulates and describes the criteria/ change in risk level/ symptoms /or behaviours required to end the segregation. The plan is required to be realistic, collaborative and transparent for patients and staff.
- Access to advocacy, complaints, external review at any time as required.
- To have daily, monthly and three monthly reviews by a range of professionals including external teams as specified in the Seclusion and Long Term Segregation policy.

If aspects of these standards are not met due to service requirements: each organisation must have escalation process to review, monitor and act on the concerns/ deficits highlighted.

1.3 Model of Care

The H.O.P.E(S)

The H.O.P.E. (S) clinical model Kilcoyne and Angus (2015)⁷ was constructed from a review of the factors found to be effective in reducing seclusion and restrictive practice and data from the Positive Intervention Programme at Ashworth Hospital. It was further informed by a research project (Hansen, 2012) which examined the important factors in progressing patients out of LTS. The model facilitates teams to use the Barriers to Change Checklist (BCC) and established progress enhancing strategies to problem solve and break down the process of LTS into targets and priorities for each individual. This plan enables staff to structure progression out of LTS and target resources effectively.

The model is a recovery based approach to working with patients in segregation. Briefly the model describes **H**arnessing the system through key attachments and partnerships.; providing **O**pportunities for positive behaviours, meaningful and physical activities; identifying **P**rotective and preventative risk and clinical management strategies; **E**nhancement of coping skills of both staff and patients and attention to maintenance. Throughout engaging in these tasks the **(S)**ystem needs to be managed and developed to provide support throughout all stages of the approach.

Debrief

The purpose of the segregation exit interviews is to gain a thorough understanding from the patient's perspective of the factors contributing to long term segregation. In addition

⁷ Kilcoyne and Angus (2015) Barriers to Change Checklist

⁸ High Secure Hospital policy and procedures for the use of seclusion and long term segregation (2015)

those factors which will enable the person to progress or improve their quality of life in the future. It ensures that all patients have the opportunity to express their feelings about the period of segregation and to discuss how we can improve both their and other service users experience in the future (contributing to the on-going refinement of progress enhancing strategies in the HOPE(S) Clinical Model of Care). This process will enable both staff and patients to identify factors that will fully inform collaborative plans (PBS, Advance Statements, Care Plans) to prevent segregation in the future. (See appendix for exit interview template). If physical restraint is used there are further de-brief questionnaires for patients and staff to capture their experience for the purposes of prevention and learning

1.4 Policy Framework

A proactive legal and ethical framework to support the development of service cultures and ways of delivering recovery focussed care and support which better meet people's needs and enhance their quality of life is key to developing organisational value based strategies. Individualised approaches that recognise, safe and therapeutic environments are most the effective for promoting both physical and emotional wellness. All restrictive interventions should only be considered in exceptional circumstances where there is a real possibility of harm to the person or to staff, the public or others.

The recently published evidence based practice guidance and reviewed Code of Practice (2015)⁸ outlines the organisations legal and ethical responsibilities to develop and maintain a whole systems approach to create and maintain a recovery focused caring environment.

See footnote

The creation of a least restrictive organisational policy must address the key issues in each of the following:

1. **DH: Mental Health Code of Practice⁹:** *Chapter 26, Safe and Therapeutic responses to disturbed behaviour.*
2. **DH: Positive and Proactive Care (2015)¹⁰:** *Reducing the need for restrictive interventions*
3. **NICE: Clinical Guidance 10.¹¹** *Violence and aggression short-term management in mental health, and community settings.*

⁹ **DH: Mental Health Code of Practice (2015)⁹:** *Chapter 26, Safe and Therapeutic responses to disturbed behaviour.*

¹⁰ **DH: Positive and Proactive Care (2015)¹⁰:** *Reducing the need for restrictive interventions*

¹¹ **NICE: Clinical Guidance 10.¹¹** *Violence and aggression short-term management in mental health, and community settings.*

4. **Skills for Health and Skills for Care (2014¹²).** *A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*
5. **NHS Protect:¹³ Meeting Needs and Reducing Distress:** *Guidance on the prevention and management of clinically related challenging behaviour in NHS settings*
6. **HM Government:** ¹⁴*The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis.*
7. **NHS England & LGA¹⁵:** *A Core Principles Commissioning Tool.*

¹² **Skills for Health and Skills for Care (2014¹²).** *A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*

¹³ **NHS Protect:¹³ Meeting Needs and Reducing Distress:** *Guidance on the prevention and management of clinically related challenging behaviour in NHS settings*

¹⁴ **HM Government:** ¹⁴*The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis.*

¹⁵ **NHS England & LGA¹⁵:** *A Core Principles Commissioning Tool.*

Section two - Clinical Guidelines

2.1 Risk Management

To anticipate and reduce the use of Long Term Segregation (LTS) through the use of a variety of Risk management tools and assessments that are integrated into patients care. Risk assessment and management plans are considered key in reducing LTS, clear goals and objectives for the patient and staff are essential in maintaining hope, providing direction and as a means of measuring progress.

This will include the use of assessment tools to identify risk factors for violence, restraint history and associated seclusion; use of a trauma assessment; tools to identify persons with risk factors for suicide and self-injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self- management.

Key Principles:

1. Risk assessment tools are available and will be used to identify Risk factors for inpatient incidents of violence and aggression using an actuarial prediction instrument such as the BVC (Brøset Violence Checklist), the DASA-IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), The HCR-20 (Historical Clinical Risk Management-20 Version 3), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan.
2. The DASA and BVC were developed specifically to assess imminent violence within psychiatric hospitals, whereas the HCR-20 is a ‘general’ violence risk assessment measure that can also be used for this purpose. The purpose of these assessments are to provide early indicators of increased risk which can be reduced by effective psycho social intervention (see progress enhancing strategies within the HOPE(S) Clinical Model of Care). Given the baseline of mental health symptoms irritability and level of paranoia of many long term segregation patients it is important these measures highlight increased risk over and above the already chronic levels of high risk propensity that patients in long term segregation display on a regular basis. Therefore high ratings on these measures should not present as obstacles to delivering the clinical model and therapeutic approaches but should indicate when levels are elevated increased vigilance, engagement and risk management.
3. Risk assessment tools will be used to address the most common risk factors for death or serious injury caused by restraint use (These include obesity, history of respiratory problems including asthma, recent ingestion of food, certain medications, poly-pharmacy, history if cardiac problems, history of acute stress disorder or PTSD).

4. Patients will have a safety planning assessment that includes the identification of individual triggers and personally chosen and effective emotional self-management interventions this will be written into their plan of care and be readily available in a crisis. These are advanced statements/PBS Plans.
5. Consideration to be given to a trauma history assessment that identifies persons at risk for re-traumatization and addresses signs and symptoms related to untreated trauma.
6. Expert and timely consultation will be available with appropriately trained staff or consultants to assist in developing individualised interventions for patients who demonstrate consistently challenging behaviours.

