

Quality Network for Forensic Mental Health Services



COLLEGE CENTRE FOR QUALITY IMPROVEMENT

Implementation Criteria for Recommended Specification: Adult Medium Secure Units

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with supplement

Standards and Criteria for Women in Medium Secure Care

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Foreword

Following publication of the Best Practise Guidance: Specification for Adult Medium Secure Services (DH 2007), Commissioners are taking a keen interest in the quality and outcomes of these services. In this context it is a pleasure to welcome these 'Implementation Criteria for Recommended Specification: Adult Medium Secure Units' developed by the Quality Network for Forensic Mental Health Services. Providing the basis for the Quality Network's self-and peer-reviews they are an accessible way for services to engage in comprehensive on-going service development and improvement for the benefit of service users.

The Quality Network for Forensic Mental Health Services was launched in 2006 and is seen as an evolving mechanism for improving service delivery. In November 2007 the Department of Health and the Quality Network held a joint conference during which the Recommended Best practice was launched and delegates were consulted on these implementation criteria. The 'Health Check Reviews' of security arrangements have since been taking place during 2008.

Over the next year commissioners expect to be working closely with the Quality Network for Forensic Mental Health Services to use these Implementation Criteria and the Quality Network's on-going annual review cycle to provide an on-going national structure for quality assurance and improvement in Medium Secure Units. In this way commissioners intend to create a process of non-judgemental peer-support for quality improvement within a wider context of increasing regulation and accountability.

Ged McCann
Chair of the National Forensic Commissioners Group

Implementation Criteria for Recommended Specification: Adult Medium Secure Units

Method

Context

These Implementation Criteria have been developed by the Quality Network for Forensic Mental Health Services from the 'Recommended Specification: Adult Medium Secure Units' (Department of Health 2007) and the Quality Network's 'Standards for Medium Secure Units' (CRTU 044, 2007). The Quality Network uses an iterative annual self- and peer-review cycle which is a well tested method for quality improvement. The Implementation Criteria have been developed with the purpose of forming the basis of the self- and peer-review questionnaires for the Quality Network for Forensic Mental Health Services. Forming the foundation of the iterative annual review cycle they provide an accessible way for services to actively engage in on-going service development towards implementing the Department of Health recommendations.

The Development of the Implementation Criteria

The implementation criteria have been developed in the following ways and stages:

- 1) The tense and where appropriate, the sentence structure of the Quality Principles in 'Recommended Specification: Adult Medium Secure Units' has been edited. This provides user-friendly and easily accessible questions for use in self- and peer-review questionnaires.
- 2) Where the Quality Principles in 'Recommended Specification: Adult Medium Secure Units' capture more than one implementation criterion, these have been divided in to separate implementation criteria. This prevents ambiguous answers.
- 3) Where possible and appropriate the Quality Principle's 'evidence' 'measure and 'frequency' have translated into implementation criteria. This supports services to provide evidence of meeting the specification via participation in the Quality Network's self-and peer-review.
- 4) The implementation criteria have been mapped on to the Department of Health 'High Level Indicators' so as to provide user-friendly cross reference.
- 5) The Implementation Criteria have been mapped on to the Department of Health Standards for Better Health. This supports services to provide evidence of meeting the Standards for Better Health via participation in the Quality Network's self-and peer-review.
- 6) The Implementation Criteria have been mapped on to the Standards for Medium Secure Units (CRTU 2007) which have formed the basis of self- and peer-reviews in cycles 1 and 2 of the Quality Network for Forensic Mental Health Services reviews.

7) In November 2007 the Department of Health and the Quality Network held a joint conference during which the Recommended Best practice was launched and delegates were consulted on these Implementation Criteria. Delegates were asked to rate the criteria 1, 2, or 3 in order of importance to the quality of care (1 = not important, 2 = important, 3 = very important). The top quartile of the mean scores are marked with a star next to the criteria number thus: *.

8) Delegates at the consultation event were also asked to consider at those Standards for Medium Secure Units (CRTU 2007) that were not included in the Department of Health Recommended Specification. They were asked to rate these standards 1, 2, or 3 in order of importance to the quality of care (1 = not important, 2 = important, 3 = very important). The top quartile of the mean scores have been incorporated in to these implementation criteria.

