	Admission to week 1	3 months	6 months	On discharge
Individual therapeutic assessments and activity	Multidisciplinary pro-active and comprehensive service to people suffering from severe and enduring mental illness who have forensic needs and will require interventions along a treatment care pathway. Initial Medical Assessment of Mental State, Diagnosis and Physical Health Agree access to restricted items in room & on ward Set initial Observation level and review daily MDT discussion of the pre-admission assessment report Discharge planning to commence	Monthly MDT review. Review progress against goals set at each MDT review Complete DIALOG Scale, HONOS-Secure. Physical health review for all patients. Specific patients may require further outcome measures, I.e. Life Skills Profile, GAF or CANSAS Ashton's Medication Audit actions to be completed monthly. Review Discharge planning progress. Initial 3 month CPA report.	Encourage attendance of monthly MDT Continued assessments as required. Review Discharge planning progress.	Complete up to date risk assessment. Provide summary of psychiatric assessments and interventions for receiving team. Check final DIALOG Scale, HoNOS-Secure and other outcome measures have been completed Update/refresh HCR 20 Risk Assessment
Individual therapeutic assessments and activity	Introduction to establish rapport Familiarise self and team with patient risk screen and immediate needs. Overall therapeutic approach underpinned by RAID principles at each stage of admission.	Psychology assessments (Specialist as required) and formulation of risk and treatment needs (e.g. START, PRAT, HCR20, SVR20, WAIS, WMS, ADI-R, ADOS-2, IPDE/PCLR Monthly MDT review Full Psychology Assessment Report for first CPA Recommendations for initial criminogenic & psychological interventions (individual & group),	Continued assessments as required. Trauma Assessment – TSQ or similar recognised tool. 1:1 and Group Psychological interventions using evidence based approaches. Support Overall therapeutic approach (RAID, DBT, etc.)	Complete up to date risk assessment. Provide summary of assessments and interventions for receiving team. Collaboration with others. Ensure individual and group sessions are closed & evaluated
Individual therapeutic assessments and activity	Referral to OT on admission Introduction by team OT to start relationship building & establish rapport.	OT assessments and formulation of functional needs (MOHOST, OSA, PALs, AMPs MOCA, MEAMS) Goal setting and therapeutic activity planning (monthly review) Complete Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), Life Skills Profile (monthly review for CPA).	Encourage attendance of planned OT groups/activities Deliver 1:1 OT interventions	Monthly review of goals and care plan Complete OT standardised outcome measures (OSA, MOHOST, AMPs). Complete final Camberwell Assessment of Need Short Appraisal Schedule (CANSAS),