2.2 Assessment of Segregation

The Barriers to Change Checklist (BCC) for LTS (Kilcoyne and Angus, 2015)

Four main domains have been identified contributing to segregation. The Barriers to Change Checklist (BCC) was developed as part of the model to break down the complex nature of LTS maintaining factors into a simple format and assess the barriers to the individual progressing out of LTS. It assesses each of the following areas:

1. System factors
2. Environment
3. Risk
4. Individual factors

Criteria for Use

The Barriers to Change Checklist (BCC) is to be completed by the clinical teams and also individually with the person in segregation. The checklist is particularly applicable where the segregation has become long term (in excess of four weeks) and/or when the clinical team are of the opinion that progress is slow or progress is not maintained. The checklist can be used with men and women of adult age.

The checklist should take approximately 20 minutes to complete. However, plan development and the discussion of significant priorities should be given more time. The checklist items are scored and then the totals are grouped into the four domains. The high scores are indicative that intervention maybe required in this area.

It attempts to clarify thinking and break down the complex issues in the process that maintains long-term segregation into discrete areas to enable staff to use the H.O.P.E.(S) model and Progress-enhancing strategies to target resources, improve formulation and impact on decision making. Once completed the checklist should be used in conjunction with the progress-enhancing strategies to turn negative responses into positive ones. This should be developed into an intervention plan with three key areas of initial focus.

2.3 Treatment Planning

Once a model of care has been identified a structured needs assessment is to be in place for formal identification of individual treatment needs.

- The assessment is to include areas that need to be assessed and how this is to take place followed by a structure for recording and evaluating individual MDT plans.
- The assessment must have patient involvement established at all stages.
- A clear formulation central of the interplay between Mental Health risk and segregation process should be identified.

All areas are to be considered including;

- Daily care needs that are a core to nursing intervention in any treatment plan
- Psycho-social interventions
- Engagement with others including MDT staff and peers
- Therapeutic interventions
- Medication needs
- Review processes and measures are to be identified for progress. This should include clear objectives as part of an exit strategy and a plan for review and forward planning.
- Barriers to change should be a clear consideration in this review process and a clear plan to progress individuals with SMART objectives identified.

Areas for consideration when treatment planning:

- Using patient's first language and vocabulary that the patient understands
- Flexible approach to care planning e.g. visual care plans
- Positive behavioural support planning
- Use of formulation
- Medication plan and pharmacy perspective

Example of a Positive Behavioural Support Plan

“THIS IS WHAT YOU HAVE TOLD US”

Recovery Support Plan (RSP) 1

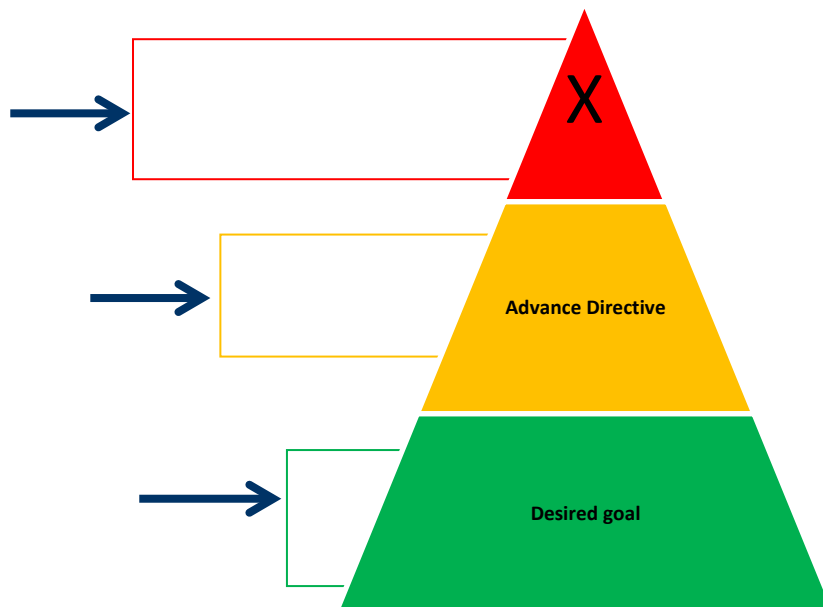
Rationale: This process must be completed with the patient to provide collaborative opportunities to answer the questions (below) in order to identify the current Risks that may hinder the patient progression to achieve their meaningful goals.

Tip: ensure you discuss the questions in numerical order

Q1: Green = desirable behaviour – appropriate interactions / engaging with staff to develop meaningful activities and advanced directives.

Q2: Red = Things that may reduce or stop you from achieving your goals

Q3: Amber = working together to feel safe to achieve and maintain your goals



Note: any changes to the patients PBSP please ensure that the nursing care plans are amend accordingly.

2.4 Clinical Model

The H.O.P.E.(S) Clinical Model

The H.O.P.E. (S) clinical model was constructed from a review of the factors found to be effective in reducing seclusion and restrictive practice and data from the Positive Intervention Programme at Ashworth Hospital. It was further informed by a research project (Hansen, 2012) which examined the important factors in progressing patients out of LTS. The model facilitates teams to use the BCC and establishes progress enhancing strategies to problem solve and break down the process of LTS into targets and priorities for each individual. This plan enables staff to structure progression out of LTS and target resources effectively it should also identify the persons responsible for every intervention in the plan by name.

The model is a recovery based approach to working with patients in segregation, through a process of engagement and collaboration. Engagement relates to the consistent attempt to interest and involve individual's in the daily social, supportive and clinical services available to them which is outwith of meeting their basic needs. Briefly the model describes **H**arnessing the system through key attachments and partnerships.; providing **O**pportunities for positive behaviours, meaningful and physical activities; identifying **P**rotective and preventative risk and clinical management strategies; **E**nhancement of coping skills of both staff and patients and attention to maintenance. Throughout engaging in these tasks the **(S)**ystem needs to be managed and developed to provide support throughout all stages of the approach.

Stages of the HOPE(S) model

The model is not linear; however the 'H' stage is almost always required as an initial starting point.

Harness the System and Engage the Person

- Stabilise the individual and the system
- Develop key attachments and a 'translator' between the patient and clinical decision making forum/team
- Create expectations of progress
- Develop proactive cultural leaders on the ward

Opportunity for Positive Structured Activity in an Enabling Environment

- Safe environments which are calm and risk managed
- Meaningful activity which includes physical activity
- Graded exposure-based plan
- Highly structured progress plan with clear criteria and responsibilities identified
- Plans have review and end points built within them
- Lead role models to shift perceptions of risk

Preventative and Protective Factors

- Analyse previous violence
- Formulate contributions of trauma, mental health symptoms, P/D, ASD etc.
- Identify risk factors and practical risk management strategies
- Identify protective strategies and relapse indicators
- Develop crisis/ PBS plan in collaboration with the individual

- Ensure debrief after progress and setbacks

Enhance Coping Skills and Maintain

- Manage and reduce anxiety for patient and staff
- Use a trauma informed care approach
- Focus on increasing emotional/coping
- Increase skills to reduce impulsivity
- Utilise the Boundary See-Saw to inform and contain dynamics with staff
- Validate and reward staff and patients for progress
- Appreciate progress is not linear
- Ensure maintenance strategies are in place for progress
- Transitions should be planned and gradual

Following identification of the Progress Interfering Domains practical strategies were developed which professionals could apply to address the domains. These Progress Enhancing Strategies are directly related to addressing the interfering domains and can be used in all stages of the HOPE(S) Framework. The strategies can be helpful in prioritising resources and interventions.

