The Clinical Model

‘A Framework of Principles’
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EXECUTIVE SUMMARY

In 2011 The State Hospital will open a new modern purpose built site which will offer high secure forensic facilities for male patients from Scotland and Northern Ireland. The vision and aspirations for the new service are the coming together through extensive planning and design which began with the Scottish Government approval of the outline business case, subsequently followed by approval of full business case in 2007 and a signed contract in 2008 with the approved contractor.

The clinical model will provide a clear platform on which we will base new ways of working and ensure best value, so that we achieve a service that is both fit for purpose as a contemporary forensic mental health and intellectual disability service and is an exemplar estate.

Statement of Intent

This clinical model will describe the way The State Hospital will provide high secure services to patients with a mental disorder many of whom have offended.

This document sets out:

- A description of the environment and estate and the patient profile
- The wider mental health context within which the service fits
- A set of principles against which patient care, policies and operational practices can be measured
- The patients pathway

Vision for the New Clinical Service

The service will provide high secure care for those who require it and we will work closely with partners in health and social care to achieve the best outcomes for each patient that will be realised through a combination of recovery, rehabilitation, risk assessment, treatment and management. All interventions will be based on the best evidence and practice in the field of forensic healthcare and will take account of the rights of individuals to lead as independent a life as possible within the context of public safety and the safety and security needs of patients.

The new hospital will provide a significant opportunity to improve care and ultimately the outcomes of the work that is done. In order to achieve this we will:

- Assess, admit, treat, manage and discharge patients using care programme approach and integrated care pathways.
- Eradicate the disjointed demarcation of services by bringing them together in the purpose built estate.
- Tailor care to the needs of patients in terms of range, timing and the least restriction necessary.
- Robustly ensure risk assessment and management plans are responsive to the changing needs of each patient.
- Employ modern technology and solutions that improve security and manage risk.
- Provide access to health and wellbeing activities that promotes engagement, recovery and hope in the future.
- Ensure that staff are trained and supported to adopt new ways of working that are based on need, rather than historical practices.
- Deliver clinical leadership by confident well equipped people who develop their teams and make use of performance management information.
Delivering the New Model
Details on how the model will be delivered will be outlined in the full text and associated appendices, however the key objectives that underpin the way in which we will deliver our objectives more effectively and efficiently are as follows;

- Demonstrate the areas that will be delivered in new and different ways and support staff to meet these challenges.
- Provide a structure that enables clinical teams to make decisions on resources and allows for greater interdisciplinary working between professional groups.
- Ensure that communication and engagement with staff and patients provides continuous opportunity to improve performance and minimise both risk and non productive ways of working.
- Provide patients with improved access to a wider, more responsive and better structured daily routine which takes account of the full week, both daytime and evenings.
- Re-affirm that prevention and treatment of ill health, both physical and psychological is the core business of all our clinical staff.
- Structure daily routines and business in a way that ensures patients have greater access to the outdoors, physical exercise and activities that promote recovery.

Framework of Principles
Nine overarching principles underpin the clinical model for the new hospital. These are:

- **Integration:** Clinical care which includes medical, psychological, social care, education and life skills development are all essential and must be coordinated and combined in care planning that tackles the needs and risks of each patient. Integration of all three security domains - physical, procedural and relational - will be fully integrated with clinical care and enhance the opportunities available to patients.

- **Patient-Focused Care:** As outlined in the National Services Framework¹, we will place patients and their carers at the centre of all service planning and delivery. In addition, the patient-focused approach will maximise the use of our buildings and estate and will enhance autonomy and choice and improve the quality of patients’ lives.

- **Individualised Care Pathways:** Each patient will have an individualised care pathway that reflects the care programme approach and begins at the pre admission assessment phase and continues to the point of discharge.

- **Positive Therapeutic Milieu:** We will create positive learning and enabling environments that support personal development and skills acquisition, recovery and encourage self management. All clinical staff will use a reflective practitioner model in their day to day working lives.

- **Supporting Staff:** It is recognised that working with this patient group will at times be demanding and difficult. Staff will be supported and developed to enable them to meet these challenges and a culture of learning and reflection will be recognised and embraced by clinical leaders and hospital managers.

- **Strengthen Multi Disciplinary Working:** Staff will adopt new ways of working that ensure communication and joint working are maximised and they will be

¹ [http://www.sehd.scot.nhs.uk/nationalframework/documents](http://www.sehd.scot.nhs.uk/nationalframework/documents)
committed to service improvement that crosses traditional professional boundaries. Staff will fully understand their contributions to the new clinical model and know how they play their part in achieving the organisation’s goals.

- **Violence Risk Assessment and Management**: Clearly set out violence risk assessments will be developed throughout the care pathway for all patients. The risk plans will make explicit the individual’s present, past and future risks and include victim safety. Clinical and security safety plans to address each component will be outlined and reviewed regularly.

- **Comprehensive Mental & Physical Health Care and Treatment**: All care whether for mental disorder or physical health and well being will be delivered and reviewed through the care planning process. Staff will understand and deliver a health promotion and rehabilitative approach in their daily work with patients.

- **Clinical Governance Strengthens and Informs Care**: Staff will demonstrate a commitment to adopting best practice and to share new learning that supports service improvement. The organisation will promote and deliver the research and clinical effectiveness agenda and monitor the performance of our services against agreed indicators. We will learn and develop from past events and reflect on incidents, accidents, complaints and concerns in a way that is positive and transparent.

Further detail on how these principles will translate into strategic actions and service design and the associated clinical gains will be contained in the main document.

**Conclusion**
The importance of service redesign and continuous improvement is essential at a time of rebuild. To replicate existing practices, policies and procedures which were designed around out dated estates and facilities will not allow the full use and benefits of our new buildings to be realised, nor allow staff to practice their skills fully in a modern health care environment. The clinical model does not aim to denote the details around these new ways of working, but importantly it sets the context in which new structures and policies can be formed. The new hospital heralds an unprecedented opportunity to modernise the experiences of the patients who require the expert care and treatment The State Hospital provides and that will impact not only on the health gains while in high security, but also in the patients’ transitions to step down levels that will follow their discharge.
1. INTRODUCTION

1.1 Purpose
The State Hospital is planning the redevelopment of its entire estate. The purpose of this document is to describe the way in which clinical services will be delivered in the new hospital. It describes how clinical teams will be organised and how they will then work, to deliver high quality effective care while they assess, admit, treat, manage and discharge or transfer patients.

1.2 National Drivers and Principles
The redevelopment of the hospital reflects a number of drivers for change. Most significant amongst these are:

- Mental Health (Care & Treatment) (Scotland) Act 2003
- The Human Rights Act and Agenda.

