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Quality Network for Forensic Mental Health Services

Annual Report 2006-2007

Tessa Hughes & Sarah Tucker CRTU 046

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Introduction

The Quality Network for Forensic Mental Health Services was set up in 2006. It is one of several networks managed by the College Centre for Quality Improvement. Adopting a multi-disciplinary approach the network aims to facilitate quality improvement and change in forensic mental health settings through a supportive peer-review network. A fundamental principle is that of listening to and being led by frontline staff and service users. The network serves to identify areas for improvement through a culture of openness and enquiry rather than inspection or blame. Members can use the results of reviews to develop action plans to achieve year on year improvement. They can also share their results with key groups locally, including commissioners, health and local authorities, those making referrals to their services and local user and carer groups.

What does the Quality Network for Forensic Mental Health Services do?

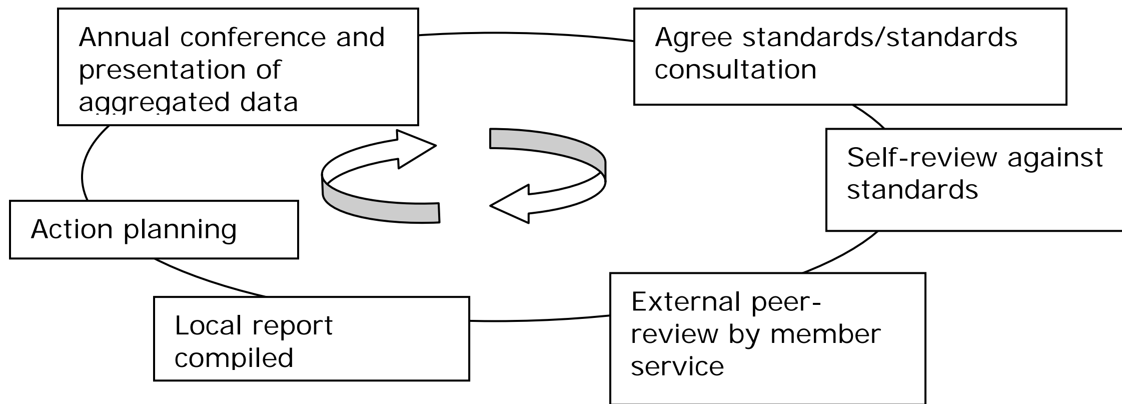
The quality network's activities include:

- Developing and applying standards for forensic mental health services through a system of self- and external peer-review;
- Supporting local implementation of best practice and national policy, as identified in the service standards;
- Producing reports for participating services that highlight areas of achievement and areas for improvement;
- Providing a national "benchmarking" service to allow services to compare their activity with other services;
- Facilitating information-sharing about best practice between members of the network;
- Supporting routine data collection, e.g. regarding clinical and cost outcomes.

The Review Process

The real benefit for member services is in taking part in the process of self- and peer-reviews. These reviews aim to improve services incrementally by applying standards, using the principles of the clinical audit cycle (see Figure 1).

The cyclical review process: (Figure 1)



Each year, the standards are applied through a process of self-review and external peer-review where members visit each other's services. The self-review questionnaire is essentially a checklist of standards for Medium Secure Units against which teams rate themselves, supplemented with more exploratory items to encourage discussion around achievements and ideas for improvement. The self-review process helps staff and service users to prepare for the external peer-review and become familiar with the standards.

During the peer-review, data are collected through interviews with staff, and service users. The results are fed back in local and national reports. Services then take action to address any development needs that have been identified. The process is ongoing rather than a single iteration.

Cycle 1 2006-2007

Eight medium secure units participated in Cycle 1 (see Appendix B) which was in effect a pilot and development phase for the quality network process. Member units undertook the self-review between September 2006 and February 2007 and received an external peer-review between October 2006 and March 2007.

Table 1. Number of Staff and Services Users Participating in Peer-reviews in Cycle 1

Staff participating as peer reviewers	37
Staff interviewed	180
Services users interviewed	70

This report

This annual report summarises the aggregated results of the reviews undertaken by the 8 pioneer medium secure units in Cycle 1 2006-2007. It

is structured around the 14 sections of the standards for medium secure units. The Standards for Medium Secure Units (MSUs) include all the Department of Health standards (Health Offender Partnerships, 2004) and extra standards identified by members of the Quality Network for Forensic Mental Health Services from a supplementary set (see Standards for Medium Secure Units, 2007).The body of the report highlights achievements, areas for improvement, and gives examples of solutions to common problems. Appendix A is a full summary of the extent to which the 8 services met the standards.