Briefly they involve strategies to:

- **Manage the environment** - such as offering low stimulation area, environments with highly rewarding, focused and structured activity to reduce and distract individuals from symptoms.
- **System management** - which involves awareness of issues between staff and patients, such as Hamilton's boundary see-saw and providing containment and positive reinforcement for both patients and staff. The use of debriefing to analyse set backs and the use of reflective practice to contain and explore dynamics.
- **Training in positive non-restrictive approaches** - for example the recovery model training, training in reducing restrictive practice, trauma informed approaches, No Force First, 6 Core Strategies, Safe wards etc. Specific training in managing the individual risks that particular individuals present enables staff to improve their confidence.
- **Leadership and culture** - having clear organisational goals and expectations regarding segregation and good care, engaging leaders both in terms of the hierarchy but also cultural leaders at ward level to progress change, awareness of national drivers and engaging in joint practice.
- **Relationships and connections** – this area is crucial and key attachments with the individual are essential and engagement sessions need to be of a high frequency and be personally rewarding for the individual. It is often necessary to have more than one 'translator' for the patients experience, who is part of the clinical team and who can provide a perspective from the individual, and it is essential these relationships are none coercive and consistent.

- **Individualised treatment strategies** – therapeutic strategies to increase emotional coping (e.g. DBT), clearly formulated care and appropriate medication.
- **Clear goals and plans** – it is essential the plan is structured with criteria for progression. Ensure it is timely and incorporates appropriate risk management strategies, is strength based, and gives hope. It is important this is communicated to staff and patients both verbally and in a written form that is done in a collaborative partnership with the patient, and is realistic with an end point. It is also important that this plan details who is responsible for each aspect of the interventions.
- **Graded exposure and activity** - the opportunity for positive, meaningful and motivating activity and distraction, which is carried out in a graded way is essential, over time the exposure should increase to a range of people and environments.

2.5 Observations

In the care and Management of patients on Long Term Segregation conducting high level observations is a highly skilled mental health intervention; each organisation will have a policy on observation and positive engagement with clear definitions of levels of observation in line with recommendations of who can instigate, increase, and decrease and review observation. The policy will outline how often reviews should take place how patients experience of observation will be taken into account ensuring that observation is underpinned by continuous attempts to engage therapeutically with regular review.

Key Principles:

1. Individuals in LTS should be observed either: Within eyesight (constant enhanced engagement and observations) or via Planned, intermittent, enhanced engagement and observation every 15 minutes.
2. At all times throughout the period of LTS a suitably skilled staff will be readily available within sight and sound of the LTS room. The nurse undertaking the enhanced engagement and observations must record patient activity every 15 minutes.
3. Wherever possible, decisions about Observations of patients on LTS should be made by the multi-disciplinary team and based on an assessment of risk (using a validated risk assessment tool), with consideration of the patient's history and an interview with the patient.

4. The level of Observation must be reviewed after positive engagement with the Patient has failed to dissipate the risk of violence and aggression.
5. Patients should automatically be offered written documentation regarding their observational need and this as a matter of course should be recorded in the plan of care.
6. The least intrusive level of observation necessary, balancing the patients safety, dignity and privacy with the need to maintain the safety of those around them will be used.
7. The patient is to be provided with information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped.
8. A record is to be made regarding decisions about observation levels in the patient's clinical notes and clearly specify the reasons for the observation.
9. When deciding on levels of observation take into account: the patient's current mental state, any prescribed and non-prescribed medications and their effects, the current assessment of risk and the views of the patient, as far as possible.
10. Record clearly the names and titles of the staff responsible for carrying out a review of observation levels and when the review should take place.
11. Staff undertaking observation should: take an active role in engaging positively with the patient and be appropriately briefed about the patient's history, background, specific risk factors and particular needs; be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment; be approachable, listen to the patient and be able to convey to the patient that they are valued.

Section Three - Monitoring and Review

3.1 DATA

Collection of relevant and clinically useful data is central to monitoring and improving practices associated with LTS reduction. It provides the foundation of other aspects of practice and should be regularly monitored and reviewed hospital wide.

1. Accurate, up to date and clinically useful data in relation to patient's care and treatment when on LTS, should be collected, reviewed and analysed on a regular basis.
2. Such data should be reviewed locally (within the team /ward) and more broadly (hospital wide) to explore trends and practices and ensure learning takes place.
3. Data should be used to inform and develop clinical practice in conjunction with evidence-based practice.
4. The data collected should also be used to inform and develop the unique but developing evidence base on LTS care, resulting in a continuous cycle of practice-based evidence and evidence-based practice.
5. All individuals involved in data collection and or recording and analysis should have a thorough understanding of the processes, principles and good practice associated with LTS ensuring accurate, reliable and relevant data collection.
6. Data should be collated and stored efficiently (in one place?) so it can be edited, and amended to ensure accuracy. Data collection systems that allow for adaptation and modification are beneficial in allowing data collection to be modified to meet the on-going needs of the service.
7. Incident data, pre and post implementation of changes in ward or individual care plans or routines may also be useful for informing and improving clinical practice and reducing risk. Recording of near misses and successful outcomes and successful de-escalation provides learning and information that can be incorporated into positive care planning.
8. Using data to explore patient change and progress can provide benefits for the patient themselves and staff teams. Where possible feedback of data to teams and patients can provide visual displays of data which can be more meaningful and show change. Feedback of data also ensures the clinical utility of data collection is observed by those involved in the processes that support it.
9. Whilst group data, trends and analyses may be useful, individual information and data may be collated, according to the unique care and treatment plans associated with individual's care. Data can then be analysed individually and incorporated in

to regular feedback processes to the patient and clinical team ensuring it is clinically relevant, meaningful, and useful to those concerned.

10. Service user data / feedback should also be routinely collected in ways and methods that are clinically relevant, meaningful and used to inform and shape current and future good practice.
11. Research and development and data collection in relation to practices associated with LTS in high secure hospitals should continue to be a focus for services, with high levels of expertise and experience in this area. Developing and contributing to the evidence base is an essential part of the process and will positively inform and shape future practice and guidance.

3.2 Monitoring and Governance

Ensuring high standards of care are developed and maintained is a central aspect of clinical governance. All high secure hospitals have a commitment to continuously improving quality of care for patients on LTS care and for the staff caring for them. Ensuring that robust processes and procedures are in place to review adherence to policy and good practice is essential in LTS care. Local (ward) and hospital wide monitoring and governance are crucial in maintaining high standards of care.

1. Data regarding patients in LTS their care plans, quality of life and needs whilst in LTS and exit care plans from LTS should continue to be monitored via a hospital wide governance group.
2. Groups should have active MDT involvement and examine compliance with policy and relevant guidance.
3. Trends in data should be examined and information should be shared ensuring that practice and policy continue to inform and develop in a collaborative manner.
4. Regular audit and monitoring should take place in relation to the fundamental aspects of LTS practice as identified within the current guidelines, including compliance monitoring, on-going education and development for staff.
5. Hospital wide groups focussing on initiatives or task focussed groups based on evidence based practice, good practice and other guidelines are a regular part of the organisations on-going commitment to reducing LTS.
6. Sharing and reviewing of governance procedures across hospital sites can also provide consistent care, sharing of good practice and development of audit and governance procedures.
7. Regular case reviews including internal and external reviews, case presentations and sharing of good practice across the high secure hospitals will also facilitate good practice.