National policy documents also include, but are not limited to:

- MEL(1999) 5
- “Patient Focus and Public Involvement”
- The Forensic Mental Health Service Managed Care Network
- HDL (2006) 48 Forensic Mental Health Services
- CEL (2007)7 Multi-Agency Public Protection Arrangements
- Rights, Relationship and Recovery (Scottish Executive, 2006)
- Delivering for Mental Health: Mental Health Action Plan (Scottish Executive, 2005)
- CEL 19 (2008) Health Service Guidance, Restricted Patients

1.3 History
The State Hospital has been in existence since 1948 and was designated a Special Health Board in 1995.

The hospital’s bed numbers have varied significantly over recent years, with less than 200 patients in the early 1990s increasing to over 260 in the early part of this century. Many factors have influenced this, the most significant being a lack of step-down facilities. Until recently this has meant that significant numbers of patients requiring medium or low security have been detained unnecessarily or entrapped in the high or ‘special’ security of The State Hospital.

Chart 1: Details the changing pattern of admission by source over a six year period.
The blueprint for forensic services in Scotland, NHSiS MEL 1999 (5), is now being implemented and medium secure units now exist in Edinburgh and Glasgow with a further unit planned for the North of Scotland, in Perth. In addition, Belfast has a medium secure unit - the Shannon Clinic. Low secure and community services are also under development around the country.

The Forensic Network - a managed care network for Forensic Services is providing central guidance and co-ordination where necessary to assist local / regional services fulfil their objectives, as well as taking an active role in ensuring that patients move effectively through the system. There is a particular impetus for this as the Mental Health (Care and Treatment) (Scotland) 2003 Act allows appeals (from those subject to high security) to a Mental Health Tribunal against detention if they are held in conditions of excessive security.

Within The State Hospital, redevelopment work has been underway since the outline business case was approved in 2004, that work involved a wide range of staff, patients, carers and other stakeholders. The main engine room for this work has been through the Redevelopment Project Board and the Organisational Development Group who commissioned working parties to produce reports and guidance on service configuration, workforce plans and application of new approaches. (Appendix 1)

The Board has undertaken to review and revise the clinical model in 2013 following the new estate being fully operational by 2011.

This document sets out:

- A description of the environment, the existing estate and the patient profile
- The wider mental health context within which the service fits
- A set of principles against which patient care, policies and operational practices can be measured
- The patients’ pathway
- The importance of clinical leadership

2. THE PATIENTS

In 2002, Kennedy² broadly outlined a brief definition of security levels based on patient needs, with high security being described in the following way: “…the level of security necessary only for those patients who pose a grave and immediate danger to others at large. Security arrangements should be capable of preventing even the most determined absconder.”

This has more recently been built upon by the work of the National Forensic Network in Scotland in developing a full Matrix of Security Standards for high, medium and low security.

The current patients’ average age is 38 years old, though they range from 18 to 68 years old. Length of stay averages 6 ½ years, although for some it is as short as 3 months and for a few it can be as long as 40 years. Patients are admitted from either other hospitals in the NHSiS, the court system or from prison (see chart 1). Following assessment and treatment, most patients return to one of these locations, and as a result of the increase in medium secure beds around the country, chart 2 shows a rise in hospital discharges with slight reductions in transfers back to prison or courts.

Around two-thirds of patients have a restriction order and a similar number have previous convictions. Most patients have a diagnosis of schizophrenia, although there is also a small number with an intellectual disability.

The majority of State Hospital patients are subject to ‘restriction’ and must be managed in accordance with the Care Programme Approach (CPA) and Multi Agency Public Protection Arrangements (MAPPA) requirements.

Where patients are admitted to The State Hospital after offending, it is often the case that the offence is of a violent or sexual nature. Many patients have histories of social and personal deprivation. Most have histories that also include drug or alcohol abuse and many have been physically or sexually abused or have a history of trauma and adverse life events. There is a high instance of co-morbid diagnosis including personality disorder, problematic personality traits and psychotic disorders.

The challenges of caring for this particular patient group include the potential risk of violent or challenging behaviour, together with the presentation of complex mental health and physical ill health risks and needs. These presenting problems are set against the need to engage people who often have difficulties forming and maintaining relationships both in their personal lives and with health and social care professionals. Often the patients have great difficulty in establishing trust and confidence in others and in practical terms this manifests itself in the form of episodes of physically or emotionally aggressive behaviour.

3. THE ENVIRONMENT

Existing Environment
The State Hospital was built in the 1930s and many of the current buildings date from that time. Attempts to modernise services with various additions and demolitions, have led to the present mix of buildings on a single site, previously the west wing of a split site. The buildings vary in age, facilities and suitability. The site is no longer fit for the purpose of delivering modern health care and indeed many of the working practices are limited by the constraints of the campus. The Mental Welfare Commission for Scotland has previously reported that the current ward configurations mean that clinical teams are often forced to work as isolated and discrete islands. This was considered to be a limiting factor in service improvement and the sharing of good practice, communication and knowledge.

The clinical services delivered by the hospital have naturally been subject to efforts to improve over time, though inevitably they have been shaped and limited by the environment. Best efforts to ensure a modern patient-centred service have been hampered by poor patient living
conditions, restricted areas for therapeutic work, uni-disciplinary buildings and poor or inadequate therapy spaces.

The physical environment of The State Hospital is a vital component in how, when and where effective modern healthcare is delivered. Well-designed facilities should stand as a visible embodiment of the commitment given to patients - that they will be well cared for, comfortable and safe.

4. THE NEW HOSPITAL ASPIRATIONS

The full business case for the redevelopment of the hospital reduces the bed complement from the current 240 to 140.

The design quality of the new hospital – its layout and facilities on both the large and small scale - will deliver a wide range of benefits improving the mental and physical health of patients, reducing the risk they may present to others and themselves, reducing the operating costs of the buildings and supporting and improving staff performance.

This gives us a unique opportunity to modernise the care and treatment that can be delivered. The hospital will be a high quality living and working environment for patients and staff, with increased staff : patient ratios supporting the delivery of the highest quality treatment. However, it is recognised that improving the environment in itself will not result in the modernisation of care and treatment. The implementation of this new clinical model will require a commitment to change and willingness to tackle challenges in order to achieve service modernisation. To do this, Clinical Teams will take their place at the centre of service planning and support systems will be developed that ensure each team has high quality performance information and access to responsive support services.

Patients will be able to access high quality treatment that is delivered promptly and effectively, that supports recovery from mental illness, maximises social and emotional functioning and reduces the risk of serious harm to self or others.

Transfer, when appropriate, should proceed speedily within a modern, safe and secure hospital. The primary function of security and safety of public, staff and patients will continue to be enhanced by ensuring that physical, procedural and relational security is of the highest order.

Our safety and security can be viewed in three distinct areas (Appendix 2):

- **Environmental Security**: Includes physical aspects such as the perimeter fence, building security, observation systems and alarm systems. It is also the provision, maintenance and correct use of appropriate buildings and equipment by properly trained staff.