How members of the Quality Network for Forensic Mental Health Services can use this report:

How well are we doing overall in comparison with the network?
Your unit's local report provides you with a summary of the number of criteria met, partly met and not met, which then yields an average score for each individual standard. These averages enabled us to obtain a measure of your unit's overall performance for each section of the service standards. Average scores for Cycle 1 are detailed in the key findings and in Appendix A so you can immediately see how well you are doing compared with the other teams in the network. Each member has also been assigned a unique team number so that you can use the graphs in this report to compare yourselves with the rest of the network.

What are the key areas of variance within the network?
The key findings highlight areas identified within each section that best discriminate services from one another, and also those standards considered to be critical to the quality of care provided.

How can we identify other services that could provide advice or support on specific areas of service development?
A summary of service development initiatives that member services have undertaken is presented in Appendix C to aid information sharing amongst network members.

ACKNOWLEDGMENTS:

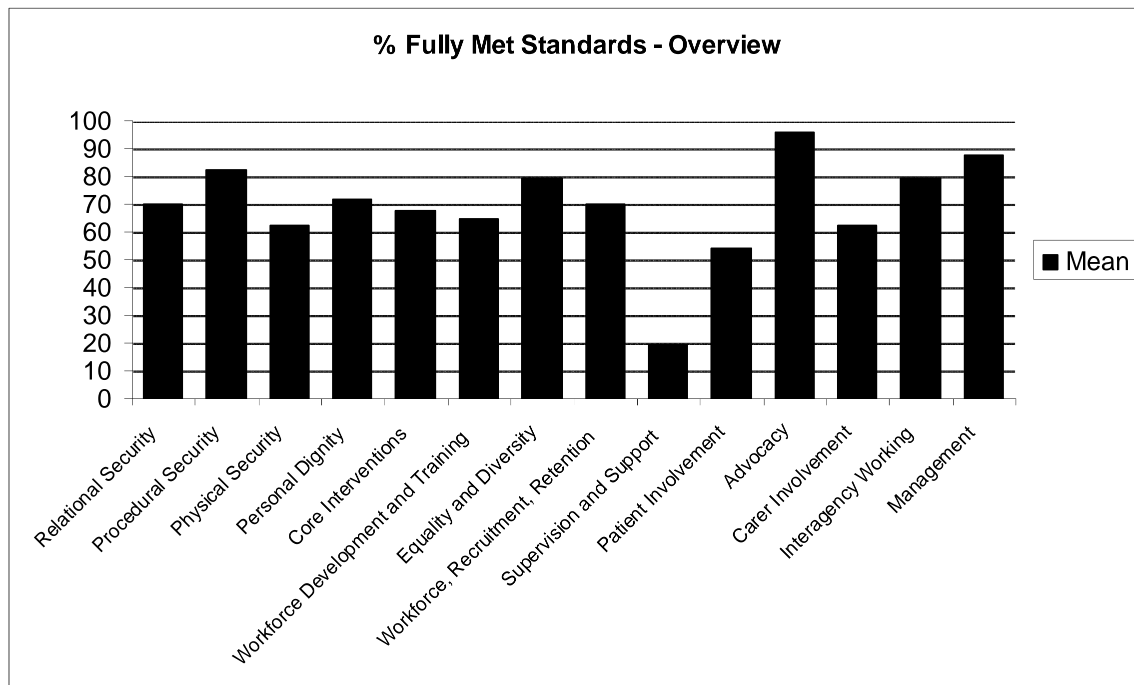
The project team gratefully acknowledges:

- The staff in member units who organised, attended and received peer-reviews
- Service users in member units who took part in the peer-review of their unit
- The Advisory Group (see Appendix E) for their continuing support and advice

Summary and Recommendations

This section outlines the key issues that emerged from the reviews as summarised in Table 1. It recommends action that units can take in response to the problems raised and action that the Quality Network for Forensic Mental Health Services will take.

Figure 2.