				and Life Skills Profile as an outcome measure.
Keeping well	On Admission – SGD admission assessment , Physical health assessment (Physical health document)Admission Checklist.docx Consultant Admission Assessment. T2/T3 review & document as clinical note. Capacity assessment for care and treatment Capacity assessment for finances. Review of MHA Section. Complete ICD -10 coding on Care Notes Review and set required level of Observation Agree initial Leave status Complete Priory Risk Screen Admission CPA within 12 weeks from admission – Information gathering from agencies involved. Ashton's Medication Audit actions to be completed. Baseline ECG, QTC monitoring before any new antipsychotic medication is prescribed.	Where possible, patients are encouraged to participate in the formulation of risk management plans and their ongoing evaluation. Medication – review, optimum regime, management of side effects, LUNSERS Encourage attendance at MDT. Complete TIR's of any SI's with MDT. Measure progress against goals set from previous MDT reviews. Complete Medical report for first CPA Review HCR-20 at first CPA Sec 17 leave status to be reviewed at CPA. Encourage community engagement and independence. Review progress to tailor continued MDT inputs. Agree treatment plan for next 6 months. Medication effectiveness review at first CPA . Ashton's Medication Audit actions to be completed monthly .	Continue treatment as required or summarise progress and communicate to others. Focus on risk management and application of skills into the community if risks agree and team allows. Review progress at CPA. Ashton's Medication Audit actions to be completed monthly.	Discharge summary of treatment and management of risks. Share relapse prevention/staying well plans with receiving teams.
Keeping well	Provide information/advice on treatment relating to mental wellbeing – e.g. psychosis care pathway, mental health awareness programme. Provide information/advice upon relevant evidenced based treatment treatments available (e.g. relating to substance use or mental health work).	Assessment of need and readiness for treatment, informed by completed assessments. Review previously completed psychological interventions assessing what was gained/learnt. If team agree readiness, offer 1-1 or group evidenced based treatment as required. Complete functional assessment for PBS Plan Review progress at CPA to tailor continued psychological inputs.	Continue treatment as required or summarise progress and communicate to others. Focus on risk management and application of skills into the community if risks agree and team allows. Review progress at CPA to tailor continued psychological inputs.	Discharge summary of treatment and management of risks. Share relapse prevention/staying well plans with receiving teams.
Keeping well	**Activities of Daily Living (ADLs)/Personal Care:** For patient to improve or maintain current level of function when engaging in activities of daily living. **Meaningful occupations:** For patient to engage in meaningful activities that maintain function and quality of life.	Identification and monthly review of ADL skill level. Identified measurable goals and outcomes for criminogenic and therapeutic groups/individual sessions (i.e. Social Skills, Anger Management, Psych-Ed, etc.)	Review engagement and progress in meeting identified goals. Re-plan therapeutic programme with MDT for next 6 months	Discharge summary of Activities of Daily Living ability, progress made and level of assistance required.

	Therapy programme: The provision of a personalised therapeutic/recreational timetable of activities to promote social inclusion. This includes criminogenic, therapeutic, creative, practical, ADL, social, animal assisted, leisure and vocational and educational activities.	Assessment of ADLs including meal planning and preparation, laundry, bed making, money handling, household skills, budgeting, functional assessments -local transport and social skills. Full OT Assessment Report for initial CPA.	Completion of individual risk skills assessments for MDT – sharps, tools , escorted leave , line of sight , in preparation for possible un-unescorted leave , access to restricted tolls , sharps etc.	
Keeping well	Nursing staff: ➢ Initial Drug Screen, if required. ➢ Record Smoking Status ➢ Weekly one to one to establish rapport/trust Social Work • Initial assessment of need • Agree frequency of contact • Request consent to liaise with family/carers • Liaise with community team	➢ Encourage attendance at monthly MDT reviews ➢ Review progress against goals set at each MDT review. ➢ Complete initial DIALOG Scale, HoNOS – Secure and repeat prior to first CPA's. ➢ Assessment in preparation for first CPA Meeting ➢ Review progress at first CPA to tailor continued inputs and therapeutic interventions ➢ Identify specific protective factors Social work: Engage with family/carers, if consent is given by patient Complete Social Circumstances Report Maintain regular contact with family/carers Pharmacist: Ashton's Medication Audit actions to be completed monthly. Patient: ➢ Participate in the formulation of risk assessment & management plans and their ongoing evaluation. ➢ Engage in Recovery pathway related activities. Nursing: ➢ Encourage social engagement and independence. ➢ LUNSERS ➢ Section 132 Legal rights explained	➢ Continue treatment as required or plan further actions to be incorporated into the keeping well recovery plan. ➢ Summarise progress and communicate to external professionals (e.g. care coordinators, NHSE) ➢ Commence agreed MDT Treatment Plan ➢ Monitor engagement in Therapeutic Programme ➢ Review agreed Sec 17 Leave Plan ➢ Co-produced PBS Plan in place and known to all staff ➢ Consider Self-medication stage 3 & 4 ➢ Review Discharge planning and progress at 6 monthly CPA.	➢ Provide summary of assessments and interventions for receiving team. ➢ Collaboration with locality team or receiving service. ➢ Complete HoNOS-Secure & DIALOG Scale, and refresh HCR-20. ➢ Current PBS Plan shared with receiving agency ➢ Up to date relapse prevention plan
Keeping connected	Review pre-admission documentation, understand support and family contact needs. Document capacity and decisions regarding family involvement / visits. Negotiate between the patient and their family or carers about confidentiality and sharing of information on an ongoing basis Explain how families or carers can help support the patient and help with treatment plans	Team to support ongoing family contact. Informed by risk assessments and following policy as required, e.g. child visiting procedures. Contact family in agreement with patient to offer initial meeting with self and MDT Engage family in Psychiatric history and Risk Assessment formulation.	Complete collaborative risk management plan with patients to support leave and integrate skills earned into use in Sec 17 community leave. Review progress at next CPA..	Complete up to date risk assessment. Provide summary of assessments and interventions for receiving team. Collaboration with external stakeholders. Complete Discharge Summary