- **Procedural Security**: Includes all patient related policies and practices which control, for example access, communications, personal finance and possessions. It also includes policies and practices in relation to quality and governance (High Secure Care Standards). In addition, contingency planning and the use of intelligence information to help clinical staff carry out safely their day to day work is a key component of this element of therapeutic security.

- **Relational Security**: Occurs through a combination of knowledge and application of the elements of environmental and procedural security, which allows staff to practice and engage safely with patients. This is achieved through
intelligence gathering from a variety of external agencies, combined with historical factors or incidents during a patient’s stay.

Realisation of the benefits identified throughout this document will be subject to regular review to ensure maximum impact on desired outcomes.

5. GUIDING NATIONAL PRINCIPLES

5.1 Millan Principles
All patients will have, or will be undergoing, assessment for a mental disorder under the terms of the Mental Health (Care & Treatment) (Scotland) Act 2003. The majority of patients will be detained for treatment of a psychotic disorder, although it is recognised that many will have a co-existing diagnosis of personality disorder.

The development of this new clinical model for the hospital parallels the implementation of the new Act, which was underpinned by an increased focus on integrated care, the human rights agenda and the findings of the Millan Committee - The Millan Principles. As a general rule, anyone who takes any action under the new Act has to take account of 10 fundamental principles and these apply to all patients in The State Hospital:

1. **Non-discrimination** - People with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

2. **Equality** - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.

3. **Respect for diversity** - Service users should receive care, treatment and support in a manner that affords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. **Reciprocity** - Where society imposes an obligation on an individual to comply with a programme of treatment or care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

5. **Informal care** - Wherever possible care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

6. **Participation** - Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be presented in an understandable format.

7. **Respect for carers** - Those who provide care to service users on an informal basis should be respected for their role and experience, receive appropriate information and advice and have their views and needs taken into account.

8. **Least restrictive alternative** - Service users should be provided with any necessary care, treatment and support in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account, where appropriate, of the safety of others.

9. **Benefit** - Any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.

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3 Millan Committee, 2001 was commissioned by the then Scottish Executive to review the mental health legislation in Scotland. Their finding formed the recommendation on which the new Act was built, and the key principles in their report are now referred to as the Millan Principles.
10. **Child Welfare** - The welfare of the child is paramount.

5.2 **10 Essential Shared Capabilities**
Working effectively to recognise and meet the needs of patients and the Millan Principles requires multi-disciplinary functioning of the highest calibre along with a meeting of medical and psychological and social models of care. *NHS Education Scotland* introduced best practice for staff working with patients with a mental disorder. Referred to as the *Ten Essential Shared Capabilities*, they reflect how mental health service users and their carers must be treated. In simple terms, the Millan Principles in the main refers to patients and how they should be treated, whereas the Ten Shared Capabilities in the main refers to how mental health staff should work with patients.

These 10 essential shared capabilities are:

- Working in partnership (with patients and others)
- Respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery
- Identifying peoples' needs and strengths
- Providing service user (patient) centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning.

These capabilities will define the attitudes, behaviours, expectations and relationships that staff will display in the new State Hospital. They will form the core of planning and delivery of future services.

5.3 **The Recovery Model**
In addition to the shared capabilities, The State Hospital clinical model endorses the *mental health recovery model* for patients, which promotes:

- Hope
- A belief in recovery
- Holding and demonstrating values and practices that reflect this belief
- Taking what people can do and want (their strengths) as the starting point in person-centred care and treatment planning
- Developing care so that service users can increase their role in their own needs and risk management
- Social inclusion and promotion of peer support worker roles

5.4 **Summary**
The overall clinical model of care at The State Hospital requires the combination of medical, psychological and social models that includes a recovery-focused approach. No one form of intervention can be singled out as more effective than another, and a combination of

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4 “The 10 Essential Capabilities for Mental Health Practice” (2004) developed by the DoH, the Sainsbury Centre for Mental Health, and NIMHE in England
5 The Scottish Recovery Network has produced recovery indicators, and is part of the Scottish Governments National Programme for Improving Mental Health & Wellbeing.
therapies, interventions and approaches are required to constitute a care plan that tackles the needs and risks for any individual.

People with a mental disorder who require high secure care are an extremely diverse group in terms of their offending profiles and psychosocial needs. As well as providing more traditional pharmacological and psychological interventions, our service will also provide life and daily living skills that include self care, employment or occupation and learning that are well recognised as being protective factors against both recidivism and the recurrence of ill health.

6. THE STATE HOSPITAL CLINICAL MODEL PRINCIPLES

To be able to satisfy these advances in mental health care, this clinical model sets out 9 guiding principles, reflective of the national perspective and trends and more specifically the best practices in the field of forensic mental health. New policy and procedural context will be built on these and all development work must refer and meet the aspirations of these principles.

6.1 Integration
Clinical care which includes medical, psychological, social care, education and life skills development are all essential and must be coordinated and combined in care planning that tackles the needs and risks of each patient. Integration of all three security domains - physical, procedural and relational - will be fully congruent with clinical care and must enhance the opportunities available to patients. Each patient will have a security profile, intelligence profile and for those who pose exceptional risks, additional measures on how these features are to be managed will be made explicit. The policies and procedures in the new Hospital must ensure that integration is well structured and involves the patient, their carers, is linked to other local or national services and is proactive in offering follow-up and after care.

6.2 Patient-Focused Care
As outlined in the National Services Framework, we will place patients and their carers at the centre of all service planning and delivery. In addition, the patient-focused approach will ensure the use of the environment will enhance autonomy and choice and will improve the quality of patients’ lives. This means that communication and involvement of patients and their carers will be open, honest and a two-way process. Patients will have the opportunity to influence service design and delivery. Complaints, concerns and comments from patients and carers will be handled sensitively and impartially. Individual diversity in terms of sexuality, faith, gender preference and physical disability will be recognised.

6.3 Individualised Care Pathways
Each patient will have an individualised care pathway that reflects the care programme approach and begins at the pre admission assessment phase, continues to the point of discharge and in many cases, follow-up after care will be provided. The use of integrated care pathways will help clinical teams to use best practice and evidence available. Patients will have the opportunity to develop through an individualised pathway of care that best meets their needs and access to services will be tailored accordingly. A range of interventions will be available and timetabled according to when and where they are best delivered. Creativity and meaningful occupations will be a core component of the daily routines and seen as an essential component of the therapeutic experience. Patients will be encouraged to actively engage in the planning and evaluation of their care.

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6.4 Positive Therapeutic Milieu
We will create positive learning and enabling environments that support personal development and skills acquisition, recovery and encourage self management. Evidence suggests that supportive interventions effectively achieve change (Spinelli, 1994). This strengthens the importance that staff adhere to the 10 essential shared capabilities which are outlined in this document. They will promote a recovery-focused culture and will foster an optimistic view with patients regarding their current and future hopes and aspirations. Interactions between patients and staff will be set within a reflective practitioner model and barriers to effective engagement must be explored in a multi professional setting. Some patients will be able to assist in the recovery of their peers and so a peer support framework will be developed.