8. Patient experience and staff involvement in improving quality of care is supported.
9. Training, education and other support mechanisms that support staff in their challenging role of caring for patients in LTS remains an on going and developing commitment by organisations.

3.3 MDT review process

Ensuring that all individuals within an organisation understand the aims, objectives and mechanisms for LTS reduction, can help facilitate positive change in relation to LTS care. The Multidisciplinary team are central in this role, their knowledge, experience and working therapeutic relationship with the patient, facilitate person-centred care planning and regular reviews ensuring the least restrictive principles and good practice are adhered to. All members of the MDT have an important contribution in developing, implementing, supporting and evaluating care when service users are in LTS care. As such, the MDT should be involved in all aspects of the LTS care plans and reviews where possible.

1. Effective multidisciplinary working is essential in improving quality and care for patients whilst on LTS and reducing time spent on LTS.
2. Having full MDT agreement about the goals and objectives of LTS care plans is crucial. Having time to discuss the functions of LTS, patient formulations and review goals they are working towards with the patient and reintegration plans back into ward routines, helps guide the decision making process.
3. All members of the MDT should be aware of, and involved in LTS reviews and evaluative processes on a regular basis.
4. MDTs should have time to review LTS plans as a clinical team on a regular basis.
5. Roles and responsibilities within the LTS care plans should be clear to those involved, ensuring shared but clear delineation of roles and responsibilities conducted in a supportive and collaborative manner.
6. Particularly complex cases of LTS care should be reviewed in collaboration with other MDTs, involving expertise from other areas of the service, ensuring consistent practice and improving sharing of clinical good practice across hospital sites.

3.4 Independent Reviews

The best practice identified for independent reviews would entail the use of independent review teams from other secure service providers.

- There is an expectation that reviews will involve direct interaction with the patient.

- Decision making will be informed by discussion with MDT members, careful exploration of the treatment plan, the appropriate level of scrutiny and challenge as well as exploring the efficacy of the identified strategy for ending LTS.
- Documentation relating to patient activity including access to fresh air
- Clear documentation must be made about the members of the review team, capturing the discussion that took place and any possible discussion and feedback for the MDT.
- Ensure compliance with the Code of Practice¹⁶ for the carrying out independent reviews.
- Reviews should include contact/discussion with patient IMHA, and commissioning authority.

3.5 Safeguarding

All policies and procedures relating to restrictive interventions need to specifically identify how the service should ensure patients are safeguarded throughout and following the intervention.

- The safeguarding procedure should also make specific reference to safeguarding patients in relation to segregation.
- There needs to be a formal agreement and agreed documentation with the local Safeguarding Team and commissioners in relation to how segregation is reported to them and what information they require for assurance.
- Advocacy involvement also needs to be directly planned for in policy and in practice including involvement within reviews (Code of Practice) with clear roles and responsibilities identified.
- Service liaison services/Complaints Services must ensure complaints procedures are robustly implemented for patients in segregation to ensure equity of provision.
- The need for all MDT staff to ensure the patient is safeguarded during review processes, ward rounds and direct contact must be made clear and must be documented with contact being maintained by all allocated MDT staff members. Safeguarding is the responsibility of all MDT members.

¹⁶ Department of Health <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

- The role of the independent review teams and other assurance mechanisms for safeguarding the patient must be clearly identified and implemented in practice.

Section Four - LTS Reduction Strategy

4.1 Models of Reducing Restrictive Practice and Seclusion

In the literature a number of approaches have been developed to reduce restrictive practice including seclusion and segregation. Whilst these approaches do not specifically focus on segregation by addressing issues such as: leadership; adopting a prevention orientated approach; ward safety and recovery cultures these approaches have been shown to be effective in reducing frequency and length of stay in seclusion. They have also had a range of other positive outcomes for service users and staff. The main approaches in this area are:

1) **Six Core Strategies to Prevent Conflict and Violence**¹⁷

(Huckshorn 2006; Huckshorn and LeBel 2009; Le Bel et al 2014)¹⁸

The core strategies are implemented at service level and involve : Leadership towards organisational change; use of data to inform practice; workforce development ;involvement of service users and their families in their care; use of strategies to reduce restraint and aggression; rigorous post event debriefing. This approach has been adapted by Duxbury et al at University of Central Lancashire for the delivery in the UK (REsTRAIN). Both these approaches have shown positive outcomes across a range of services including reduced levels of seclusion and restraint 90% in three years (Huckshorn, 2012, NASMHPD, 2014) reduced injuries, reduced medication use and length of stay, increased satisfaction with care and reduced staff sickness.

2) **No Force First**

(Ashcraft and Anthony 2008; Ashcraft, Bloss and Anthony 2012)¹⁹

The implementation of NFF varies across services but is based on the principles of transforming ward culture and practice from one of containment to one of recovery through the application of a trauma informed, person centred, recovery based approach. The central tenet of the approach posits that all restrictive interventions are seen as a treatment failure as they can be detrimental to supporting recovery. The basic outline of the approach 1) strategic sign up and policy 2) a redefinition of restrictive practice as a negative outcome 3) development of a programme to roll out the strategy which is informed by data 4) Peer support and advance directives 5)

¹⁷ Huckshorn KA (2005), *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* (Alexandria [VA], NASMHPD)

¹⁸ Huckshorn, K.A (2006). Re-designing state mental health policy to prevent the use of seclusion and restraint. *Administration and Policy in Mental Health*,33, 482-491

Huckshorn, KA., & LeBell, J.L. (2009). Improving safety in mental health treatment settings: Preventing conflict, violence and the use of seclusion and restraint. In S.S. Sharfstein, F.B. Dickerson & J.M. Oldham (Eds). *Textbook of hospital psychiatry* (pp. 253-265). Washington, DC: American Psychiatric Publishing

¹⁹ Ashcraft, L., & Anthony, W.A (2008). Eliminating seclusion and restraint in recovery-orientated crisis services, *Psychiatric Services*, 59(10), 1198-1202.

Ashcraft, L., Bloss, M. & Anthony, W.A (2012). Best practices: The development and implementation of “No Force First” as a best practice. *Psychiatric Services*, 63(5), 415-417).

development of therapeutic risk partnerships between patients and staff 6) culture change 7) workforce development 8) executive sign up. Descriptive data indicates this is an effective approach at reducing seclusion and restraint to zero levels. However, the studies in this approach are small scale and levels of incidents appear to be relatively low in the first instance.