A: Safety and Security

1: Physical Security

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A1*	There is a physical security document (PSD) that defines the physical security including the perimeter creating the secure area which is annually reviewed	A1	1.1		
A2*	There is a secure perimeter of EITHER: <ul style="list-style-type: none"> A 5.2 metre fence of weld mesh surrounding the whole unit OR: <ul style="list-style-type: none"> A 5.2 metre fence of weld mesh joining reception and surrounding the remainder of the unit OR <ul style="list-style-type: none"> Of integral design formed by the building creating the enclosed secure area. Building design and specification must be as detailed in this specification, particularly windows and climb points OR <ul style="list-style-type: none"> Integral buildings forming the perimeter with a 5.2 metre fence around the sports area/field. 	A2	1.2	3.2 3.3 3.4	C20a
A2.1*	There is a record of the number of escapes from within the secure area	A2		1.46	C7c
A3*	Patients receive all their care and treatment within the secure perimeter unless they are authorised leave from the secure perimeter under Section 17 of the Mental Health Act 1983.	A3			
A4*	There is a daily recorded inspection of the perimeter which is reviewed quarterly.	A4	1.3	2.17 3.5 3.6	C20a
A5	There is no shrubbery close to or on the perimeter fence or buildings that form the perimeter.	A5			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A6*	The lighting within the secure area of the perimeter provides good observation during the hours of darkness and particularly to allow appropriate and safe response in an incident.	A6			
A7*	There is a recorded maintenance programme for the perimeter which is reviewed quarterly.	A7			C21
A7.1*	Action plans are implemented to remedy weakness or compromises identified in the maintenance of the perimeter.	A7			
A8*	The fencing posts are on the non-patient side of the fence.	A8			
A9*	Reception is EITHER: <ul style="list-style-type: none"> • Within the secure area OR: <ul style="list-style-type: none"> • Forms part of the perimeter. AND: <ul style="list-style-type: none"> • Where reception is part of the perimeter the rear of the building within the secure area must be protected against climbing. 	A9			
A10*	Where the fence meets buildings or other fences there are no gaps between the joins and no climbing aids.	A10			
A11*	There are essential gate entry points within the perimeter only.	A11			
A12*	Gate entry points operate with EITHER: <ul style="list-style-type: none"> • An air-lock system OR: <ul style="list-style-type: none"> • A double locked gate accessible by manual control by authorised individuals only. 	A12		3.10	C20a
A12.1*	Gate staff have a list of authorised individuals	A12			
A13*	Gate entry points are on a separate locking suite with keys issued, accounted for and controlled by reception.	A13		3.12	C20a
A14*	Gate locks are integral to the gates.	A14			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A14.1*	Gate locks are not accessible from the external side of the perimeter.	A14			
A15*	Gates do not provide opportunity to breach the perimeter security	A15			
A15.1*	Gate lock design and secure ground bolt fittings cannot be used to aid climbing.	A15			
A15.2*	Gates are fitted to prevent egress under the gate.	A15			
A15.3*	Gates are fitted with double skinning to assist in the prevention of climbing	A15			
A16*	Gate housings do not provide a climbing aid with adjoining buildings.	A16			
A17*	<p>Where building roofs form part of the perimeter they are protected against climbing (in ways which are not intended to cause injury e.g. revolving spikes, razor wire/barbed wire) in one or more of the following ways:</p> <ul style="list-style-type: none"> • Gooseneck capping • Flexible secure topping (FST) • Weld mesh fence – with or without FST – fixed from below the eaves to a height of 5.2 meters. • Infrared alarm on the roof (in combination with one of the above) • Hanging eaves with projection a minimum of 1200mm from the face of the building 	A17			
A18*	Where the building roofs surround courtyards or patient access areas there are no climbing points (e.g. poor sighting of light fittings, trees, unprotected window sills, water drain pipes, the placing of air conditioning units.	A18			
A19*	Furniture is fixed in all courtyards.	A19			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A19.1*	Staff check courtyards before use and remove any items presenting a security hazard.	A19			
A19.2*	In courtyards access doors, doors to stores or facilities, lighting postings, fixings, CCTV fixings, sports fixings etc. do not provide a climbing aid.	A19			
A19.3*	In courtyards gardening and recreational equipment is kept securely when not in use.	A19			
A20*	Window frames and fixings are described in the PSD.	A20			
A20.1*	There is a maintenance programme for windows considering wear and tear over time and weakness of fittings.	A20			C21
A21*	Windows forming part of the perimeter in patient areas (e.g. bedrooms, communal areas) are designed to prevent the passage of contraband.	A21			
A22*	Windows not forming part of the perimeter are not open more than 125mm and are capable of being locked open and shut.	A22			
A22.1*	Where windows have restraining bars these do not provide a climbing aid to the roof.	A22			
A23*	Windows and frames are set within the building masonry.	A23			
A24*	Ceiling designs do not allow patients access to the ceiling/roof void.	A24			
A25*	There is a secure locking system in place, either manual, electronic, magnetic or a combination of these.	A25	1.5	3.13 3.15	C20a
A26*	A senior member of staff manages reception.	A26			
A27*	Reception is staffed 24 hours per day 7 days week.	A27			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A28*	There is a key management system in place which accounts for all secure pass keys including those in store, those issued, those held in reception.	A28	1.6		
A28.1*	All keys are accounted for at least twice day	A28		3.17	C20a
A28.2*	Spare replacement keys are under the control of a senior manager and kept secure away from reception.	A28			
A28.3*	Secure keys are issued, returned and accounted for in reception.	A28		3.18	C20a
A28.4*	Secure keys are on a sealed ring and only secure pass keys are on this ring.	A28			
A28.5*	Secure pass keys are not taken out of the secure perimeter.	A28			
A28.6*	Estates secure area access keys are kept in reception	A28			
A29*	Staff entering the secure area can obtain keys only upon production of a valid identity card/tally.	A29			
A29.1*	Staff are not be issued with keys until they have undertaken security induction	A29	4.4		
A30*	Secure keys are attached to staff at all times (including when used in the lock)	A30			
A30.1*	A belt, lanyard and pouch is provided to all staff with secure keys	A30			
A30.2*	Where electronic cards are in use and where they provide automatic pass they are secured to staff.	A30			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A31*	Reception has an electronically controlled air lock operated by reception, there is no entry to the reception office/control room from within the air lock and entry to that office is be controlled by reception.	A31	1.4	3.10	C20a
A32*	There is a back up system and the default position for doors in case of failure of the electronic system.	A32			
A33	Locks within the secure area, which provide access to courtyards or open areas within the perimeter, are on a separate suite from internal pass doors. These keys are issued, controlled and accounted for by reception.	A33			
A34*	All non secure pass keys controlled, issued and accounted for on the wards are kept in locked cupboards separately from ward keys.	A34			
A35*	Keys to medication storage are always attached to a qualified member of staff issued and accounted for within the ward.	A35			
A36*	Alarms are hardwired alarms or personal issue alarms and	A36	1.7		
A36.1*	There is the capacity to identify the location of an activated alarm	A36	1.7		
A36.2*	Alarm systems and personal alarms are tested daily.	A36	1.7	3.21	C20a
A36.3*	There are enough personal alarms to allow for replacements.	A36	1.7	3.20	C20a
A36.4*	Personal alarms are controlled, issued, returned and accounted for by reception.	A36	1.7		
A36.5*	Personal alarms are secured to staff at all times.	A36	1.7		
A37*	Where CCTV is in use, reception monitors coverage of the perimeter, reception frontage and access from the secure area to reception.	A37			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A38	Ward staff monitor CCTV in relation to visits.	A38			
A39*	Visiting areas for children are covered by CCTV.	A39			C2
A40*	There is a security committee chaired by the forensic services director or equivalent.	A40			
A41*	There is a full-time security lead.	A41			
A42	There is a way for patients to raise an alarm in an emergency			3.22	C20a
A43	The unit operates within the appropriate legal framework in relation to the use of physical restraint			3.23	C5a
A44	The circumstances and justification for using physical restraint are recorded immediately; every such incident is documented within 24 hours (one working day); the RMO is informed and a report is submitted by the nurse in charge to the Trust management in line with Trust incident reporting policy			3.24	
A45	The unit is well designed and has the necessary facilities and resources for people requiring medium secure care			3.26	C21
A46	There are areas with clear lines of sight to enable staff to monitor patients who need closer observation			3.27	C20a
A47	Entrances and exits are designed to enable staff to see who is entering or leaving			3.28	C20a
A48	Patients have supervised access to computers with relevant risk assessment			3.29	
A49	All confidential case materials, e.g. notes, are kept in locked cabinets or locked offices			3.31	C20b

A: Safety and Security

2: Procedural Security

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A50*	There is a procedural security index document (PSID), which lists the procedural policies which is annually reviewed.	A42	2.1		
A50.1*	All policies are annually reviewed	A43 - A71			
A51*	There is a searching policy which includes patient searching, bedroom searching, and ward and off ward areas, and the searching of visitors.	A43		2.10	C20a
A52*	There is a policy on management of violence and aggression (NICE guideline 25).	A44		2.5	C3
A53*	There is a policy on use of seclusion.	A45		3.25	
A54*	There is a policy on use of forced medication including rapid tranquilisation.	A46		2.13	
A55*	There is a policy on observation.	A47			
A56*	There is an anti bullying policy (for those who are bullying and those who are bullied).	A48		2.6	C14c
A57*	There is a policy on prevention of suicide and management of self harm.	A49		2.7	C1b
A58*	There is a policy on transportation of patients (e.g. to court or acute hospital).	A50		2.19	C7c C13a