6.5 Supporting Staff
It is recognised that working with this patient group will at times be demanding and difficult. Staff will be supported and developed to enable them to meet these challenges and a culture of learning and reflection will be recognised and embraced by our clinical leaders and our hospital managers. To achieve this, psychological mindedness will be a clear feature in the selection, training and supervision of all clinical staff. The School of Forensic Mental Health will play an integral part in staff support and development and all staff will have personal development plans that reflect the aims of the organisation. Policies and procedures will be formed that take account of organisational and individual learning needs.

6.6 Strengthen Multi Disciplinary Working
Staff will adopt new ways of working that ensure communication and joint working is maximised and they will be committed to service improvement that crosses existing traditional professional boundaries. Staff will fully understand their contributions to the new clinical model and know how they play their part in achieving the organisation’s goals. The new configuration of hubs and clusters of wards and the articulation with the activity centre will ensure joint working is seamless and that the historical professional silos are not replicated. Staff will have the skills and confidence to work in a variety of settings which reflect the overall needs of patients as against traditional environmental boundaries. We will have well staffed multi disciplinary teams which afford the opportunity to provide a holistic and comprehensive approach to patient care and treatment. All teams will practice in a consistent manner in accordance with the agreed objectives of the care and treatment plan. One member of each clinical team will take the role of clinical leader and this will usually be the Responsible Medical Officer.

6.7 Violence Risk Assessment and Management
Clearly set out violence and risk assessments will be developed throughout the care pathway for all patients. The risk plans will make explicit the individual’s present, past and future risks and include victim safety. Clinical and security safety plans to address each component will be outlined and reviewed regularly. The Risk Management Authority published good practice Standards and Guidance for Risk Management and these will be fully implemented. The Care Programme Approach will be maximised to implement and monitor our procedures and transitions across the forensic network and other agencies contributions will be carefully planned and monitored.

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7 Demystifying Therapy (Ernesto Spinelli 1994)
8 Psychological mindedness is an ‘umbrella term’ which denotes a person’s capacity to reflect on themselves, others, and the relationship between these... In essence, it means to more deeply consider the causes and meanings of behaviour, thoughts and feelings. (Bluckert, 2007)
6.8 Comprehensive Mental & Physical Health Care and Treatment
All care, whether for mental disorder or physical health, will be delivered and reviewed through the care planning process. Staff will understand and deliver a health promotion and rehabilitative approach in their daily work with patients. Working practices and staff training will reflect the complex health needs of patients and an emphasis on holistic and healthy living models, including the prevention and management of long term conditions, will be promoted and delivered by all. The living environment for patients will be active, will positively emphasise health improvement and will support changes to their lifestyle and routines. Physical activity and access to outdoor spaces will be an integral part of everyday routines for patients and staff.

6.9 Clinical Governance Strengthens and Informs Care
Staff will demonstrate a commitment to adopting best practice and to share new learning that supports service improvement. The organisation will promote and deliver research and clinical effectiveness and monitor the performance of our services against agreed indicators. We will learn and develop from past events and reflect on incidents, accidents, complaints and concerns in a way that is positive and transparent. Policies and procedures will emphasise the importance of respecting the rights of patients and carers to be treated with respect and dignity. There will be systematic reviews of working practices and stringent performance management will be implemented across the organisation. We will continue to develop a culture of research and evidence based practice through projects that will enhance the clinical outcomes for patients.

7. THE VALUE OF AN INTEGRATED MODEL

Although many mentally disordered offenders may be diagnosed as having more than one psychiatric condition, it is often the combination of medical and social factors which leads to their offending behaviour (MEL 5 1999).

Research looking at interventions for and treatment of patients in high secure care has pointed to the need for an eclectic approach that delivers an integrated combination of pharmacological and psychotherapeutic interventions from different schools. In terms of the ‘what works’ literature for the mentally disordered within a forensic setting, research suggests that interventions and therapies are most successful when they are:

- Intensive
- Long-term
- Theoretically coherent
- Well structured
- Engages the service user and makes sense to them
- Takes account of their hopes and aspirations
- Well integrated with other services
- Tied into follow-up care

These facets will form a core feature of care and treatment planning in service delivery. The need for involvement and transparency for the patient will be highlighted; this will be achieved through exemplary multi-disciplinary team working and good communications. Throughout each patient’s journey through The State Hospital, care plans and treatment goals will be explicit and documented. Risk assessments will reflect current and future risks and be responsive to the range of environments where care takes place. All interventions will focus

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10 (Livesley, 2003).
11 (Bateman & Fonaghy, 2000):
on recovery and health promotion, the management of risk and an understanding of the
patient’s personal and social circumstances. These shared goals will be the priority for all
clinical staff.

8. DELIVERING THE CLINICAL MODEL

The remainder of this document will describe the way services will be delivered in the new
Hospital and how the patients’ day will be structured to ensure maximum benefit is gained
during their stay in hospital. The procedural and operational details will be explored and
agreed in a variety of working groups that will use this document as a basis for service
development and improvement. It is essential that staff, patients and carers are supported to
see how the clinical model and subsequent plans relate to themselves; in the work they do
and the care they receive. By making the messages clear, the model will gain widespread
ownership and implementation will be successfully achieved.

9. ORGANISATION OF SERVICES

9.1 Hub and Clusters
In the main living areas for patients, there will be 4 hubs. Each hub will have 3 wards and 3
multi-disciplinary clinical teams. Ideally the multi-disciplinary clinical teams (Appendix 3) will
work flexibly across the hub, working with a patient from admission until discharge / transfer
from the hospital irrespective of where they are within the hub. In each hub, there will be an
area to which patients are admitted for assessment to start their early recovery. A patient may
progress to the other wards within that hub for further rehabilitation within the hospital prior to
transfer. Each ward will have a maximum occupancy of 12 patients and a dedicated nursing
team supported and enhanced by other core professionals. In one particular hub, one of the
wards will be the Intellectual Disability Service which will run in parallel to the generic male
mental disorder service. Each clinical team will have a clinical leader identified who will ensure
the smooth running of the environment and services for patients in their care. Due to the
complex and severe needs of the patient group, the service will have the capacity to move
patients between different care areas or wards.

9.2 Multi Professional Staff
A multi professional meeting structure will be developed that ensures the daily business of
care is delivered in a way that makes best use of the skills and abilities of the multi
professional staff available. Some of these meetings will be daily and be led by the clinical
leader, the nurse in charge or the hub manager.

9.3 Co-location of Core Clinical Team Members
Staff will move around the hubs to support patients and facilitate participation in therapeutic
activities. Each clinical team will have a ‘live’ action plan that reflects the priorities for service
development and improvement. The clinical leader will be responsible for maintaining this
document and reporting on progress to the hospital managers. Staff will be used flexibly
within the hub and cluster to ensure therapeutic activity is delivered in an integrated fashion
and higher intensity care will also available, when required, to those who need it.