3) Safewards

(Bowers et al., 2013; Bowers, 2014)²⁰

The *Safewards Model* of conflict and containment for use on psychiatric wards. The model identifies six broad causal factors of conflict on wards, which may result in the implementation of restrictive measures such as restraint and seclusion. The Safewards incorporates a prevention orientated approach to conflict

The model takes a broad systemic approach to attempt to explain the ward dynamics, and the six originating domains include: (1) the patient community, (2) patient characteristics, (3) the regulatory framework, (4) the staff team, (5) the physical environment and (6) factors outside the hospital. This model views the psychiatric ward as a complex and dynamic system where phenomena (such as restraint and seclusion) cannot be considered in isolation, but can be attributed to a multitude of causal factors within the broader system of the organisation (Bowers et al., 2014). The model recommends the implementation of 10 practical strategies for example, soft (positive) words, which are simple practical interventions that wards can use to change practice and culture and mutually agreed standards of behaviour.

Summary

McNeil summarises that the approaches identified all describe developments in the following key areas:

1. Organisational and clinical leadership;
2. Development and promotion of a detailed seclusion reduction policy;
3. Monitoring and publication of data;
4. Applying changes to staffing;
5. Continuous workforce development;
6. Utilisation of a *recovery* based, trauma informed approach that focuses on collaborative care and client strengths;
7. Risk assessment and advanced management plans;
8. Review procedures and collaborative post incident debriefing;
9. Enhancing the physical and therapeutic milieu.

The models adopt a prevention orientated approach and emphasise the importance of the provision of recovery focussed and trauma informed care. The development of a therapeutic physical environment that reflects a culture of recovery rather than containment is a further central theme. Other common features include workforce development and effective leadership, both of which are considered central to driving organisational culture change. The overall aims of seclusion reduction in conjunction with the promotion a recovery based approach to clinical care are significant in all approaches. McNeil (2015) documented a comprehensive review of the literature which is embedded in the appendix.

²⁰ Bowers, L., Stewart, D., Papadopoulos, C., & Lennaco, J.D. (2013). Correlation between levels of conflict and containment on acute psychiatric wards: The city-128 study. *Psychiatric Services*, 64(5), 423-430.

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 299-508.

4.2 Patient Inclusion/Involvement

Patient involvement and the patients' perspectives are key factors in the process of prevention and reducing the use of Long Term Segregation (LTS).

The Nice Guidelines on user involvement) provide an overview of good practice in relation to user involvement²¹.

Involving and incorporating the patients' perspective in developing their positive behavioural plan/care plan risk sharing partnerships in relation to LTS can improve patient care and experience and enhance outcomes. Having clear goals and patient led objectives set by the patient is considered essential in supporting the patient's progression.

Having clear measurable co-produced goals creates a sense of hope about the future, a vision of how to progress and a sense of positive change. Teams should use principles outlined in good practice guidelines, such as the NICE guidelines on involvement and actively engage with the patient in creative ways to involve them in their care and treatment.

Some key principles of Involvement are outlined below:

1. Teams should adopt the promotion of person-centred care that takes into account patients' needs preferences and strengths whilst under LTS management.
2. Patients to make informed decisions about their care and treatment under LTS in partnership with their Multi-Disciplinary Team (MDT).
3. A process of shared decision making between patients, the Clinical Team (and carer/where appropriate) should be in place.
4. Patients to be enabled to have full involvement in their positive behavioural support plans/care planning and review the plan should reflect their opinion.
5. Positive behavioural support/care plans should be written with or by the patient. Small changes can lead to big improvements over time; teams should work with patient to achieve incremental change.
6. Patients to be actively encouraged to work in partnership with their carers wherein they are receiving consistent support, treatment and care in an atmosphere of hope and optimism, and celebrate achievement.
7. Staff to take time to build trusting, supportive, empathic and non-judgemental relationships as an essential part of care with the aim of fostering their autonomy, promoting active participation in treatment decisions and supporting self-management.

²¹ NICE (guidelines on involvement)

8. Patients are to be informed of, and supported in, developing their personal advance statements and advance decisions and these are to be documented in their care plans with copies held by the patient.
9. Where possible and appropriate given the risks, consideration may be given to Peer Support or Experts by Experience being involved in supporting patients in LTS. Such support can be beneficial in improving collaboration, increase levels of engagement and promote hope for recovery.

4.3 Training and workforce

All services where restrictive interventions may be used must have in place ***restrictive intervention reduction programmes*** which reduce the incidences of violence and aggression and ensure that less detrimental alternatives to restrictive interventions are used. Such programmes should be planned in the context of robust governance arrangements, a clear understanding of the legal context for applying restrictions and effective training and development for staff.

All Hospitals should have a policy on workforce development and training for staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions. The policy should specify who will receive what level of training (based on training needs analysis) and how often they will be trained.

The High Secure Services have produced a Positive and Safe Training manual which provides robust organisational governance for trainers and the training provided for the purpose of reducing violence whilst utilising a hierarchy of primary, secondary and tertiary responses to proactively and proportionately respond to escalating risk.

The focus of this developed model of training is to support the available best practice guidance and code of practice to create individualised and recovery focussed pathways to proactively reduce the likelihood of using more restrictive responses to managing aggression and violence.

4.4 Leadership and Quality Improvement Methodology

Leadership is important in influencing good practice, promoting development and good practice around LTS.

Leadership can be provided by a range of professionals working as a Multi-Disciplinary Team (MDT) to support, guide and develop in relation to LTS.

Specific good examples include; good leadership in clinical teams, psychology services, nursing leadership positions and specialised services such as the PIPS (Positive Intervention Programme) teams¹.

LTS minimisation and reduction should be prioritised by a service as part of reducing restrictive practice programmes. All aspects of the organisation will need to understand the rationale, aims and objectives of the service and the plans in place.

Strong leadership, effective communication and good clinical team working helps all staff in developing their practice in relation to LTS.

Leadership at ward level must ensure patients nursed in LTS are provided with psycho-social or focused rehabilitation that is effective in teaching living, learning, recreational and working skills.

Teams should be encouraged to use methods/tools to improve their understanding of patient needs to reduce LTS such as using the Barriers to Change Checklist (BCC)¹. The use of the BCC allows teams to formulate individual plans of care that are creative and reflect the needs of the patient, the enabling of the environment and the best use of staffing skills and resource.

The teams may also find it beneficial to use quality improvement methodology, such as driver diagrams to consider organisational and clinical factors that need to be addressed to improve services. There should be local quality improvement support within services. Additionally there is a significant amount of information available electronically for teams to utilise.

Key Principles:

1. LTS reduction is to link with principles of recovery and include building a trauma informed system of care.
2. Teams require time and effort to discuss the functions of LTS, patient formulations and the goals they are working towards with the patient and how they plan to reintegrate the patient back into ward routines.
3. Leadership developing an individualised hospital based LTS reduction action plan based on a performance improvement and prevention approach.
4. Leadership commitment and intention to use and monitor real time data in the reduction of LTS.
5. Leadership commitment to create a collaborative, non-punitive environment to identify and work through problems by communicating expectations to staff and to be consistent in maintenance of effort.
6. Leadership evaluation of the impact of reducing LTS on the whole environment. This includes issues such as increased destruction of property, extended time involved in de-escalation attempt, additional admission assessment questions, debriefing activities and processes to document event, etc.
7. Leadership to set up a staff recognition project to reward individual staff, unit staff and S/R champions for their work on an on-going basis and be accountable through routine reports and reviews.