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A59*	There is a policy on the use of handcuffs.	A51			
A60*	There is a policy on escort procedures.	A52			
A61*	There is a policy on leave of absence including Section 17 leave.	A53			
A62*	There is a policy on the control of illegal substances.	A54	2.4	2.12	
A63*	There is a policy on substance misuse.	A55		2.12	C23
A64*	There is a policy on the control of prescribed medication and drugs.	A56		2.13	
A65*	There is a policy on the prosecution of offences within the unit which is agreed with the police and CPS.	A57			
A66*	There is a policy on patient possessions.	A58			
A67*	There is a smoking policy.	A59			C23
A68*	There is a policy on the management of patient's monies.	A60			
A69*	There is a policy on the censorship of material including pornography.	A61			
A70*	There is a policy on the control of mail and use of telephones.	A62		2.18	C7c
A71*	There is a policy on the control of tools used in therapy or education or ward areas.	A63			
A72*	There is a policy on prohibited items and a clear statement of these in reception and provided to all visitors, patients and staff and as a minimum this will include mobile phones, cameras, firearms, weapons, chewing gum, bluetac.	A64	2.3		

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A73*	There is a policy on the use of computers and access to the internet.	A65		2.18	C7c
A74*	There is a policy on visiting procedures including child protection issues.	A66	2.5		C2
A75*	There is a policy on patient confidentiality.	A67		2.22	C7c C13c
A76*	There is a policy for managing critical incident reviews.	A68		2.11	
A77*	There is a policy on patient roll checks.	A69			
A78*	There are contingency plans in place agreed with the police as a minimum.	A70	2.2	2.11	C1b
A79*	Contingency plans are annually tested by desktop exercises.	A71			
A79.1	Contingency plans are tested by a live exercise involving one or other of the emergency services every 24 months.	A71			C22a
A80	There are written policies and procedures that implement the requirements of the Care Programme Approach (CPA)			2.3	
A81	There is a procedure regarding obtaining consent from patients			2.4	C13b
A82	The procedure for resuscitation of patients is clearly documented, resuscitation equipment is available and its location is clearly identified			2.8	
A83	There is a policy for prompt response to staff alarms			2.15	C1b
A84	There is a policy in place to ensure issues of equality and diversity are regularly monitored			2.20	C18

A: Safety and Security

3: Relational Security

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A85*	There is a multi-disciplinary team assessment for all patients prior to admission.	A72	3.3	1.1	
A85.1*	The assessment prior to admission results in the admission of those in need of care and treatment in a medium secure setting only	A72			
A86*	There is a work force plan in place, which is annually reviewed.	A73	3.2	1.17	C5b C5c C11a
A86.1*	The work force plan references appropriate ratios of qualified to unqualified nursing staff, appropriate numbers of staff on duty per individual unit, reflects the complexity of patient need and the risk associated with that patient group.	A73	4.2	1.171 .22 1.23	C11a
A87	The ratio of consultant psychiatrists to patients is 1:13-16 for acute MSU and 1:20 for longer stay patients.	A74	3.1		
A88*	All staff have had enhanced CRB checks.	A75	3.8	8.4	C10a
A89*	There are regular multi-disciplinary individual patient care reviews and assessments.	A76		1.16	C5a
A90*	There is a programme of clinical supervision for all staff.	A77	4.3	9.1	C5b
A90.1*	There is a programme of continued professional development (CPD) and personal development plans (PDPs) for all staff which are annually reviewed	A77	4.3	6.2	C5c C8b C11c

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A91*	There is an annually reviewed training and development strategy which includes the provision of security training.	A78		6.1 8.3	C11a C11b
A92*	There is a staff training programme including a security input and annual security awareness training.	A79	4.5	8.3	C11b
A93*	There is a risk management strategy incorporating assessment and management of risk which is annually reviewed	A80		1.11 1.38 1.40 1.46	C1a C7c C1b
A94*	There is a planned programme of treatment with a minimum of 25 hours per week per patient of structured activity which is reviewed quarterly	A81		5.3	
A94.1*	The programme of treatment includes occupational therapy	A81		5.13	
A94.2*	The programme of treatment includes psychological sessions	A81		5.6- 5.12	
A94.3*	The programme of treatment includes substance misuse therapy	A81		5.9	C23
A94.4*	The programme of treatment includes offence related therapy	A81		5.14	
A94.5*	The programme of treatment includes access to real opportunities to work	A81			
A94.6*	The programme of treatment includes structured activity programmes	A81			
A94.7	The programme of treatment includes structured leisure time	A81			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A94.8*	The programme of treatment includes unstructured free time	A81			
A95*	All patients will have an initial plan in place within 24 hours of admission.	A82	3.4	1.10	C19
A96	The assessment takes into account relevant history, problems, issues, legal status and risks			1.2	
A97	There is a clearly defined process for the admission of people to the unit			1.3	
A98	Those presenting as high risk or with more severe conditions are given priority with assessment			1.9	C19
A99	All patients on admission have an initial risk assessment			1.11	C7c; C1b
A100	Patients are given a copy of the management or care plan or have ready access to it			1.14	C16
A101	There is a core day described in each patient's individualised care plan (A description of the core day may also be found elsewhere e.g. in ward programme or individual timetable)			1.15	C16
A102	There are clear and effective systems for communication and handover within staff teams			1.18	C1b
A103	There are regular multi-disciplinary team meetings for clinical matters and administration, and the team is consulted on relevant management decisions such as developing and reviewing operational policy			1.19	C5b
A104	There are multi-disciplinary teams identified as part of the staffing establishment, with each team including psychiatrists, nurses, psychologists, occupational therapists, and social workers			1.21	

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A105	The unit has access to a substance misuse specialist or dual diagnosis specialist either working as part of an integrated or parallel model		1.29		
A106	The unit has access to a range of practitioners offering psychotherapeutic sessions		1.30		
A107	The unit has access to a range of education professionals which include teachers, a special educational needs co-ordinator, an educational psychologist, and career guidance		1.31		
A108	All staff can demonstrate an understanding of their role in relation to meeting the complex needs of patients		1.32		
A109	The variance between staff in post and establishment is minimised		1.33		C11a
A110	The number of nursing staff on the unit is sufficient to safely meet the needs of the patients at all times		1.34		
A111	Extra nursing cover is available when needed, e.g. there is access to additional on-call staff in emergency		1.35		
A112	The unit is staffed by permanent staff and agency staff are used only in exceptional circumstances		1.36		C11a
A113	There are published and monitored plans to deliver therapy and treatments in line with planned programmes		1.37		C5a;C5b