The core clinical team members will have office accommodation within the hub and clusters.
This will provide quick and efficient access to the clinical teams’ collective skills and expertise
and improve communication and the sharing of information.

9.4 The Activity Centre
The activity centre will provide a variety of services tailored to meet the leisure, employment,
learning, recreational and physical health needs of patients. In addition, a menu of
psychological interventions and creative therapies will be provided in the activity centre that complements the care aims of each patient. Therapists, nursing and psychology staff will be able to work between the hubs and activity centre to facilitate treatment in the most suitable environment possible. The activity centre staff will be fully integrated into the clinical conversations and decisions affecting the risk assessment and management of all patients using these facilities.

9.5 The Hard to Reach Patient
For some patients access to the activity centre may not be achievable at certain points in their stay, however this should not prevent access to similar services at a hub level that support recovery and health gains. In these circumstances, activities that meet clinical needs should be delivered within the hub and clusters, this may include activities normally undertaken in the activity centre.

9.6 New Partnerships
New approaches to service delivery that include partnerships with external agencies can offer a seamless longer term engagement with follow-on after care. These will be explored and incorporated through the workforce plans and will evidence both value for money and that some service components could be delivered better by other expert agencies.

9.7 Clinical Security
Clinical security staff will provide assistance and guidance to clinical teams on procedural and environmental aspects of the care plan. They will work for and support the clinical teams and be a source of auditing practices and monitoring performance against agreed standards.

10. CLINICAL CARE PATHWAY

10.1 Typical Journey of Care
The patient journey through the State Hospital will be covered in the Integrated Care Pathway model and adherence to these principles will be monitored by the clinical teams and by the hospital managers. The care programme approach will be employed for all patients from the point of admission through to discharge.

Referrals to The State Hospital will come from a number of sources. Most commonly, referrals will come from prisons, courts and other local and regional psychiatric services. Most patients referred from other psychiatric services will be from low and medium secure forensic units. There might be rare circumstances in which someone is referred who is currently in the community or from a different setting. All referrals to the hospital will be discussed at a multi-disciplinary referrals meeting. At this meeting, there may be additional requests for further information prior to the referral being allocated to one of the clinical teams for assessment.

There may be occasions when referrals are not assessed as it is clear from the information provided that an admission to conditions of high security is not appropriate. In such cases, this will be discussed with the referrer and advice may be given on alternative management strategies within their current environment or alternative services which may be more appropriate.

10.2 The Five Phases of the Care Pathway
The phases outlined in the care pathway follow the typical progression during a period of admission. They are: (Appendix 4)

- Pre-admission assessment
- Admission
- On-going in patient care and treatment
• Consolidation of recovery
• Discharge

Each phase requires clinical teams to focus on care elements, tasks or interventions that best meet the changing needs at any given time. Clinical effectiveness staff will support clinical teams to develop pathways and key elements in line with recognised best practice and evidence, and technological solutions to the reporting and monitoring of these pathways will be developed.

10.2.1 Pre-admission Assessment
The pre-admission phase requires a comprehensive assessment that takes account of medical and social circumstances and risks and concludes with the clinical team’s decision to either admit the patient or report back to the referring agency with their reasons not to admit clearly outlined. This will always be done in partnership with the referring agency and the local forensic service and within agreed timescales.

10.2.2 Admission
Once the decision to admit has been reached by the clinical team, under the guidance of the Responsible Medical Officer, the priorities for this phase are on the containment and management of the behaviours, management of crisis and the identification of risks associated with the patient. Furthermore the introduction of pharmacological treatment will begin if indicated and a full and thorough case conference and subsequent care plan will be produced. During the admission phase following stabilisation of mental state, access to a growing range of tailored activities and environments will take place under the guidance of the clinical team. At this stage the care programme approach will have been established and links to local services will be consolidated and agreed.

10.2.3 Ongoing Inpatient Care and Treatment
Ongoing inpatient care and treatment will begin following the assessment phase which may take a period of two months or more. During this period of the care pathway, patients are likely to be in receipt of a wide range of therapies and psychological interventions. The objectives will focus on regaining or restoring behavioural control and the reduction of symptoms of mental disorder will have begun. A rehabilitative focus which ensures all health and wellbeing is catered for is key within this phase of the patient pathway.

For those with more challenging behaviour, such services will be tailored to meet the needs in an environment that best meets their care and security needs. This care can be best described as intensive care and may at this point require an increase in staff interactions and supervision.

10.2.4 Consolidation of Recovery
Following a period of rehabilitation and the consolidation of learning skills through tailored treatment plans, the patient will begin the process of reduced exposure to external control measures as they become more able to self regulate. The focus will move to consolidation of psycho-educational themes relating to the reason for admission and the clinical team will begin to work in partnership with the patient to identify suitable options at their disposal after discharge.

10.2.5 Discharge
When the decision has been reached by the clinical team and the receiving service that a patient is ready to progress to the discharge phase, then the planning will be done jointly between The State Hospital's clinical team and the receiving local team. At this point the care programme will already be detailed and agreed and act as a
guide to assist and facilitate the transfer process. All patients will be transferred or discharged under CPA and in accordance with MAPPA requirements when appropriate. Following discharge, links with the State Hospital’s clinical team members may continue for a short time, dependent on clinical need.

11. THE PATIENT’S DAY

The patient’s day will be managed pro-actively and each patient will have their own timetable which will include a range of activities that are therapeutic, creative, promote life and social skills, education and learning, involve physical exercise and makes productive use of leisure time. The timetable will be agreed and regularly reviewed by the clinical team - this may be carried out by the key worker on behalf of the care team. Each timetable will have a balance between therapy that is related to their admission or offence and also have a mix of education or learning, productivity, living skills activities, recreation and leisure pass times. The hospital will aim to ensure that all patients acquire the minimum national standards of physical exercise each week which is thirty minutes of exercise, five times a week.

Appointments with clinical staff will be booked into the patient timetables so that they know in advance who is due to see them and where this will take place.

The therapeutic aspects of care will be delivered in both individual sessions and in group work. Some sessions will take place in the hub and clusters and the majority within the activity centre. Patients will take part in regular sessions with their nursing key worker or associate key workers - this will be at least on a weekly basis.

Structured meaningful activity and therapy will be provided for each patient and there will be a minimum of 21 sessions per patient per week - this will include evenings and weekends. For those patients who are more challenging, treatment sessions maybe shorter in duration and take place on or near the ward, however the frequency should be the same.

The importance of work that provides meaning and a sense of productivity whether in the form of vocational rehabilitation or a less structured approach will be available to each patient. There is clear evidence that people with a mental disorder achieve a better long term outcome if they are able to engage in meaningful work related tasks. Services will identify opportunities for patients to take on tasks and roles that reflect this ethos.