8. Leadership to address staff culture issues, training needs and attitudes.
9. Leadership to review the hospital plan for clinical treatment activities in an effort to assure that active, daily, person centred, effective treatment activities are offered to all patients receiving services; that these services are offered off wards preferably and that persons attending have some personal choice in what activities they attend.

4.5 Clinical Example of the Positive Intervention Programme (PIP) at Ashworth Hospital

The PIP is an integrated specialised team that support patients and the clinical teams in the management of LTS. The team consists of registered nurses, nursing assistants and MVA instructors. The PIP Service uses recovery based principles to provide patients with positive relationships and meaningful activities to improve their mental health and quality of life and enables the service to address the physical health needs of patients. The PIP promotes positive culture change using the HOPE(S) model and principles of trauma informed care to progress patients out of LTS in a collaborative way.

APPENDIX 1

- **BCC CHECKLIST**
- **HOPE(S) GUIDE**



BCC GUIDE UP TO
DATE VERSION AUGU

APPENDIX 2

Guideline Exit Interviews for Patients Progressing Out of Seclusion and Long-Term Segregation

Explain that the details of this interview will be put in the clinical notes as the patient's perspective/story of the seclusion/segregation. In each question explore with the patients any unhelpful or helpful factors. After the interview record the responses in the [Patients View] in the [Seclusion] section of PACIS. Acknowledge that the experience in segregation was likely to have been very difficult and upsetting. Express a commitment that as a service we will be working hard to try to prevent such negative experiences from happening again in the future as they get in the way of progress and recovery and are unhelpful for everyone.

For Patients who have been in Seclusion and Segregation:

- 1) What were the events which led to your seclusion?
- 2) Do you think seclusion was needed at that time?
- 3) Do you think other different approaches would have helped you at that time?
- 4) What was your experience of seclusion?

- PROMPTS: -**
- Quality of room
 - Relationships with staff
 - Availability of Care team
 - Treatment plan
 - Were there any on-going / repetitive problems for you or staff?
 - Did seclusion make you feel better or worse?
 - Did you feel safe?
 - Was it easy to access staff and get your needs met?
- 5) Do you think that you were in seclusion for too long? If yes, what were the problems / barriers which prevented the seclusion been ended?
 - 6) Do you have any worries about being out of seclusion and / or up on the main ward? If yes what are they?

- 7) Is there a plan in place that you have been involved in, to help you stay out of seclusion in the future?
- 8) Are there any difficulties you would like to discuss because of the effect that seclusion has had on you?

For Patients who have been in Long Term Segregation:

- 9) Did you have involvement with the PIP team? How did you find the team and the activities provided? Is there anything you think would make the service better?
- 10) When you were progressing out of segregation did the association plan help? Was it too fast / too slow?
- 11) What three things stopped you progressing out of segregation?
- 12) What three things were the most important in helping you progress out of segregation?

APPENDIX 3

Guideline Interviews for Patients About Their Experiences of the Use of Restraint

Explain that the details of this interview will be put in the clinical notes as the patient's perspective/story of the restraint episode. In each question explore with the patients any unhelpful or helpful factors. After the interview record the responses in their clinical notes. Acknowledge that the experience of restraint was likely to have been very difficult and upsetting. Express a commitment that as a service we will be working hard to try to prevent such negative experiences from happening again in the future as they get in the way of progress and recovery and are unhelpful for everyone.

Restraint Interview:

Explain the details of this interview will be added to the clinical notes as their perspective on the incident:

- 1) What were the events which led to you being restrained?

2) Do you think it was necessary / fair to restrain you at this time? (If not tell me more about this)

3) Are there any things that staff or you could have done differently at this time which might have helped? (If yes what were they?)

4) Did you feel safe at the time and afterwards? (What was helpful or unhelpful?)

5) Has anyone discussed with you how the restraint might have affected you?

6) Do you have a crisis plan in place to prevent incidents like this happening in the future? If so does this need changing? (What would you add in or take away? or are there things you want the care team to think about which might help you in the future?)

7) Have you spoken to the staff involved? And are there any outstanding problems which need sorting out?

8) Have you spoken to the Care team about the review of this incident?

Read out the account so the patient can check it is an accurate summary before entering the information in their clinical notes.

APPENDIX 4

Guideline Questions for Staff About Their Experiences of the Use of Restraint As Part of the De-Brief

1) What has been the impact of this incident on staff a) are there issues which need addressing at reflective practice / supervision? b) Are there any issues which need highlighting to the Positive & Safe Violence Reduction Training Department.

2) Was the patient restrained in a prone position (face down), if so what was the reasons for this? How long were they in this position? Were their vital signs monitored throughout the restraint? Was compliance gained with the physical observation policy? And if not was a clear rationale provided and documented?

3) What was the impact on other patients and are there any issues which need to be addressed with particular individuals or in the ward community? (If so inform Ward manager).

4) Could this incident have been managed any differently? a) Was the crisis plan / care plans followed b) If not what were the barriers? c) How could the plan be changed

to prevent incidents like this in the future? d) Any recommendations should be highlighted to the Care team and communicated across staff teams.

APPENDIX 5

Seclusion Review of Literature – McNeil 2015



Seclusion - Literature
review - Ashworth.doc

APPENDIX 5



1 Protocol for Joint Working between the National Secure Forensic Mental Health Service for Young People and the High Secure Adult Mental Health Service in the management of adolescents under the age of 18 who may require care and treatment in conditions of high security

1.1 Background and Context

It is recognised that no adolescent under the age of 18 would ordinarily require care and treatment in conditions of high security. Such occasions **are and should be rare**. However; in the event that this is considered, this paper sets out the circumstances in which the providers of medium secure Child and Adolescent Mental Health Services (CAMHS) and the providers of adult high secure mental health care should work together and the expectations of each in a number of scenarios.

Medium Secure CAMHS are commissioned by NHS England (NHSE) and provided from the following units in England:

1. The Gardener Unit, Manchester – Greater Manchester Mental Health NHS Foundation Trust
2. The Alwood Clinic, Newcastle - Northumberland Tyne and Wear NHS Foundation Trust
3. Ardenleigh, Birmingham – Birmingham and Solihull mental health NHS Foundation Trust
4. Bluebird House, Southampton – Southern health NHS Foundation Trust
5. Malcolm Arnold House, Northampton – St Andrew's Healthcare

The service is provided in line with national guidance on best practice in the

provision of adult medium secure services, adapted to reflect the different needs of young people, and is the most secure mental health service for children and adolescents commissioned by NHSE.

Protocol for Joint Working between the National Secure Forensic Mental Health Service for Young People and the High Secure Adult Mental Health Service in the management of adolescents under the age of 18 who may require care and treatment in conditions of high security

1. Introduction to the protocol

1.1 The purpose of this paper is to identify when the two services should work together and to set out the expectations of commissioners in these circumstances. It has been driven by the need to ensure that:

- young people with mental health problems are treated in a setting that is appropriate for their age and clinical need
- young people are treated under conditions of no greater security than is justified by the degree of danger they present to themselves or others
- the transition from one service to the other should be seamless, planned and implemented effectively with the minimum of delay and disruption to the patient
- the care and treatment of young people in both services is informed by the most relevant specialist clinical expertise available

2. Scope of Protocol

2.1 This protocol applies in the following scenarios:

- A referral is received for a young person under the age of 18 that suggests they may require a higher level of security than is available within medium secure CAMHS.
- An existing patient is proving extremely difficult to manage and presenting as a grave risk to others within medium secure CAMHS.