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A114	The unit promotes an open, blame-free culture for reporting incidents			1.39	C8a
A115	The unit keeps records of the following measures concerning risk assessment:			1.41	C7c
A116	Number of periods of escorted access taken by in-patients			1.42	C7c
A117	Number of periods of unescorted access taken by in-patients			1.43	C7c
A118	Number of abscondings from escorted access as percentage of escorted access taken			1.44	C7c
A119	Number of failures to return from unescorted access as percentage of access			1.45	C7c
A120	Number of escapes within last 12 months			1.46	C7c
A121	Discharge targets are agreed as part of the discharge planning process			1.49	
A122	When a patient needs to transfer to services for older people, a joint review is undertaken to ensure effective hand-over takes place			1.50	C6
A123	Section 117 meetings are held prior to the discharge of all patients detained under a treatment section of the Mental Health Act			1.52	

A: Safety and Security

4: Serious and Untoward Incidents

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A124*	There is a serious and untoward incident policy which is annually reviewed	A83	2.6	1.38 2.14	C1a
A125*	There is a clear system in place to identify record, report and follow up serious and untoward incidents.	A84	2.6		C1a C24
A126*	There is a system in place to report incidents to the relevant commissioners in line with the lead commissioners reporting policy on serious and untoward incidents. This includes initial notification within 24 hours of the incident and a full detailed SUI report within 7 days of the incident.	A85			C1a C21
A127*	Untoward incidents are continually monitored to identify trends and learning points.	A86			C1a C21
A127.1*	There are mechanisms in place to share learning beyond the immediate service/provider concerning incidents	A86			C1a

A: Safety and Security

5: Safeguarding Children and Child Visiting Policies

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
A128*	There is a policy on child visiting/child contact which is annually reviewed	A87		3.32	C2
A128.1*	There are visiting facilities in place for children (people 18 years of age and under) to visit patients which are external to the ward area but within the secure area appropriately supervised by staff with suitable play areas and facilities (HSC/1999/222: LAC (99)32).	A87			C2
A129*	There is a policy on safeguarding children which complies with National quality principles which is annually reviewed.	A88		3.32	C2
A130*	There is staff awareness training on safeguarding children and child visiting.	A89			C2
A131*	There is a designated Lead for Safeguarding Children in the MSU	A90			C2
A132*	There is a designated lead in place in the Provider Unit (Recommendations of the Victoria Climbié Inquiry January 2003).	A91			C2

B: Clinical and Cost Effectiveness

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
B1*	There are annually reviewed clear care pathways linking high, medium and low security providers to ensure patients needs are addressed and timely move on achieved across the care pathway.	B1		5.1 1.47- 1.52 2.2	
B2*	There is effective care co-ordination for all patients in line with National guidance on CPA which is reviewed on an annual basis.	B2	3.6	1.12	C5a
B3*	There is a designated lead MSU(s) for an area, identified by the relevant secure commissioner, which acts as gatekeeper for all potential referrals to high security.	B3			
B4*	All patients from a designated area (defined by the commissioner) requiring MSU are treated in the MSU designated as the lead for that area unless there are capacity or issues of needs of the patient which mean that the service is not appropriate. This is reviewed on a quarterly basis	B4			
B5*	Designated MSUs work with commissioners as part of the contract to review all patients for whom that MSU is the relevant unit and who are placed elsewhere for reasons such as lack of capacity, security or due to the need for a specialised service.	B5			
B6*	Commissioners maintain contact with patients placed out of area and may require the "home area unit" to review the patient's progress. Where this is the case, the "home MSU" and the relevant case manager from the commissioning team will attend CPAs or visit the patient as required to ensure co-ordinated and agreed through care unless agreement has been reached for formal transfer to the new area.	B6			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
B7*	There clear admission criteria agreed with commissioners as part of the Service Level Agreement which are available to potential referrers.	B7		1.3 1.6	C16
B8*	There is a clear written policy for referrals, admissions, transfers and discharges.	B8		1.4 1.8 2.2 2.19	
B9	The provider identifies the responsible PCT for every individual planned admission, even where the service user is known to the service.	B9			
B10*	All patients have a link person/care co-ordinator from their home area services whose responsibilities include the facilitation of ongoing links and the patient's care pathway.	B10			
B11*	The provider facilitates links to the home area services of each patient in terms of local statutory (health and social care) and voluntary services and maintains these to ensure timely and appropriate discharge/transfer arrangements are put in place.	B11			C6
B12*	Where patients from the MSU catchment area are in high security, the MSU develops and maintain links with the high secure team and participates in all CPA meetings to ensure timely transfer of the patient when ready to leave high security.	B12			
B13*	All patients have an individual care plan, drawn up in collaboration with the patient on admission and a first CPA review held within 3 months of admission.	B13		1.13 1.14 1.15 1.16 10.2	C16 C17
B14*	The unit adheres to Home Office requirements in respect of annual statutory returns and reports on restricted patients required to facilitate the care pathway.	B14			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
B15*	There is a multi-disciplinary assessment to determine readiness for discharge/transfer.	B15		1.48 1.50 1.51	C6
B16*	The provider maintains and makes available to referrers and service users a list of the interventions, range of evidenced based and clinically effective treatments and resources that can be provided from external sources.	B16		1.5 1.6 5.16	C16 C5a
B17*	There is patient centred multi disciplinary working, which ensures clear and agreed clinical leadership and governance arrangements.	B17		1.19 1.21	C5b
B18*	There are adequate numbers of appropriately trained staffed at all times ensuring that a full multi-disciplinary service is delivered meeting the needs of the current patient population.	B18 A73		1.17	C5b C5c C11a
B19*	The service contributes to best practice from evidenced based research, published best practise and clinical guidance.	B19		5.21 5.22	C12
B20*	The service seeks to be involved in R&D relevant to the service development.	B20		5.21 5.22	C12
B21*	The service ensures there are regular reviews for patients transferred from prison (a) on remand (b) on sentence to assess suitability for return to prison.	B21			
B22	There are clear care pathways identified which are reviewed regularly			5.1	

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
B23	Unit managers who are nursing staff have had further training in management and team leadership			6.10	C11a
B24	Training needs are informed through the skills needed within the unit, staff development plans and supervision systems which have assessed in the last year			6.11	C5c
B25	There is a recruitment policy statement			8.1	C11a
B26	Reasons for staff leaving are established, particularly where there is a high staff turnover (e.g. exit questionnaires or interviews are used)			8.5	
B27	Staff take up of supervision and support is regularly monitored and audited			9.3	C5b;C5 d
B28	All staff receive regular supervision totalling at least one hour per month from a person with appropriate experience			9.4	C5b
B29	Junior staff have regular supervision totalling at least one hour per week and are able to contact a senior colleague as necessary			9.5	C5b
B30	There are regular forums for all staff to reflect on their experience of the work			9.6	C5b
B31	There is an identified duty doctor available at all times to attend the unit			13.3	C22a