Supervision and Support

Clinical supervision for most practitioner groups largely exceeds that which is recommended in the standards. This is commendable. By contrast, in the majority of units reviewed there is a lack of provision of clinical supervision for nursing staff. Indeed, the majority of services are even failing to provide the recommended minimum of one hour per month supervision for these staff. While many of the nursing staff interviewed expressed enthusiasm for engaging with a programme of supervision, part of the reason for the lack of provision is inadequate protected time for supervision. In the context of the heavy emotional demands made in particular on frontline staff in secure forensic settings, this is a matter of concern.

Recommendation 1- Supervision and Support
Managers to ensure that time is protected for nurses and other frontline staff to have regular clinical supervision as a matter of priority.

What will the Quality Network for Forensic Mental Health Services do?
Facilitate means by which members can share good practice, for example via the e-mail discussion group (msu@cru.rcpsych.ac.uk), and the provision of opportunities for member units to liaise.
Ensure that supervision and support for nurses is a focus for measuring progress in cycle 2 of the reviews.

Workforce Development and Training
Overall, the units perform highly against standards related to recruitment policy, mandatory training and induction programmes. However, there are a number of individual standards where most units perform poorly. Of particular concern is that over half of the units fail to provide annual security awareness training. Management staff interviewed are rightly concerned about such shortfalls and cite funding the release of frontline staff as the cause.

Recommendation 2 – Workforce Development and Training
Managers to review resources and structures for releasing frontline staff for training so as to ensure adequate time is protected for frontline staff training.

Recommendation 3 - Workforce Development and Training
Managers to review staff training and development strategies to ensure adequate training and development plans are in place for all staff.

What will the Quality Network for Forensic Mental Health Services do?
Facilitate means through which members can share good practice, for example via the email discussion group and the provision of opportunities for member units to liaise.
Ensure that training for frontline staff is a key focus of the second review cycle.

Core Interventions
Given the value placed on clinical treatment in the context of medium secure units by contrast to custodial settings, it is worrying that access to an adequate range of interventions is often limited. Most units provide an inadequate range of psychological and creative therapies. For example, cognitive therapy is available in only six units. Of greater concern is that access to interventions is often limited by insufficient staffing levels to escort patients off the wards, and in some units limited room space is an obstacle.

Recommendation 4 – Core Interventions
Clinicians to take a lead in reviewing the range of psychological and creative therapies provided to ensure that it is comprehensive, evidence based and appropriate to the needs of the client group.

Recommendation 5 – Core Interventions
Clinicians to take a lead in working with service managers to review strategies for ensuring patients have regular access to treatment interventions. This review could consider staff availability, treatment room availability and training frontline staff to deliver interventions.

What will the Quality Network for Forensic Mental Health Services do?
Highlight issues concerning gaps in core interventions to commissioners.
Ensure that core interventions are a key focus of the second review cycle.

Personal Dignity, Equality and Diversity
Service users consistently speak of how highly they value their relationships with staff, and in particular, frontline staff. It is reassuring and commendable that in all units staff demonstrate respect for patients. Moreover, it is very positive to find that developing gender specific care is a priority in a number of the units. However, in two units the standard for ensuring that basic needs (such as bathroom facilities) are provided for is not fully met. This is unacceptable and where applicable requires immediate attention. Lack of awareness about equality and ethnic and cultural issues is also a worrying area of concern in two units.

Recommendation 6 - Personal Dignity
Where units are not providing basic needs, managers to address specific issues with host organisation as a matter of urgency. This report may be a useful tool to take to commissioners, highlighting where services diverge from practice across units.

Recommendation 7 – Equality and Diversity
Managers review, implement and monitor strategies for raising awareness of ethnic and cultural issues.

What will the Quality Network for Forensic Mental Health Services do?
Disseminate these areas of concern to commissioners via the annual report.

User Involvement
It is encouraging that user involvement has clearly become an area of focus across the units. However, many of the structures in place are new and still developing. Staff have not been trained in how to implement structures and solicit meaningful patient involvement. Subsequently, a significant proportion

of patients find the involvement to be tokenistic. Generally policies are still not readily accessible to patients and patient input is not sought in their development.