3. Existing medium secure CAMHS patient

3.1 Medium secure CAMHS care for the most challenging young people with mental health problems; there may however, be circumstances when it is appropriate to involve the designated high secure hospital team in the care of a patient. The involvement of high secure services should be considered when a young person meets the following criteria:

3.2 The patient is assessed as presenting a grave and immediate risk and

- can only be managed with long periods of seclusion
- requires sustained periods of 3:1 or higher supervision
- is displaying highly unpredictable levels of violence and aggression,

and

- has shown no response to treatment.

In these circumstances, a joint assessment should be arranged involving a clinician from another medium secure CAMHS and the catchment adult medium secure unit who may refer the case to the appropriate high secure hospital team.

3.3 The joint assessment should consider four options

1. advice and suggestions concerning alternative interventions within the existing medium secure CAMHS unit
2. transfer to an alternative medium secure CAMHS unit
3. an extra care package at either the current or alternative medium secure CAMHS unit with input from the designated high secure hospital team
4. an extra care package at the designated high secure hospital, incorporating input from the medium secure CAMHS team.

3.4 Whichever option is agreed, it should be made clear how both age appropriate care and high levels of security will be achieved. The areas relating to referral and pre-admission care planning will apply here also.

3.5 It is anticipated that the young person will be nearing their 18th birthday; absolutely no admissions will take place of anyone under the age of 17.

4. New Referrals

4.1 Referrals to medium secure CAMHS are made directly to one of the centres (this is usually the centre closest geographically to the referrer). The referral is then considered at the weekly national referral coordination meeting of clinicians from all six centres and allocated to the most appropriate service. Appropriateness is determined by proximity to the patient's home, gender, presence of learning disability, availability of beds and current capacity of the service. There is a fast-track process for emergency referrals.

- 4.2 Referrals to high secure hospitals are made directly to the referrals manager at the relevant geographical catchment hospital.
- 4.3 It is accepted that the **referral of a person under the age of 18 to high secure services is and should be a rare occurrence**, however any referral to high secure care from CAMHS should only be made following referral to and assessment by the responsible adult medium secure unit for the patient. It must be noted
- The standard for admission to high secure care is that the patient presents a grave and immediate risk
 - The referral should then be made supported by both by the medium secure CAMHS and adult medium secure services and with the knowledge and approval of the commissioners responsible for the patient. (Access Policies determine how referrals to adult MSU's are made)
- 4.4 Medium secure CAMHS clinicians are the only clinicians able to determine whether a young person is suitable for admission to medium secure CAMHS.
- 4.5 High secure clinicians are the only clinicians able to determine suitability for admission to adult high secure services.
- 4.6 All parties (this will include social services, health care commissioning and other relevant agencies) should agree that the admission of the adolescent to high secure care is appropriate. It is essential, therefore, that all referrals of young people under the age of 18 are considered by clinicians from medium secure CAMHS in the first instance.
- 4.7 The Nominated Officer in high secure services should be involved in any admission of a person under 18 years old. The Nominated Officer will liaise with the Chair of the Local Safeguarding Children Board and the host Local Authority Director of Children's services. In the event that a referral of the adolescent to a high secure hospital is accepted by all parties for admission it is essential that the treatment and care plans are developed jointly and approved by all agencies including the relevant social services department prior to any admission taking place. **These care plans should be clear when specifying how age appropriate care will be achieved.**
- 4.8 Each high secure provider should ensure that an appropriate number of its staff maintain up to date training in child protection, and that it has appropriate links with its local Safeguarding Board, has a named lead doctor and lead nurse for child protection and is able to meet other statutory and good practice requirements.

- 4.9 The high secure provider will ensure the relevant members of its staff maintain an awareness of current issues in child and adolescent mental health, which may include participating in joint training or establishing joint posts with medium secure CAMHS.
- 4.10 The medium secure CAMHS provider will support the high secure provider in meeting these requirements by giving access to suitable training and support re child protection.
- 4.11 It would be appropriate when a risk assessment/ management plan is drawn up under Direction 33 of the High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011, reference is made to continuing co-operation with medium secure CAMHS services. This will provide further expert advice in the management and treatment of this group of children.
- 4.12 The care plan and pathway should be clear how both age appropriate care and high levels of security will be achieved.

5. Existing CAMHS Patient – 18 plus

- 5.1 If a young person is retained in medium secure CAMHS beyond their 18th birthday for clinical or other reasons and is later considered to require treatment in conditions of high security a process as outlined at paragraph 4 to paragraph 5 may still be required dependent upon care and treatment needs.

6. Transfer arrangements

- 6.1 A transfer date will be agreed by agencies that may include representatives from social services, health, Her Majesty's Prison and Probation Service (HMPPS), Ministry of Justice (MOJ) and NHSE high secure commissioners and case managers. Both the medium secure CAMHS and the high secure providers will use their best endeavours to ensure the patient is transferred as planned.
- 6.2 When a transfer is agreed the family and nearest relative should be advised of the transfer arrangements and date prior to the patient being moved.
- 6.3 When a transfer is delayed, the medium secure CAMHS provider should inform the appropriate NHSE commissioner and the high secure provider should inform its lead commissioner who will agree a course of action to ensure a safe transfer takes place at the earliest possible opportunity.

- 6.4 Where a patient is to transfer to adult MSU or other relevant adult services current transitional arrangements will apply.

7. Adult in High Secure Requires CAMHS-type Intervention

- 7.1 The high secure hospitals employ staff from a variety of disciplines with a broad range of skills. The nature of their client group, however, means they have minimal expertise in child and adolescent mental health (CAMHS).
- 7.2 There may be occasions when an 18-year old has been referred directly to the catchment high secure hospital by their current responsible clinician. It may be that the 18-year old is considered on assessment to have needs more typical of an adolescent and is more likely to respond to the therapeutic interventions more typically associated with CAMHS.
- 7.3 If this is the case, the patient's responsible clinician should contact the lead clinician at the nearest medium secure CAMHS centre, who will arrange for the patient to be reviewed by appropriate members of the clinical team to support the care and treatment plans on admission. They may maintain an overview of the care until such a time as the high secure team and the medium secure CAMHS team feel confident the patient's needs are being met.

8. Summary

- 8.1 The admission of a young person **under the age of 18 years is a rare occurrence** and it is unlikely that a referral will be made in the next twelve months. However, this **protocol should be reviewed annually**.

Alison Cannon

Regional Head of Mental Health
North of England Specialised Commissioning

Team Reviewed November 2018

Note: people under the age of eighteen years are legally classed as children

References: to be updated

- Best Practice Guidance Specification for adult medium secure services, Department of Health and Health Offender Partnership, 2007

4.4 Leadership and Quality Improvement Methodology

Leadership is important in influencing good practice, promoting development and good practice around LTS.

Leadership can be provided by a range of professionals working as a Multi-Disciplinary Team (MDT) to support, guide and develop in relation to LTS.

Specific good examples include; good leadership in clinical teams, psychology services, nursing leadership positions and specialised services such as the PIPS (Positive Intervention Programme) teamsⁱ.