C: Governance

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
C1*	There is a clear complaints procedure.	C1		2.21	C14a
C1.1*	Complaints are continually monitored to identify trends and learning points which are reviewed quarterly	C1			C14c
C2*	Systems are in place that ensure patients (particularly those vulnerable to exploitation e.g. financially, emotionally or sexually) are not subject to bullying by other patients or visitors or staff and that this is managed effectively.	C2 A48		2.6	C14c
C3*	Risk management strategies are implemented	C3 A80		1.11 1.38 1.40 - 1.46	C1a C7c C1b
C4*	All staff understand the security policy and how to operate within the policy	C4 C5 C6			
C5*	All staff receive basic security procedure induction training on their first day at the service.	C5	4.4		C11b
C6*	All staff are kept up to date on issues of security awareness and policy implementation.	C6 A78 A79	4.5	6.1 8.3	C11a C11b
C7*	All mandatory training is undertaken and regularly updated (E.g. First Aid, Fire, COSHH).	C7		2.16	C11b
C8*	All staff are trained in the Management of Aggression and Violence (NICE 25).	C8		6.7	C11a

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
C9*	Training is provided for all staff on their legal position in relation to leave of absence and the legal position in the use of restraint and/or force.	C9		6.6	C11a
C10*	Training is provided for all staff in diversity, meeting patient ethnic cultural and gender needs and anti-discriminatory practice.	C10		6.5	C7e C11a
C11*	There are clear policies on disciplinary and grievance procedure; whistle blowing policy, discrimination, harassment, bullying and violence.	C11 A44 A48		2.6 2.5	C14c C3
C11.1*	Training is provided on disciplinary and grievance procedure; whistle blowing policy, discrimination, harassment, bullying and violence policies	C11			
C12*	All staff are supported to train and develop their needs and skills appropriate to the patient group, to develop the service and the wider needs of the service to ensure an appropriate, motivated and skilled staff base.	C12 A77		6.2	C8b
C13*	Training is provided on the management of relationships between patients and between patients and staff.	C13		6.9	
C14*	Training is provided on the user perspective and user participation.	C13			
C15*	Pre-registration training in all relevant disciplines is accredited.	C14			
C16*	There are links and communication channels with higher education institutions	C14			
C16.1*	The service is recognised as providing a learning environment.	C14			
C17*	Clinicians participate in regular clinical audit and reviews of clinical services.	C15		5.24	C5d

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
C18*	There is a strategic approach to planning to meet the service needs.	C16 A73		1.171 .22 1.23	
C18.1*	There is strategic plan for training, encompassing all known initiatives and that is subject to regular review.	C16 A78		6.1 6.11 8.3	C11a C5c C11b
C19*	There is systems in place to ensure compliance with Improving Working Lives (IWL) requirements with records of: <ul style="list-style-type: none"> • Knowledge skills framework and • Professional registration 	C17			
C20*	There are records of a robust clinical supervision.	C18 A77		9.1	C5b
C20.1*	There is a list of supervisors.	C18			
C20.2*	There is adequate time made available for supervision to be delivered.	C18		9.2	C5b
C21*	There are identified leads from clinical teams and managers who contribute to relevant local networks including strategic, operational and mentally disordered offender meetings.	C19		13.1	C22a
C22*	Clinical teams and managers actively participate in developing and maintaining liaison links with key agencies including prisons; courts; local authority social care, Primary Care Trusts, Strategic Health Authority, education, housing, employers, voluntary agencies etc to facilitate the care pathway and the provision of a comprehensive mental health service.	C20		13.1	C6 C22a
C23*	Clinicians and managers maintain good links with the Home Office and ensure their target deadlines/requirements are met.	C21			C22a
C24*	The unit adheres to the guidelines for re-patriation of foreign Nationals.	C22			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
C25*	Clinicians and managers link to high secure services in respect of assessment and transfers within forensic services to ensure timely, smooth access to services and adhere to the timescales set out in the care pathway (appendix 4).	C23 B1		5.1 1.47- 1.52 2.2	C22a
C26*	Networks of clinicians/professional groups to meet as required e.g. to discuss service development, meeting as groups and with commissioners.	C24			
C27*	There is a named Executive and non-Executive Director who will take a leadership role and responsibility for secure services.	C25			
C27.1*	There are clear lines of accountability to the Board and a management structure, which include clear lines of accountability for all staff.	C25		14.1	C7a
C28*	Lead clinicians are involved in the commissioning process.	C26			
C29*	There is a clinical governance strategy, which is implemented.	C27			C7a
C30*	There is a policy in place, which is implemented to ensure all employees are empowered to promote openness, honesty, probity, accountability, economic and efficient use of resources.	C28			
C30*	There is appropriate management and finance support provided to the service to manage its budget.	C29		14.2	C7d
C31*	There is high quality financial management to oversee and manage use of resources.	C30		14.2	C7d
C32*	The financial management optimises the use of public funds, reduces risk to the public and ensures patients receive appropriate treatment.	C31		14.2	C7d

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
C33*	There are systems in place to manage benefits payments for transferred prisoners	C32			
C34*	There is information communications technology to support clinical care e.g. to manage and monitor referrals; admissions; bed vacancies etc.	C33			
C35*	Clinical teams utilise computerised systems for care management records which in turn feed into monitoring of services by commissioners.	C34			
C36*	Information returns are submitted on a monthly basis in line with National Forensic system to the relevant commissioner.	C35			
C37*	The Race Relations Act is implemented and the service has undertaken a Race Impact Assessment.	C36		7.1 7.2	C7b C7e C18
C38*	All legislative quality principles are maintained, e.g. Mental Health Act, Human Rights Act, Disability and Discrimination Act, Health and Safety at Work Act, Food Safety Act, Infection Control, Control of Medicines, Race Relations Act, Working Time Directive etc (this list is not exhaustive).	C37		2.9	C4a C7e
C39*	The unit Social Care Service ensures that it follows current best practice protocols identified. e.g.; "Protocols for secure services" NIMHE 2003 and any subsequent best practice guidance.	C38			
C40	There is equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence			7.2	C18
C41	Telephone numbers for external agencies are available (e.g. Citizens Advice Bureau, statutory regulatory bodies, Commission for Racial Equality)			7.3	
C42	There is information available on how to get independent help and advocacy in making complaints			11.3	

D: Patient Focus

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
D1*	Patients are supported in their personal care including dental hygiene.	D1		4.11	C13
D2*	Resources are allocated for patients clothing and are targeted appropriately and mindfully of relevant cultural needs promoting choice and individuality and to help patients achieve a good personal self-image.	D1		4.11	C13
D3*	There is access to personal care facilities including hairdressing.	D3			
D4	There is access to services which support patient's improved well being e.g. aroma-therapy.	D4			
D5*	There is an implemented policy to meet individual cultural needs of patients are met.	D5		7.1	C7b C7e C18
D6*	There is an implemented policy to ensure systems are in place to allow for translation services, sign language. Written information must be provided in an appropriate number of languages and formats.	D6		7.1	C7b C7e C18
D6.1*	Written information is provided in an appropriate number of languages and formats.	D6		7.1	C7b C7e C18
D7*	There is a multi-faith room is available for use by all patients.	D7		7.1	C7b C7e C18
D8*	There is an implemented policy setting out the consultation and involvement of carers in the care provided.	D8		12.1	C16