Recommendation 8 – User Involvement
Managers and frontline staff to augment strategies for involving users by visiting prison therapeutic communities/attending Community of Communities (a Quality Network for Therapeutic Communities, managed by the College Centre for Quality Improvement) peer-reviews to gain further ideas and inspiration for good practice in user involvement in secure settings.

What will the Quality Network for Forensic Mental Health Services do?
Facilitate observational visits for Quality Network for Forensic Mental Health Services reviewers at Community of Communities peer-reviews.

Environment and Facilities
There is a marked variation in the quality of physical environment across the units, some being attractive, spacious and recently purpose built and others very old, in need of urgent refurbishment and redesign to meet the demand of contemporary standards for patients' personal dignity. Only five of the eight units fully meet the standard for being well designed and having the necessary facilities, and this is a matter of concern.

What will the Quality Network for Forensic Mental Health Services do?
Support local efforts to secure funding for refurbishment of new buildings, e.g. by contacting senior staff and commissioners to explain which standards are compromised by poor environment and facilities and the implications of this for safety, security, rights and dignity.

Security
The variation across the units in relation to standards for physical security is striking. The variation concerns key standards: three quarters of units fully meet standards for a defined perimeter and the same proportion for a secure locking system. Alongside this, it is encouraging that relational and procedural security are scored highly across the units. Given this, it is questionable as to whether this is a matter of concern in those units with lower physical security scores, or whether other forms of security make for a safe enough environment. There is an important question here about what level of physical security defines medium security.

Key Findings Cycle 1 2006-2007

1: Relational Security

Key Findings

Number of standards in Relational Security	52
Average percentage of criteria fully met by the 8 units	70%

Achievements

- The admission process in all of the units is conducted within standards. For example, all units provide an initial treatment plan within 24 hours following admission, six of the units fully meeting the standard here.
- There are no unmet standards regarding risk and safety across all eight units. This includes recording information such as periods of unescorted access taken, and promoting an open and blame free culture for the reporting of incidents.

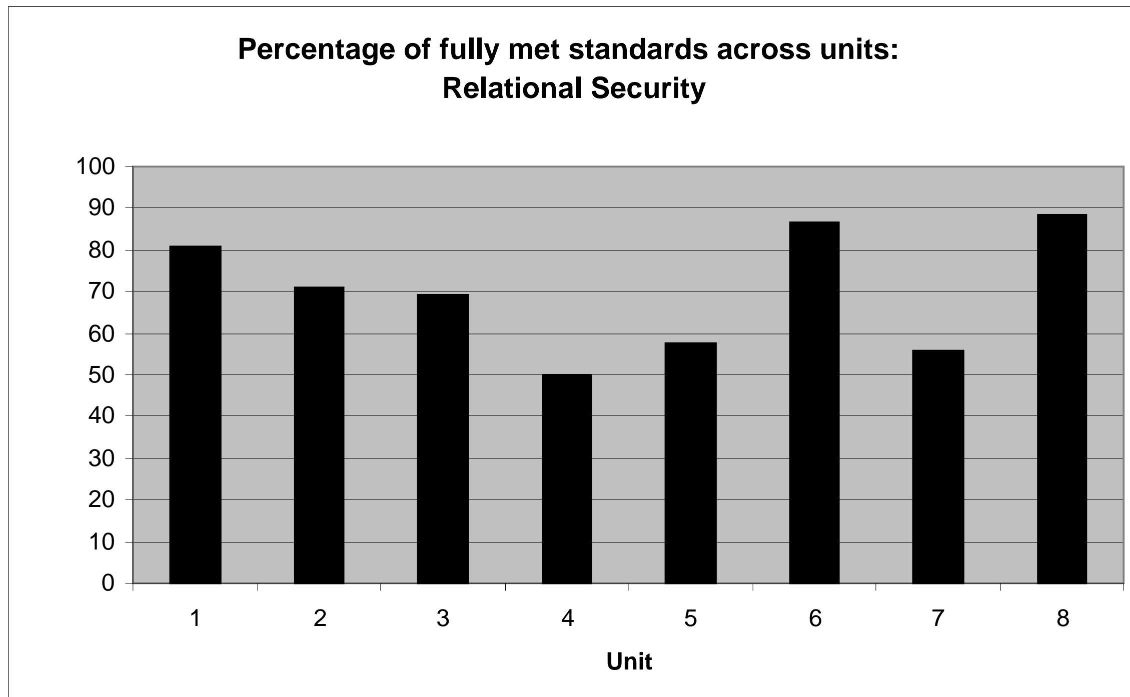
Areas for Improvement

- There is a lack of detail about the aims of admission, the current programme and modes of treatment provided in information given to prospective patients and relevant professionals. Only two of the units fully meet the standard.
- There is difficulty within the units in linking ward level and MDT communication systems. Only two of the units fully met the standard for clear and effective systems for communication.