The importance of an active, healthy routine will be promoted by all care staff and patients will have at least 2 periods of time per day outdoors, whether they require to be escorted or not. For those who have more intensive care needs this can be facilitated by using the ward garden areas.

Maintaining contact with family and friends is an essential factor not only for patient’s sense of wellbeing but also in their long term recovery from illness. Technological solutions will be introduced that improves access to telephones with the least restriction required for any patient.

Some patients may be able to contribute towards the running of their ward area, or have acquired skills in areas such as sports, arts or other pursuits. Training will be available to these patients so that they may offer support to other patients using the peer support worker role or buddy system.

There will be a flexible approach towards the need to return to the wards for meals, as these can be provided in the activity centre. Patients will be able to move around the activity centre.
from one area to another and this will be supported by technological solutions and coordination between the centre and the control room.

Activities in the evenings and weekends have historically been limited, which can be frustrating for some patients and for others encourages a sedentary lifestyle to develop. The new hospital will offer a range of leisure and recreational activities in keeping with the routines available to the general public. The activity centre will offer sessions that allow the majority of patients to leave the wards during these times.

Daily planning meetings within the hub and clusters will include allocation of staff to all areas that provide therapeutic activities, to ensure that session cancellations are minimised.

Decisions to withdraw or withhold access to off ward activities will be recorded and reviewed and must never be used as a punitive measure. Any changes to timetables which result in a reduction of access to activity should be proportionate to the circumstances and involve the least restriction necessary to protect the patient and ensure the safety of others.

Therapeutic activity in wards will be reflective of a therapeutic milieu approach so that patients and staff use real experiences to explore problems, find solutions and promote socially desirable behaviour. There will be daily opportunities on each ward when the staff and patients engage together in structured activity - this may take the form of discussion groups, games, physical exercise and community meetings.

12. CLINICAL LEADERSHIP

In order to achieve the aspirations inherent in this model, a commitment to embrace the necessary changes is required. To do this, staff must be prepared and ready to take on the associated challenges in advance of 2011. We will continue to build on existing leadership development programmes and support first line managers to deliver on the balanced scorecards to effect positive changes. By 2011, the organisational development plan will fully inform staff training and support staff leadership skills and the governance agenda.

While there is no universally agreed definition of clinical leadership, Kotter\textsuperscript{12} stated that leadership is “delivered through complex systems by engaging partners in the pursuit of major, transformational change”. The New Ways of Working\textsuperscript{13} agenda noted that clinical leaders drive service improvement and effective team working to provide excellence in patient care and that a strategic vision is essential.

This clinical model makes reference to the importance of having a clinical lead in each team. These leaders will be essential in guiding the team members and providing an expert clinical view of the available resources and services and how best they can meet the needs of patients. This will usually be the Responsible Medical Officer.

13. CONCLUSION

The importance of service redesign and continuous improvement is essential at a time of rebuild. This clinical model sets out the context and future direction for the redesign and improvement of high secure services at The State Hospital. Our new hospital heralds an unprecedented opportunity to modernise the experiences of the patients who require the expert care and treatment that is to be provided. This modernisation agenda will impact not

\textsuperscript{12} Kotter, 1988 The Leadership Factory
\textsuperscript{13} http://www.newwaysofworking.org.uk
only on the health gains while in high security, but also in the patient’s transitions to step down levels that will follow their discharge.

The new service will deliver:

- An estate providing an environment that supports rehabilitation and recovery, with modern technological solutions to assist and support the care agenda and allow greater access to the outdoors and physical activity.

- Policies and procedures that will ensure that patients and carers are fully involved in the care they receive and are treated with dignity and respect.

- New ways of working that will allow closer working between professions and better use of resources both staff and buildings and treatment by a well equipped skilled workforce, with strong clinical leadership in every team.

- A patient day that will be flexible and fulfilling and services that will be provided at times more suited to the activity, such as evenings and weekends where leisure and recreational activity takes place.

- Smaller wards with improved staff / patient ratios.

- Modern buildings that are comfortable and offer the best access to therapy spaces.

This model has been developed with the assistance of a wide stakeholder group and is reflective of both the local and national landscape of care standards in a high secure forensic setting. The ultimate aim is to provide care and treatment for those with a mental disorder and rehabilitate patients back into society where they can play an active and productive role. In doing this, the Hospital, alongside partners / other agencies, will play an essential role in the current and future protection of the public.

14. APPENDICES

1. Membership of Redevelopment Project Board and Organisational Development Group

2. Excerpt of Security Matrix especially for High Security

3. Multi Disciplinary Team Membership

4. Generic Patient Pathway
   - Referral and Pre Admission
   - Assessment and Care Planning
   - Ongoing Care Delivery
   - Discharge / Transfer from The State Hospital
### Project Board Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andreana Adamson</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Doug Irwin</td>
<td>Security Director</td>
</tr>
<tr>
<td>Hazel Robertson</td>
<td>Finance Director</td>
</tr>
<tr>
<td>Stephen Milloy</td>
<td>Nursing Director</td>
</tr>
<tr>
<td>Rebecca Chalmers</td>
<td>General Manager</td>
</tr>
<tr>
<td>Chris Chittock</td>
<td>Employee Director</td>
</tr>
<tr>
<td>Dr John McGinley</td>
<td>Psychology Director</td>
</tr>
<tr>
<td>Dr Steve Young</td>
<td>Associate Medical Director</td>
</tr>
<tr>
<td>Jim Loudon</td>
<td>Interim HR Director</td>
</tr>
<tr>
<td>Katie Rae</td>
<td>Non Executive Board Member</td>
</tr>
<tr>
<td>Alex MacLeod</td>
<td>Skanska</td>
</tr>
<tr>
<td>Grieg Jamieson</td>
<td>Skanska</td>
</tr>
<tr>
<td>Brian Campbell</td>
<td>Currie &amp; Brown</td>
</tr>
<tr>
<td>Fiona McCade</td>
<td>Currie &amp; Brown</td>
</tr>
<tr>
<td>Mike Baxter</td>
<td>Scottish Government</td>
</tr>
</tbody>
</table>