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
D9*	There is evidence of patient involvement in all aspects of the service including their own care plan and quality monitoring and service improvement programmes at the service.	D9		10.1	C13b C17
D10*	All patients have access to independent civil advocacy.	D10	4.1	11.1	C14a C16
D11*	There are systems and support to enable a successful independent civil advocacy service to be operated.	D11		11.1 11.2	
D12*	The unit works with visitors and families on their health and well being, for example, coping with stress, conflict resolution and sustainable transport plans for visiting.	D12			
D13	Staff demonstrate respect for patients			4.8	C13a
D14	Staff are made aware of complaints that are relevant to their work and the outcome of the complaints process			4.10	C7b
D15	Patients have access to a telephone in a private area, within the limits of safety and risk assessment			4.15	C20b
D16	There is indoor and outdoor space for recreation within a medium secure perimeter			4.17	C21
D17	Patient's rights and what they can expect are explained, for example, they are given a copy of the Patient's Charter or similar document			4.19	C16
D18	Restriction of liberty of the patient occurs within the appropriate legal framework, under the provision of the Mental Health Act			4.20	
D19	The programme of activities offered is planned in consultation with patients			5.23	C17

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
D20	Patients are consulted about the unit environment and have choice when this is appropriate			10.3	C17
D21	Patients are encouraged to personalise their bedroom spaces appropriately. (Pictures of nude bodies or pictures of children may be inappropriate)			10.4	
D22	Feedback from patients and carers is used to improve the quality of the unit			10.5	C14c, C17
D23	The unit's policy and procedures are agreed through discussion with the whole unit			10.6	

E: Accessible and Responsive Care

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
E1*	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.	E1 D8 D9		10.1 12.1 10.5 10.6	C13b C14c C16 C17
E2*	There are clear criteria for admission to and transfer /discharge from services which will be agreed with commissioners and will be communicated to all referrers. The service ensures that the discharge procedures are operated in line with the pathway (appendix 4).	E2 B7 B8 B11		1.3 1.4 1.6 1.8 2.2	C16
E3*	An initial verbal response regarding appropriateness of an urgent referral is given within 24 hours and an initial multi-disciplinary assessment is made for urgent within 7 days.	E3			
E3.1*	A verbal notification of the outcome for urgent referrals is given within 24 hours of the assessment and a formal written assessment follows within 7 days.	E3			
E4*	For routine referrals, an initial response as to whether a MDT assessment is appropriate is notified within 14 days with and an initial MDT assessment within 1 month.	E4			
E4.1*	For routine referrals a decision is made within 2 weeks and a bed offered within a further 6 weeks.	E4			
E4.2*	There are systems in place to offer advice and management support to the referrer whilst a bed is awaited and if there is a problem with achieving the timescale for admission, the service contacts the relevant commissioner within 24 hours of a decision that the person needs a bed in line with the lead commissioner's local system for reporting unmet needs.	E4			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
E4.3*	There is a quarterly reviewed audit of waiting times for referrals	E4			
E5*	Wards normally have no more than 15 beds.	E5			
E6*	Patient facilities are single sex and adhere to the Safety, Dignity and Privacy policy.	E6		4.11 4.12	C13a C20b
E7*	Therapy services for women only are available and accessible	E7			
E8	The unit provides advice to referrers where they require an opinion on management of a patient which may then lead to a referral for medium secure care.	E8			
E9	The unit provides advice on management of complex patients to general mental health services when this will support maintenance of the person at a lesser level of security and to prevent inappropriate referrals.	E9			
E10*	The unit adheres to Home Office requirements in respect of annual statutory returns and reports required to facilitate the care pathway.	E10 B14 C21			
E11*	There are systems and SLAs/contracts in place with provider(s) of acute care to ensure timely access for physical ill health which require hospital care and an in-patient or out-patient for urgent, acute or chronic conditions.	E11			
E12*	There is a system in place for emergency response to physical ill health problems	E12			
E12.1*	All staff receive regular update training on basic first aid skills and CPR.	E12			
E12.2*	There is at least one nominated member of staff on each ward, on each shift able to use CPR techniques until an emergency team arrives	E12			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
E12.3*	Emergency access systems allow urgent admission of an ambulance if required.	E12			

F: Care Environment and Amenities

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
F1*	The unit adheres to key policies including hospital cleanliness and high quality environments	F1		4.21	C4a C21
F1.1*	There is a cleaning programme which is regularly audited	F1			C4a C21
F2*	Guidance on Safety, Dignity and Privacy is addressed	F2 E6		3.1 4.11 4.12	C13a C20a C20b
F3*	All accommodation is provided in single rooms, with all new builds and upgrading programmes providing en suite accommodation.	F2 E6		3.1 4.11 4.12	C13a C20a C20b
F3.1*	Patients can wash and use the toilet in privacy unless clinical risk prevents this.	F2 E6		4.11	C20b
F4*	Graffiti and damage to environment is not tolerated and any that occurs is removed/cleaned/painted/repared within 48 hours.	F4			C21
F4.1*	There is a policy in place to deal with inappropriate soiling of the environment	F4			
F5*	There is a rolling programme of maintenance of the environment including furnishings, fittings and equipment.	F5		4.21	C21
F6*	Damaged furniture is not left in patient areas.	F6			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
F7*	There are clean, hygienic and modern bathroom facilities, offering a choice of showers or baths.	F7 F1			C21
F8*	Bathroom and shower areas free of ligature points.	F8			
F9*	There is a system in place to formally assess the clinical environment at least six monthly to ensure that ligature points are identified and appropriate action taken.	F9			
F9.1*	There is a system in place for staff to report any ligature points identified with prompt follow up action	F9			
F10*	Dietary advice and support is available from qualified dieticians reflecting the value of good quality food on a person's wellbeing.	F10			
F10.1*	Patients are provided with meals which are of a high quality, offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity, are varied and appealing and reflect individual's cultural and religious needs. (Better Hospital Food – Department of Health 2004).	F10		4.13	C15a
F11	There is a designated dining area			4.22	C21
F12	There are facilities appropriate to the patient group, e.g. a pool table and board/console games are provided			4.23	C21
F13	There are facilities for patients to make their own hot and cold drinks and snacks			4.24	C21
F14	Books and magazines are provided in recreation areas for patients			4.25	C21

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
F15	Access to media (e.g. TV, video, audio and internet) is monitored with safeguards in place			4.26	C21
F16	The unit contains an adequate number of large and small rooms designed for individual and group work			5.17	C21
F17	There is a room large enough for staff and patients to meet, where everyone can see and hear each other			5.18	C21