	Ensure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the patient and their family or carers.	If patient consents, invite relative to first CPA Agree access to telephone/mobile/internet.		
Keeping connected	Review pre-admission documentation, understand support needs and required family contact. Discuss with MDT.	MDT to support ongoing family contact, if patient has consented. Informed by risk assessments and following policy as required, e.g. child visiting procedures. Psycho-educational information to be provided to families through family events (every quarter?*) Contact family in agreement with patient to help inform risk assessments as required. Provide any specialist assessments which might impact on communication with others, e.g. cognitive functioning assessments, autism, anxiety. Input into completion of initial HCR-20 Risk Assessment Review progress at CPA to tailor continued psychological inputs for next 6 months.	Complete collaborative risk management plan with patients to support leave and integrate skills earned into use in community. Review progress at CPA to tailor continued psychological inputs.	Complete up to date risk assessment. Provide summary of assessments and interventions for receiving team. Collaboration with others. Input into any Relapse Prevention Plans created with receiving team
Keeping connected	**Connected with family**: For patient to have regular contact and feel connected to with the important people in their life. **Spiritual interventions**: For the patient to be able to engage in spiritual based activities that are meaningful to them.. **Community access**: For patient to have assessed access to the local area and community outside of the hospital if agreed by RC/MDT. **Education assessments.** Our education staff offer Basic skills assessments (English / Maths) and dyslexia screening. They also work with colleagues to make written word ' easy read; offer	Identify with patient the social and personal relationships (key people involved in supporting the recovery journey). Patients are able to maintain and develop friendships and social networks outside of the hospital environment. The team provides information and encouragement to patients to access local organisations for peer support and social engagement. Including: - Voluntary organisations, Community centres, Local religious/cultural groups, Peer support networks, Recovery colleges, Vocational services	Review social and community based interventions provided.	Patients are supported to visit new accommodation/ placements and have graded leave before discharge. Liaise with receiving team regarding patients functional needs and ability Discharge summary of social community based interventions provided, progress made and level of assistance required.
Keeping connected	➢ Review pre-admission documents, understand support needs and family contact. Discuss as a MDT. ➢ Discharge planning to commence including estimated date of discharge	Social work ➢ Support ongoing family contact. ➢ Contact family in agreement with patient to inform risk assessments/incidents as required. ➢ Invite family to initial CPA, if patients wants this	➢ Support access to Section 17 leave and integrate skills learned into use in community.	External care coordinator: The external care coordinator will be expected to complete any required referrals to the