Solutions

- Develop information for prospective patients, which covers the aims of admission and programme of treatment, in consultation with patients.
- Review communication systems within units and consider developing formal guidance detailing responsibilities of staff groups. The development of a meaningful unit wide meeting is recommended in addition.

Figure 3.



Achievements

Relational security was scored highly overall. It emerged from the peer-review visits that providing a high level of relational security is a priority across all of the units.

All of the units have systems and processes in place for good quality MDT assessment prior to admission, although the extent to which full MDT involvement occurs in practice is variable. The majority of units have medical and nursing assessments, with other disciplines such as psychology contributing as needed. The admission process is conducted to a high standard across the units, for example, all units provide an initial treatment plan within 24 hours following admission.

There are no unmet standards relating to Risk and Safety. All of the units fully meet the standard for promoting an open, blame-free culture for reporting incidents, according to both management and frontline staff interviewed. Further, all of the units provide an annual report on risks and incidents to enable the unit to learn from risks and provide a safer environment; six of the units are doing so to a standard sufficient to fully meet the standard.

Areas for Improvement

The information provided for prospective patients and relevant professionals does not meet standards in the majority of units. Only two units fully meet the standard specifying that the information should contain a clear

description of the aims of admission, the current programme and modes of treatment, and two units have no information at all to address the needs of prospective patients.

The development of written care pathways is a variable process across services. Particularly in reference to patient consultation, this is an area in which work is generally in progress at present. The main task for units is to formalise the current procedures here. Several of the units also need to extend the scope of the pathways to cover long term care plans and discharge plans.

Services have a range of approaches to providing a core day for patients; the extent to which this is individualised and recorded varied. The core day may include activities such as sport, creative therapies, relaxation sessions and life skill classes such as cookery. Half of the units provide comprehensive daily programmes of activities and therapy which are individually tailored for patients in reference to care plans. Other units provide relatively sparse ward level programmes of activity. Levels of patient engagement and staff availability to implement the programmes are variable.

Systems for communication and handover for staff generally need improvement. Only two of the units fully meet standards for clear and effective communication. In the majority of units communication systems are undergoing a period of progress, for example, three of the units have recently implemented computerised notes systems. Ward level handover systems are largely effective and meetings within the MDT similarly. The difficulty for most of the units is in linking the two strands of communication.

The staffing complement is an area that reflects the individual context of the services, with no pattern emerging across the members. For example, the standard for the ratio of consultant psychiatrists, specifying one for every fourteen beds, is unmet by three of the units, fully met by three and partly by two.

2: Procedural Security

Key Findings

Number of standards in Procedural Security	22
Average percentage of criteria fully met by the 8 units	82%

Achievements

- Procedural security is an area of achievement across the units, as indicated by the average percentage of fully met criteria above. Six of the standards are fully met across every unit. For example every unit has search polices and observation and monitoring polices for those at risk of suicide that meet specified standards.