G: Public Health

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
G1*	All patients have access to a primary healthcare service.	G1	3.7	4.1	C6
G2*	All patients have at least daily supervised free access to fresh air outside the building as a minimum.	G2		4.16	
G3*	All patients have their primary healthcare needs assessed on admission and reviewed at least annually or more frequently if required.	G3		4.2	C6
G3.1*	Physical healthcare needs are identified in the patient's treatment plan. The plan includes any treatment regimes as prescribed.	G3			
G4*	There is a policy in place for admission physical health check and availability of primary care including a review of the currently prescribed medication and a full physical examination.	G4			
G5*	Screening programmes are available in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health.	G5	3.7	4.2	C6
G6*	Support is given to help patients to cease smoking (in preparation for changes to legislation due to be implemented July 2008 on smoking). E.g. provision of smoking cessation programmes	G6			C23
G7*	There is a policy on patient, visitor and staff smoking in line with government policy.	G7			C23
G8*	There are clear guidelines and policies on patient sexuality.	G8			

No.	Implementation Criteria	HOP Quality Principle	HOP High Level Performance Indicator	Standards for MSUs	Standards for Better Health
G9*	There are clear guidelines and policies on guidelines for staff on patient's sexual behaviour.	G9		4.18 6.19	C11a
G10*	There is a protocol for dealing with allegations of sexual and serious sexual assault agreed by police and consulted upon by the Crown Prosecution Service.	G10			
G11*	The provider should ensure that the advice and input from dieticians ensures that patients access good quality, nutritious meals that enhance and support the care and treatment they receive, particularly in respect of addressing potential obesity.	G11 F10		4.13	C15a
G12*	There is access to health trainers or equivalent.	G12			
G13*	There is a policy and/or working group which addresses Healthy Settings approaches to promoting well being and physical good health in patients and staff.	G13			
G14*	There is identification and application of some relevant aspects of the General Medical Services Quality and Outcomes Framework to primary care of patients in secure MH/ LD settings (for example, identification and treatment of high blood pressure or diabetes).	G14			
G15*	There is access to Health Promotion support in line with expectations in the community, including alcohol and addictions, physical activity; diet and nutrition.	G15			C23

Standards and Criteria for Women in Medium Secure Care

Method

Context

The Corston Report, (Home Office, 2007), a review of the needs of women within the Criminal Justice System, highlights that "*women and men are different. Equal treatment of men and women does not result in equal outcomes.*" Echoing this view and, given the Gender Equality Duty placed upon the public sector by the Equality Act (2006), work is currently ongoing to develop a set of service standards specifically designed to address the needs of women in Medium Secure care.

The Development of the Standards and Criteria

1) Literature Review

A bibliography of key documents was compiled from professional bodies, other quality networks and experts¹. These were reviewed and standards were identified or derived from guidance and recommendations.

2) Consultation

The consultation process had three parts:

- (i) Focussed discussion groups for staff and service users
- (ii) Consultation Workshop (1 November 2007)
- (iii) Postal Consultation

2.1) Focussed discussion groups for staff and service users

Forty Medium Secure Units throughout the United Kingdom (both NHS and independent sector) were identified and invited to participate; a series of focussed discussion groups were held with service users and staff in the eight services that responded. These were fairly well dispersed throughout England and Wales and included women only services, mixed services and a learning disability service (see acknowledgements). The discussion focused on: milieu; family and carers; the process of care; security; health; and treatment which were identified from the literature as important topics.

2.2) Consultation Workshop 1 November 2007

A consultation draft of Standards for Women in Medium Secure Care was developed from the literature review and the focused discussion groups. Approximately thirty professionals, drawn from both the National Health Service and independent providers, and including clinical, managerial and academic staff, participated in small group based discussions at the Consultation Workshop on 1 November 2007. They were asked to examine the standards and criteria, rate their importance and provide a critique of both the standards themselves and the language and terminology used.

¹ See Appendix 2 for a list of key documents

2.3) Postal Consultation

On the basis of view and feedback given at this consultation workshop a second draft of the standards was developed. These were sent out to key stakeholders, clinicians, managers, and service users. They were asked to rate the standards in order of importance to the quality of care. The postal distribution list also included the eight services that had participated within the initial consultation to provide front line staff and service users with feedback on the usefulness of the initial discussions and also to gain their comments. Stakeholder organisations consulted included CSIP, WISH, NOMS, Health Offender Partnerships and the forensic commissioner network.

3) Editing

Following the literature review and tripartite consultation process the final version of the standards was edited.

A: Safety and Security

The unit provides an environment that is safe and secure. There is a balance between physical, procedural and relationship security

A1w	Initial assessments and individual care plans include key components which are particularly pertinent to women
A1.1w	<ul style="list-style-type: none"> • self-harm
A1.2w	<ul style="list-style-type: none"> • gender specific formulation of risk
A1.3w	<ul style="list-style-type: none"> • cultural needs
A1.4w	<ul style="list-style-type: none"> • physical health issues
A1.5w	<ul style="list-style-type: none"> • effects of medication
A1.6w	<ul style="list-style-type: none"> • eating disorders
A1.7w	<ul style="list-style-type: none"> • trauma (including domestic and sexual violence)
A1.8w	<ul style="list-style-type: none"> • alcohol and substance misuse
A1.9w	<ul style="list-style-type: none"> • family and primary carer roles
A2w	Policies regarding restraint and seclusion address the potential requirement for individualised care needs e.g. Previous trauma or abuse, physical health issues, advanced directives
A3w	The service has policies that address the issues of maintaining privacy and dignity during episodes of restraint and seclusion
A4w	There are clear and consistent policies for the individualised management of women who self harm
A5w	There are clear and consistent policies for the individualised management of women who harm others
A6w	Staff are trained in a range of sophisticated interventions designed to minimise the frequency and severity of self harm
A7w	All routine intramuscular injections are administered by female staff

A8w	Emergency intramuscular injections are administered by female staff wherever possible and, when administered by male staff, a female chaperone is present
A9w	All overnight observations in bedroom areas are undertaken by female staff
A10w	Written and oral information is available at the time of prescribing regarding the potential impact of medication on women's health and wellbeing e.g.
A10.1w	<ul style="list-style-type: none"> • Weight gain
A10.1w	<ul style="list-style-type: none"> • Menstruation
A10.2w	<ul style="list-style-type: none"> • Pregnancy
A10.3w	<ul style="list-style-type: none"> • Breast feeding
A10.4w	<ul style="list-style-type: none"> • Menopause
A11w	The information is available in an accessible form, taking account of cultural diversity, language, literacy and communication deficits
A12w	There is a designated room or suite for family visiting that is outside of the ward environment
A13w	The family visiting room or suite has:
A13.1w	<ul style="list-style-type: none"> • Age-appropriate toys, games and activities
A13.2w	<ul style="list-style-type: none"> • Baby-changing facilities
A13.3w	<ul style="list-style-type: none"> • Appropriate toilet facilities
A13.4w	<ul style="list-style-type: none"> • Kitchen facilities (risk assessed access)
A13.5w	<ul style="list-style-type: none"> • A secure outdoor area
A14w	The family visiting room or suite is of sufficient size to allow observations to be undertaken from a discrete distance
A15w	Staff that facilitate child visiting have undergone appropriate training in child protection
A16w	There are sufficient staff available to enable children to visit during evenings and weekends

B: Clinical and Cost Effectiveness

The service promotes clinical and cost effectiveness and maintains a high quality care that meets the needs of service users and staff.