	➢ Decide on remote contact with family e.g. access to mobile phones, internet access, letters etc. Social work: ➢ Contact family with patient's consent Share the hospitals visiting arrangements and procedures for telephone contact with family/friends. Ensure visiting is pre-planned and suitable safeguards are in place ➢ Process approved visitors. ➢ Confirm Next of Kin and Nearest Relative details ➢ Document patient's capacity and decision making around family involvement / visits. ➢ Agree with the patient confidentiality and sharing of information with family members on an ongoing basis ➢ Gain family's view of admission and initial treatment plan. ➢ Explain how families or carers can help support the patient and help with treatment plans Ensure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the patient and their family or carers.	➢ Review Social needs at initial CPA Nursing: ➢ Ensure patient is aware of access to internet policy/arrangements including use of Social Media. ➢ Ensure Advance directive is in place	➢ Update the external team (Care coordinator) regularly and to invite all the relevant professionals that will be involved within the patient care pathway. Social work: Arrange S117 meeting prior to any Mental Health Tribunals.	placements they identify as suitable. Liaise with family and community SW regarding discharge planning
Keeping safe	Review pre-admission documentation, communicate risks to MDT members. Identify specific risks e.g. self-ham and suicide, vulnerabilities in functioning. PBS plan commenced as working collaborative document. Initial pan to be completed by week four. MAPPA contact/communication as required. Identify any Sexual Harm Prevention Order conditions	Input into safeguarding meetings and follow policy as required. Input into decision making regarding Sec 17 leave, access to restricted items, family contact and so on as informed by risk assessments. Reflective practice and specific training for staff to address individual needs/difficulties and continue to improve patient care. Complete specific assessments as required, e.g. SRAMM for suicidal risks. Review progress at CPA to tailor continued psychological inputs.	Continue as per 3 months. Communicate any necessary risk management plans and review regularly as teams. Review progress at CPA to tailor continued psychological inputs.	Complete up to date risk assessment. Identify any specific vulnerabilities. Provide summary of assessments and interventions for receiving team. Collaboration with others, including MAPPA as required.

Keeping safe	Review pre-admission documentation, communicate risks to MDT members. Identify specific risks e.g. self-ham and suicide, vulnerabilities in functioning. PBS plan commenced as working collaborative document. Initial pan to be completed by week four. MAPPA contact/communication as required. Identify any Sexual Harm Prevention Order conditions	Input into safeguarding meetings and follow policy as required. Input into decision making regarding Sec 17 leave, access to restricted items, family contact and so on as informed by risk assessments. Reflective practice and specific training for staff to address individual needs/difficulties and continue to improve patient care. Complete specific assessments as required, e.g. SRAMM for suicidal risks. Review progress at CPA to tailor continued psychological inputs.	Continue as per 3 months. Communicate any necessary risk management plans and review regularly as teams. Review progress at CPA to tailor continued psychological inputs.	Complete up to date risk assessment. Identify any specific vulnerabilities. Provide summary of assessments and interventions for receiving team. Collaboration with others, including MAPPA as required.
Keeping safe	**Mobility/Transfers** (equipment/seating/wheelchair): For patient to have equipment provided to enable independence with mobility and transfers. **Sensory needs, emotional regulation and self-sooth**: For patients to be able to self-sooth and regulate emotions in order to manage periods of distress or anger.	Assessment of mobility, transfer and other physical needs needs Input into Clinical Risk Assessment by MDT Assessment of sensory and emotional regulation needs. Input into creation of PBS plan	Review needs and sensory interventions provided.	Discharge summary of community engagement and sensory ability, progress made and level of physical assistance, mobility aids, required. Ensure small aids and equipment required by patient go with them or are available at future service
Keeping safe	➢ Review pre-admission assessment, communicate historical risks to team members. ➢ Identify specific risks e.g. self-ham and suicide, vulnerabilities in functioning via Priory Risk Screen. ➢ Offer Suicide Safety Plan, if applicable ➢ Set appropriate level of observation in conjunction with admitting doctor ➢ Agree initial access arrangements to specific Restricted Items Social work: ➢ MAPPA contact/communication as required. Verify presence of any legal restrictions (exclusion zones, sex offender's register, licence conditions etc.)	Social work ➢ Input into safeguarding meetings and follow policy as required. ➢ Family contact initiated and offer to meet RC/MDT. ➢ Any public protection issues identified will be discussed by the MDT: this will inform decisions around leave – MAPPA referral if indicated. Nursing ➢ Minimum Monthly review of Risk Screen ➢ Risk assessments and following policy for visitors as required, e.g. child visiting procedures. Complete START if required ➢ Complete TIR reviews with MDT of any SI's	➢ Communicate any necessary risk management plans and review regularly as a team. ➢ Focus on risk management and application of skills into the community if risks agreed and team allows.	MDT ➢ Complete up to date risk assessment. Identify any specific vulnerabilities. ➢ Provide summary of assessments and interventions for receiving team. ➢ Social work ➢ Collaboration with others stakeholders & agencies, including MAPPA as required.