### ODG Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Milloy</td>
<td>Nursing Director</td>
</tr>
<tr>
<td>Alexandra More</td>
<td>PARS Team Leader</td>
</tr>
<tr>
<td>Angus Walker</td>
<td>Senior Security Manager</td>
</tr>
<tr>
<td>Doug Irwin</td>
<td>Security Director</td>
</tr>
<tr>
<td>Dr Callum MacCall</td>
<td>RMO</td>
</tr>
<tr>
<td>Dr John McGinley</td>
<td>Psychology Director</td>
</tr>
<tr>
<td>Ed Finlayson</td>
<td>Head of Social Work</td>
</tr>
<tr>
<td>Frank Reilly</td>
<td>Workforce Planning Manager</td>
</tr>
<tr>
<td>Gill Urquhart</td>
<td>AHP Lead</td>
</tr>
<tr>
<td>Iain Dickson</td>
<td>Staff side Representative</td>
</tr>
<tr>
<td>Jackie McQueen</td>
<td>PFPI Co-ordinator</td>
</tr>
<tr>
<td>Jean Byrne</td>
<td>Organisational Development Manager</td>
</tr>
<tr>
<td>Jim Glendinning</td>
<td>Redevelopment Project Nurse</td>
</tr>
<tr>
<td>Jim Loudon</td>
<td>Interim HR Director</td>
</tr>
<tr>
<td>Joyce Earl</td>
<td>Social Work Team Leader</td>
</tr>
<tr>
<td>Linda Robertson</td>
<td>PARS Team Leader</td>
</tr>
<tr>
<td>Morag Slessor</td>
<td>Head of Psychology</td>
</tr>
<tr>
<td>Neil Sommerville</td>
<td>Head of Clinical and Risk Governance</td>
</tr>
<tr>
<td>Paul Oakes</td>
<td>Lead Nurse</td>
</tr>
<tr>
<td>Rebecca Chalmers</td>
<td>General Manager</td>
</tr>
<tr>
<td>Sandra Dunlop</td>
<td>Training and Professional Development Manager</td>
</tr>
<tr>
<td>Stephen Fleming</td>
<td>Security Manager</td>
</tr>
<tr>
<td>Tom Morgan</td>
<td>Ward Manager</td>
</tr>
</tbody>
</table>
## EXCERPT OF SECURITY MATRIX SPECIFICALLY FOR HIGH SECURITY

### ENVIRONMENTAL SECURITY

<table>
<thead>
<tr>
<th>Delineator</th>
<th>High</th>
</tr>
</thead>
</table>

### DESIGN AND CONSTRUCTION

| Perimeter (e.g. Fence)       | 5.2m secure fence, additional motion detection perimeter. |
| Control of Access to the Site| Airport level security. |
| Building design to deter escape | Robust construction able to withstand determined escape with tools. |
| Window / Door Security       | Prison service approved locks, airlock systems, some break-proof windows, some use of electronic control of doors. No external windows. |
| Furniture design             | |

### EQUIPMENT

| X-ray / Metal Detector / Ion Detector | X-ray machine, arch and handheld metal detector, ion detector, sniffer dogs from partner organisations if required. |
| Personal Alarm Systems             | Location specific security alerted and tannoy to hospital campus and response team |
| Physical Restraints                | Handcuffs for exceptional leave. |
| Campus Observation (CCTV)          | Complete campus and perimeter, kept 3 weeks |
| Availability of additional secure area for behaviourally disturbed patients | A range of individual secure areas with bedroom and living space. |

### PROCEDURAL SECURITY

<p>| Patients Phone Calls        | Can be monitored or stopped. |
| Patients Letters / Mail    | All post x-rayed. Can be monitored Section 117 MH(S)Act 1984 – with additional statutory powers. |
| Patients electronic mail / access to the internet | No access |
| Staff Communications       | Received mail is x-rayed |</p>
<table>
<thead>
<tr>
<th>Delineator</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ITEMS – RESTRICTED (or prohibited)</strong></td>
<td></td>
</tr>
<tr>
<td>Searching Patients</td>
<td>On admission, following LOA, regular personal and regular room searches.</td>
</tr>
<tr>
<td>Searching visitors, official visitors, staff</td>
<td>Searched if metal detectors are set off and random entrance and egress searches. Bags searched if suspicious item seen in x-ray imaging.</td>
</tr>
<tr>
<td>Drug Access / Screening</td>
<td>Urinary drug screening on basis of clinical need and on admission and random screening.</td>
</tr>
<tr>
<td>Alcohol Access / Screening</td>
<td>No access to alcohol permitted.</td>
</tr>
<tr>
<td>Access to pornographic materials and / or materials portraying violence</td>
<td>Routine screening and controlled access.</td>
</tr>
<tr>
<td><strong>ITEMS – Daily Living Equipment</strong></td>
<td></td>
</tr>
<tr>
<td>Cutlery</td>
<td>Restricted metal cutlery – counted after use, supervised meals.</td>
</tr>
<tr>
<td>OT Equipment (e.g. kitchen)</td>
<td>Graduated access following individual risk assessment and MDT approval.</td>
</tr>
<tr>
<td>Fire setting materials (e.g. cigarette lighters)</td>
<td>Controlled / limited access, no fire setting material with patients.</td>
</tr>
<tr>
<td><strong>ITEMS – Access to money, valuables and belongings</strong></td>
<td></td>
</tr>
<tr>
<td>Access to belongings</td>
<td>Limited number of items and limited access</td>
</tr>
<tr>
<td>Access to money / valuables</td>
<td>Dependant on individual assessment of capacity. Money and valuables are also restricted on site and on LOA for security reasons.</td>
</tr>
<tr>
<td><strong>PEOPLE - Visitors</strong></td>
<td></td>
</tr>
<tr>
<td>Visitor ID and approval</td>
<td>Identification required then special ID provided and checked on exit. Prior approval by MDT. Visitors must agree code of conduct.</td>
</tr>
<tr>
<td><strong>PEOPLE (Child Visitors)</strong></td>
<td></td>
</tr>
<tr>
<td>Child Visiting Policy</td>
<td>Social Work Assessment required, approval via MDT.</td>
</tr>
<tr>
<td>Visiting Arrangements Procedure</td>
<td>Special family visiting suite away from clinical area.</td>
</tr>
<tr>
<td><strong>Delineator</strong></td>
<td><strong>High</strong></td>
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<tr>
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</tbody>
</table>

**PEOPLE – Internal Movement between clinical areas in a psychiatric Facility**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Grounds access for some patients – monitored by CCTV, some escorted. Prohibited areas in the campus.</td>
</tr>
<tr>
<td>Visitors / official visitors</td>
<td>Escorted – bussed to location of visit.</td>
</tr>
<tr>
<td>Staff</td>
<td>Electronically recorded and restricted access to some areas.</td>
</tr>
<tr>
<td>Provision of recreations / therapies</td>
<td>On campus range of secure activities</td>
</tr>
</tbody>
</table>

**PEOPLE – Patient absence from the Hospital**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Pass (e.g. ‘testing out’)</td>
<td>Usually a minimum of 2 escorting staff.</td>
</tr>
<tr>
<td>Exceptional LOA (e.g. court, hospital)</td>
<td>Handcuff meeting, police liaison, and more escorting staff.</td>
</tr>
<tr>
<td>Prevention and Management of Absconsion</td>
<td>Individual Risk Assessment for each LOA, usual to have 2 or more staff escorting. Individual risk assessment of grounds access. Range of multi-agency contingency plans, network of sirens.</td>
</tr>
<tr>
<td>Prevention and Management of Escape</td>
<td>Contingency Planning, liaison with police, siren.</td>
</tr>
</tbody>
</table>