B1w	The service actively encourages the identification and development of gender specific and gender sensitive step-down facilities
B2w	The service is committed to the development of age appropriate secure services for women
B2.1w	Graduates from adolescent forensic services
B2.2w	The ageing secure care population
B3w	The service does not use male bank or agency staff within medium secure inpatient wards for women
B4w	The rationale for determining the gender of escorting staff is defined within the unit leave policies

C: Governance

The service has managerial and clinical leadership that ensure probity, quality assurance, quality improvement and patient safety are maintained.

C1w	The unit will liaise with local physical health care services, including:
C1.1w	<ul style="list-style-type: none"> • Accident and Emergency department
C1.2w	<ul style="list-style-type: none"> • Obstetrics and Gynaecology
C1.3w	<ul style="list-style-type: none"> • Primary Care services
C2w	All new staff undergo a basic induction that includes information regarding the specific needs of women in medium secure care
C3w	There is an ongoing programme of appropriate gender specific training for all staff who come into contact with female patients
C4w	The service-specific programme of training will include:
C4.1w	<ul style="list-style-type: none"> • Gender-responsive practice
C4.2w	<ul style="list-style-type: none"> • Inclusive practice and issues of discrimination
C4.3w	<ul style="list-style-type: none"> • Culturally responsive practice
C4.4w	<ul style="list-style-type: none"> • Victim issues (including domestic and sexual violence, other trauma and supporting disclosure)
C4.5w	<ul style="list-style-type: none"> • Gender influenced presentation of mental illness
C4.6w	<ul style="list-style-type: none"> • Personality disorder
C4.7w	<ul style="list-style-type: none"> • Eating Disorders
C4.8w	<ul style="list-style-type: none"> • Deliberate Self Harm
C4.9w	<ul style="list-style-type: none"> • Child Protection and liaison with Children's Services

C5w	Service users are involved in the ongoing development of gender specific policies and procedures
C6w	There is externally facilitated reflective practice or similar supervision that is available for both ward-based staff and the MDT

D: Patient Focus

The service is patient-focused, with an emphasis on mutual respect and maintenance of individual dignity. Service users are supported to contribute to decisions regarding their own care and treatment.

D1w	There is access to specialist gender-specific advocacy services
D2w	There is access to personal care facilities, e.g. hairdressing
D3w	The service provides a range of basic toiletries and sanitary products
D4w	The service has policies for the provision and dignified distribution of basic toiletries and sanitary products for women who are cared for in seclusion or intensive treatment areas
D5w	The service provides suitable hair and skincare products for women from BME communities
D6w	There are forums through which women can give their views, and receive feedback, in a safe and confidential manner including community meetings, MHAC visits, hospital manager visits, PALS, independent advocacy

E: Accessible and Responsive Care

Patients receive services promptly and have a choice in the treatments they can readily access.

E1w	Medium-secure inpatient wards for women have no more than 12 beds
E1w	The pre-admission assessment team ideally includes at least one female member of staff
E3w	The initial assessment includes identification an appropriate gender-sensitive care pathway
E4w	Service users are involved in decisions regarding the gender of their key worker
E5w	There are female staff available on the ward at all times
E6 w	There is a mixed gender staffing team (approx. 70%:30% female: male)
E7w	The multi-disciplinary team is mixed gender across both professional disciplines and levels of seniority.
E8w	Gender specific factors have been addressed in the development of risk and offence related interventions
E9w	The service offers gender specific access to all therapeutic and recreational activities
E10w	The service offers mixed-gender access to appropriate therapeutic and recreational activities
E11w	There are sufficient staff available to facilitate access to therapeutic and recreational activities

F: Care Environment and Amenities

The service provides a safe and supportive environment for all patients.

F1w	At ward level, medium secure inpatient services are single sex
F2w	All women have access to gender specific living areas (to include quiet rooms and dining areas)
F3w	All women have access gender specific sleeping areas
F4w	All women have access to gender specific bathing and toileting facilities that do not require them to pass through an area designated for male patients
F5w	There is the facility for all women to lock their bedroom doors, with a system that can be overridden by staff in an emergency
F6w	There is a structured programme of activities that addresses the social, functional and therapeutic needs of women
F7w	The structured programme includes age appropriate activities
F8w	The structured programme of activities is regularly reviewed and is responsive to both clinical need and service user requests
F9w	There is access to outdoor space for women only that is private and secure
F10w	The outdoor space is fit for purpose (e.g. exercise, relaxation, horticultural activities)

G: Public Health

The service adheres to the principles *Choosing Health* and has a comprehensive programme that incorporates disease prevention, screening and longer-term management.

G1w	All women have access to a female General Practitioner and practice nurse
G2w	Timely access to physical healthcare is equivalent to guidelines for waiting times in community primary care
G3w	All women have access to information and support regarding sexual health e.g. contraception, sexually transmitted infections
G4w	All women have access to primary and secondary screening programmes, e.g. cervical screening, mammography
G5w	The service provides health promotion information regarding issues specifically relating to women

Appendix 1: Acknowledgements

We would like to acknowledge the following the following groups and individuals whose comments have helped enriched the development of Standards and Criteria for Women in Medium Secure Care. All service users and staff who participated in the initial consultation process form the following units: Edenfield Centre, St Andrew's Women's Medium Secure Service, St Andrew's Learning Disability Women's Medium Secure Service, Joydens Unit, Bracton Centre, Dartford, Trevor Gibbens Unit, Fromeside, Caswell Clinic, Runwell Centre, Runwell Unit.

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Appendix 2: References

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(As noted in method these have been mapped on to the Implementation Criteria)

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Appendix 5: Order Form

Further copies of these Implementation Criteria with Standards and Criteria for Women in Medium Secure Care can be obtained by copying and completing this form:

I would like to order _____ copies of the Implementation Criteria at **£10** each

Title: (Dr, Mr, Mrs, Ms etc.):

First name:

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Please indicate your preferred method of payment:

a) I enclose a cheque for £ _____ made payable to 'The Royal College of Psychiatrists'

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Appendix 6: Feedback Form

We hope you have found the Implementation Criteria with Standards and Criteria for Women in Medium Secure Care useful and would appreciate your feedback. Your comments will be incorporated, with the approval of members of the quality network, into future editions of this publication.

1. Have you found these standards useful? Yes No

Comments:

2. Do you have suggestions for new sections/topic areas or new standards or criteria you would like to see included in future versions?

3. Do you have any general suggestions about this document that would improve its usefulness?

4. What is your profession?

Thank you for taking the time to complete this form. Your comments will be considered carefully.

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