	➢ Any safeguarding concerns – clear plan of action if any concerns noted ➢ To undertake Capacity assessment for finances and confirm receipt of all appropriate benefits ➢ Ensure full transfer of property/money held at previous hospital/placement. ➢ Ensure MISPER in place Nursing: Inform Patient of his/her rights under the Mental Health Act 1983, verbally and in writing, and document accordingly, at least at 3-monthly intervals Facilitate access to legal representation and advocacy. Review legal status in accordance with MHA and Code of Practice.			
Keeping healthy	Review pre-admission documentation, understanding risks and needs in relation to keeping healthy. Identify Smoking Status – offer NRT of choice within 30 minutes of admission Admission – Week 1 Refer to GP /Register with GP Practise, Dentist and Optician. Patients on Clozapine: Daily Bowel movement monitoring. Elimination Records in place. Develop Patient Hospital passport – information that the staff accompanying patients can take with them during A & E attendances or routine appointment attendance. SGD – Physical health clinics	Update Patient passport with MDT. Review Smoking Cessation support at each MDT Review Include Physical Health needs and monitoring arrangements into Treatment Plan at initial CPA Continue with SGD Physical Health Clinics	Continue as per 3 months. Review progress at CPA	Complete up to date risk assessment. Collaborate and provide information to receiving team any information which may impact on heathy lifestyle.
Keeping healthy	Review pre-admission documentation, understanding physical health risks and needs in relation to keeping healthy.	Team to support healthy lifestyle ongoing – to contribute to discussions. Provide any specialist assessments which might impact on decision making, e.g. cognitive functioning assessments, capacity assessments and best interest decisions. Review progress at first CPA to tailor continued psychological inputs.	Continue as per 3 months. Review progress at CPA to tailor continued psychological inputs.	Complete up to date risk assessment. Collaborate and provide information to receiving team any information which may impact on heathy lifestyle.
Keeping healthy	**Maintaining a healthy lifestyle**: The OT team to assess and ascertain if the patient need support with maintaining a healthy lifestyle. Recovery college offer regular Heathy lifestyles courses eg sleep hygiene , cooking for others	Patients are supported to plan a menu, shop for ingredients and cook a meal as part of their rehabilitation programme. Patients are offered access to personalised healthy lifestyle interventions such as healthy diet, physical activity and Smoking Cessation. Liaise with Dietician and Fitness Staff.	Review healthy lifestyle interventions provided.	Discharge summary of healthy lifestyle interventions provided, progress made and level of assistance required.

Keeping healthy	Nursing ➢ Physical health assessment (Physical health document) ➢ SGD admission assessment , ➢ GP referral to be made ➢ Complete choking assessment ➢ Register with dentist and optician ➢ Confirm dates of any impending medical/dental appointments. ➢ Baseline investigations including ECG especially before any new antipsychotic medication commencement. Nursing: ➢ Develop Patient Hospital passport – information that the staff accompanying patients can take with them during A & E attendances or routine appointment attendance.	Nursing: ➢ Update Patient Hospital passport. ➢ Continue with SGD Physical Health Clinics ➢ Monitor BP, pulse, temperature and weight and respirations at least monthly. ➢ Standardized assessments such as CANSAS and Dialog to be used to evidence outcomes	Physical health team 6 Months physical health check	Collaborate and provide information to receiving team any information which may impact on patient's physical health & wellbeing. Ensure safe transfer of information to local GP/receiving team/key stakeholders.

Black – Medical

Blue- Psychology

Red - Occupational Therapy

Green – Nursing/SW