LTS minimisation and reduction should be prioritised by a service as part of reducing restrictive practice programmes. All aspects of the organisation will need to understand the rationale, aims and objectives of the service and the plans in place.

Strong leadership, effective communication and good clinical team working helps all staff in developing their practice in relation to LTS.

Leadership at ward level must ensure patients nursed in LTS are provided with psycho-social or focused rehabilitation that is effective in teaching living, learning, recreational and working skills.

Teams should be encouraged to use methods/tools to improve their understanding of patient needs to reduce LTS such as using the Barriers to Change Checklist (BCC)ⁱ. The use of the BCC allows teams to formulate individual plans of care that are creative and reflect the needs of the patient, the enabling of the environment and the best use of staffing skills and resource.

The teams may also find it beneficial to use quality improvement methodology, such as driver diagrams to consider organisational and clinical factors that need to be addressed to improve services. There should be local quality improvement support within services. Additionally there is a significant amount of information available electronically for teams to utilise.

Key Principles:

1. LTS reduction is to link with principles of recovery and include building a trauma informed system of care.
2. Teams require time and effort to discuss the functions of LTS, patient formulations and the goals they are working towards with the patient and how they plan to reintegrate the patient back into ward routines.

3. Leadership developing an individualised hospital based LTS reduction action plan based on a performance improvement and prevention approach.
4. Leadership commitment and intention to use and monitor real time data in the reduction of LTS.
5. Leadership commitment to create a collaborative, non-punitive environment to identify and work through problems by communicating expectations to staff and to be consistent in maintenance of effort.
6. Leadership evaluation of the impact of reducing LTS on the whole environment. This includes issues such as increased destruction of property, extended time involved in de-escalation attempt, additional admission assessment questions, debriefing activities and processes to document event, etc.
7. Leadership to set up a staff recognition project to reward individual staff, unit staff and S/R champions for their work on an on-going basis and be accountable through routine reports and reviews.
8. Leadership to address staff culture issues, training needs and attitudes.
9. Leadership to review the hospital plan for clinical treatment activities in an effort to assure that active, daily, person centred, effective treatment activities are offered to all patients receiving services; that these services are offered off wards preferably and that persons attending have some personal choice in what activities they attend.

4.5 Clinical Example of the Positive Intervention Programme (PIP) at Ashworth Hospital

The PIP is an integrated specialised team that support patients and the clinical teams in the management of LTS. The team consists of registered nurses, nursing assistants and MVA instructors. The PIP Service uses recovery based principles to provide patients with positive relationships and meaningful activities to improve their mental health and quality of life and enables the service to address the physical health needs of patients. The PIP promotes positive culture change using the HOPE(S) model and principles of trauma informed care to progress patients out of LTS in a collaborative way.

APPENDIX 1

- **BCC CHECKLIST**
- **HOPE(S) GUIDE**



BCC GUIDE UP TO
DATE VERSION AUGL

APPENDIX 2

Guideline Exit Interviews for Patients Progressing Out of Seclusion and Long-Term Segregation

Explain that the details of this interview will be put in the clinical notes as the patient's perspective/story of the seclusion/segregation. In each question explore with the patients any unhelpful or helpful factors. After the interview record the responses in the [Patients View] in the [Seclusion] section of PACIS. Acknowledge that the experience in segregation was likely to have been very difficult and upsetting. Express a commitment that as a service we will be working hard to try to prevent such negative experiences from happening again in the future as they get in the way of progress and recovery and are unhelpful for everyone.

For Patients who have been in Seclusion and Segregation:

- 1) What were the events which led to your seclusion?
- 2) Do you think seclusion was needed at that time?
- 3) Do you think other different approaches would have helped you at that time?
- 4) What was your experience of seclusion?

PROMPTS: -

Quality of room

Relationships with staff

Availability of Care team

Treatment plan

Were there any on-going / repetitive problems for you or staff?

Did seclusion make you feel better or worse?

Did you feel safe?

Was it easy to access staff and get your needs met?

-
- 5) Do you think that you were in seclusion for too long? If yes, what were the problems / barriers which prevented the seclusion been ended?
 - 6) Do you have any worries about being out of seclusion and / or up on the main ward? If yes what are they?
 - 7) Is there a plan in place that you have been involved in, to help you stay out of seclusion in the future?
 - 8) Are there any difficulties you would like to discuss because of the effect that seclusion has had on you?

For Patients who have been in Long Term Segregation:

- 9) Did you have involvement with the PIP team? How did you find the team and the activities provided? Is there anything you think would make the service better?
- 10) When you were progressing out of segregation did the association plan help? Was it too fast / too slow?
- 11) What three things stopped you progressing out of segregation?
- 12) What three things were the most important in helping you progress out of segregation?

APPENDIX 3

Guideline Interviews for Patients About Their Experiences of the Use of Restraint

Explain that the details of this interview will be put in the clinical notes as the patient's perspective/story of the restraint episode. In each question explore with the patients any unhelpful or helpful factors. After the interview record the responses in their clinical notes. Acknowledge that the experience of restraint was likely to have been very difficult and upsetting. Express a commitment that as a service we will be working hard to try to prevent such negative experiences from happening again in the future as they get in the way of progress and recovery and are unhelpful for everyone.

Restraint Interview:

Explain the details of this interview will be added to the clinical notes as their perspective on the incident:

- 1) What were the events which led to you being restrained?
- 2) Do you think it was necessary / fair to restrain you at this time? (If not tell me more about this)
- 3) Are there any things that staff or you could have done differently at this time which might have helped? (If yes what were they?)
- 4) Did you feel safe at the time and afterwards? (What was helpful or unhelpful?)
- 5) Has anyone discussed with you how the restraint might have affected you?
- 6) Do you have a crisis plan in place to prevent incidents like this happening in the future? If so does this need changing? (What would you add in or take away? or are there things you want the care team to think about which might help you in the future?)
- 7) Have you spoken to the staff involved? And are there any outstanding problems which need sorting out?
- 8) Have you spoken to the Care team about the review of this incident?

Read out the account so the patient can check it is an accurate summary before entering the information in their clinical notes.

APPENDIX 4

Guideline Questions for Staff About Their Experiences of the Use of Restraint As Part of the De-Brief

- 1) What has been the impact of this incident on staff a) are there issues which need addressing at reflective practice / supervision? b) Are there any issues which need highlighting to the Positive & Safe Violence Reduction Training Department.
- 2) Was the patient restrained in a prone position (face down), if so what was the reasons for this? How long were they in this position? Were their vital signs monitored throughout the restraint? Was compliance gained with the physical observation policy? And if not was a clear rationale provided and documented?
- 3) What was the impact on other patients and are there any issues which need to be addressed with particular individuals or in the ward community? (If so inform Ward manager).
- 4) Could this incident have been managed any differently? a) Was the crisis plan / care plans followed b) If not what were the barriers? c) How could the plan be changed to prevent incidents like this in the future? d) Any recommendations should be highlighted to the Care team and communicated across staff teams.

APPENDIX 5

Seclusion Review of Literature – McNeil 2015



Seclusion - Literature
review - Ashworth.dc