**MISCELLANEOUS**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>High Secure Forensic Hospital Policies.</td>
</tr>
<tr>
<td>Contingency Planning</td>
<td>Range of multi-agency contingencies for hostage, riot, escape, barricade, rooftop.</td>
</tr>
</tbody>
</table>
Multi Disciplinary Team Membership

Each Clinical Team will be made up of a range of core professions, and these are:

- Psychiatrists - Responsible Medical Officers
- Junior Doctors
- Social Workers - often Mental Health Officers
- Psychology staff - including Consultants and other grades
- Allied Health Professions - Dieticians
  - Occupational Therapists
  - Music and Arts Therapists including Drama Therapists
  - Physiotherapy
  - Speech and Language Therapists
  - Podiatrists.
- Registered Nurses
- Pharmacy
- Security Liaison staff - Security Managers

Some of these professions will be present in each clinical team; however some will provide expert advice and guidance to teams when this is clinically indicated such as speech and language therapy, music therapy or pharmacy.

Other staff providing direct care to patients are healthcare support workers who will be employed in the hubs and clusters, and also the work of the activity centre. These staff will bring a range of previous experience which includes other care settings, or technical skills such as horticulture, art and crafts or phlebotomy. These staff will work across professional lines under the guidance of trained clinical team members.

The primary care service includes the expertise of general practitioner, practice nurse, visiting professionals such as ophthalmology, podiatry, dentist amongst others.
Pre-admission assessments done by Medical, Nursing, Others? Admit?

State Hospital Multidisciplinary Referrals Meeting
- refer for assessment?

No

Pre-Admission Assessments

Yes

Allocation to Clinical Team for assessment

Admission to State Hospital

Urgent Admission

Referral to State Hospital

Referrals mostly from:
- medium /low secure forensic units
- prisons /counties.
More rarely from:
- community
- or other settings

Report back to referring agency with reasons

Yes

No

Report back to referring agency with reasons

Admission to State Hospital

MULTIDISCIPLINARY ASSESSMENT
(ADMISION)

ASSESSMENT (INPUTS)
1) Mental health assessment
2) Physical health assessment
3) Initial Risk Assessment
4) HCR-20
5) BEST Index nursing assessment
6) FITECH
7) Nutritional assessment
8) Drug & alcohol assessment
9) Cultural assessment
10) Provide Reports: Nursing, Medical, Psychology, Social work, Security, Pharmacy, OT
11) CPA process initiated
12) Invite Stake holders, including patient & carer to Case Review
13) Invite relevant external agencies as required
14) Carer assessment
Pharmacy ON admission will carry out medicine reconciliation

ADMISSION CPA REVIEW
(8-12 weeks after admission)
Need for ongoing care and treatment at the State Hospital?

Yes

Treatments/ Interventions

No

Go to ‘Discharge/Transfer’, step (2)

CASE REVIEW
1) Provide information for patient & carer
2) Treatment Plan & HCR-20 discussed and compiled
3) Diagnosis recorded (if none yet - 'under assessment')
4) Identify Problems & Strengths
5) Formulate interventions to address objectives
6) Consent to treatment?
7) Record attendance

TREATMENT/INTERVENTIONS
(OUTPUTS)
All treatment plan objectives, including:
• Nursing interventions
• Psychological therapies (incl Activity Centre & Hub and Cluster based therapies)
• Medication & monitoring
• Physical health interventions
• Occupational therapy
• Update risk assessment
• PARS
• Social Work
• Others as req (e.g. dietetics, advocacy, speech therapy)
The State Hospitals Board For Scotland

Generic Patient Pathway:

Ongoing Care Delivery

Appendix 4 cont.

**INTERMEDIATE CPA REVIEW**
(at 6 month mark)

- Need for ongoing Care & Treatment at the State Hospital?
  - **No** Go to ‘Discharge/Transfer’, step (2)
  - **Yes** TTTT

**MULTIDISCIPLINARY ASSESSMENT**

**TREATMENT/INTERVENTIONS**

**ANNUAL CPA REVIEW**
(4-6 wks ahead of significant date)

- Need for ongoing care & treatment at the State Hospital?
  - **No** Go to ‘Discharge/Transfer’, step (2)
  - **Yes** Treatments/Interventions

**ASSESSMENT**

1. Mental health review
2. Risk Assessment update
3. Physical health review
4. Psychological therapies (including ward based psych therapies)
5. Medication & monitoring
6. Physical health interventions
7. Occupational therapy
8. Risk assessment
9. Social Work
10. Others as req (e.g. dietetics, advocacy, speech therapy)

**CASE REVIEW**

- Provide information for patient & carer
- Treatment Plan discussed and updated
- HCR-20 discussed and updated (including WAAMP or RAMP)
- Diagnosis updated and recorded
- Record of attendance
- Review previous objectives
- Review Problems & Strengths
- Contingency Plan
- Advance statement
- Medication review

**OBJECTIVE REVIEW**

- If required, it is between Intermediate and Annual Reviews, at 3 and 9 month mark an OBJECTIVE REVIEW may be held. Main items on agenda would likely be:
  1. Review of prev objectives
  2. Professional feedback
  3. Setting of new objectives

**DISCHARGE/TRANSFER CPA MEETING**

**DISSCUSSION**

- All treatment plan objectives, including:
  1. Mental health review
  2. Treatment Plan discussed and updated
  3. HCR-20 discussed and updated (including WAAMP or RAMP)
  4. Provide Reports: Nursing, Medical, Psychology, Social Work, Security, Pharmacy, OT, PARS
  5. Input by others as req (e.g. dietetics, advocacy, speech therapy)
  6. Contingency Plan

**Discharge/Transfer from TSH**

**Pre-CPA Meeting**

- Identify contacts (e.g. receiving RMO)
- Explain CPA process to patient & carer
- Invite relevant external agencies
- Invite patient & carer if patient consents to Discharge CPA meeting
- Mental health review
- Physical health review
- Risk Assessment review & update
- Advance statement
- Provide Reports: Nursing, Medical, Psychology, Social Work, Security, Pharmacy, OT, PARS
- Input by others as req (e.g. dietetics, advocacy, speech therapy)
- Draft Contingency Plan

**Case Review**

- Review of care plan objectives
- Professional feedback
- Setting of new objectives

**Discharge/Transfer CPA Manager responsible for Co-ordination of Discharge CPA**

**One week prior to discharge/transfer**

- CPA Manager compile CPA Portfolio for distribution

**Discharge/Transfer From the State Hospital**

**CPA Manager responsible for Co-ordination of Discharge CPA**

The State Hospitals Board For Scotland

Generic Patient Pathway:

Discharge/Transfer from TSH