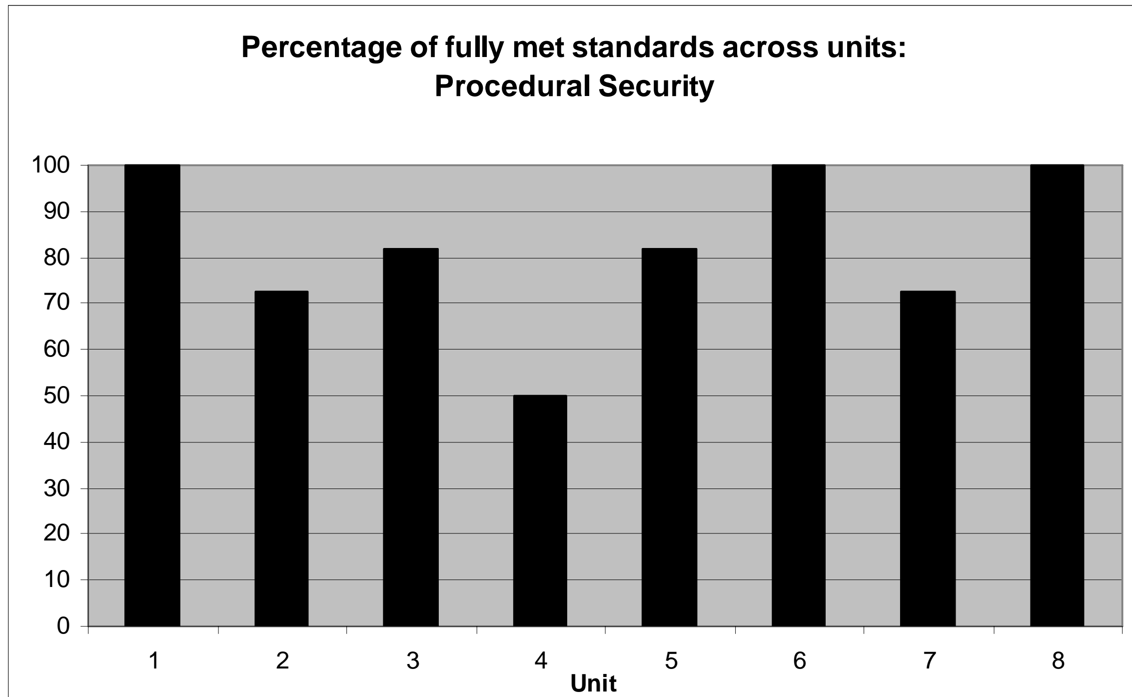
Areas for Improvement

- Policies for administering drugs at dosages above BNF recommendations are variable. Only five units fully meet the standard for policy regarding high dose prescribing.
- Only five units fully meet the standard for policy that ensures issues of equality and diversity are regularly monitored.
- Five of the eight units do not have in place all policies and procedures outlined in the standards.

Solutions

- All units to develop a policy for administering dosages above BNF recommendations. Participation in the Prescribing Observatory for Mental Health (Royal College of Psychiatrists Centre for Quality Improvement) audit of high dose prescribing in forensic mental health could be used to stimulate discussion and develop a policy.
- All services to ensure that a comprehensive set of policies and procedures is in place to meet standards. Where there are gaps, the quality network email discussion group (msu@cru.rcpsych.ac.uk) may be a useful tool for sharing across services.

Figure 4.



Achievements

Broadly, all of the units have relevant, accessible, authorised, up to date policies and procedures in place to address the key areas of practice outlined in the standards.

A number of the standards for procedural security are fully met across all of the units. These include policies for the observation and monitoring of patients who are at risk of suicide; searching policies in relation to patients, visitors, bedrooms, and off ward areas; a policy for prompt response to staff alarms and a written complaints procedure.

Areas for Improvement

There is variability across the units in several areas of policy and procedure, for example, policies for administering drugs at dosages above BNF recommendations. Five of the units fully meet the standard for having a policy, two partly meet it and one unit has no policy in place. Several of the units audit themselves against the Royal College of Psychiatrists standards and comments to support the standard included that they 'do not have a culture of medication' and that it is 'managed through practice and vigilance'.

Units vary also in the protocols that are in place for the risk assessment of patient access to telephones, the internet and cameras. Six of the units fully meet the standard. This was a priority for many of the units given the rapid advances that are occurring in such technology. Developing protocols to cover technology with recording capabilities is an area of focus, although two

of the units do not allow patient access to such technology, including the internet.

Contingency plans agreed with the police and emergency services are not fully in place for two of the services. The remaining six units fully meet this standard, although some reported that links are informal and rely on a proactive approach from the service.

Only five of the units fully meet the standard for having a policy in place to ensure issues of equality and diversity are regularly monitored. The policies that are in place are generally Trust level and not tailored to local level.

3: Physical Security

Key Findings

Number of standards in Physical Security	32
Average percentage of criteria fully met by the 8 units	63%

Achievements

- Seven of the eight units issue all staff who work in the secure unit with a personal alarm
- In general, the area of restraint and seclusion is well addressed across the units

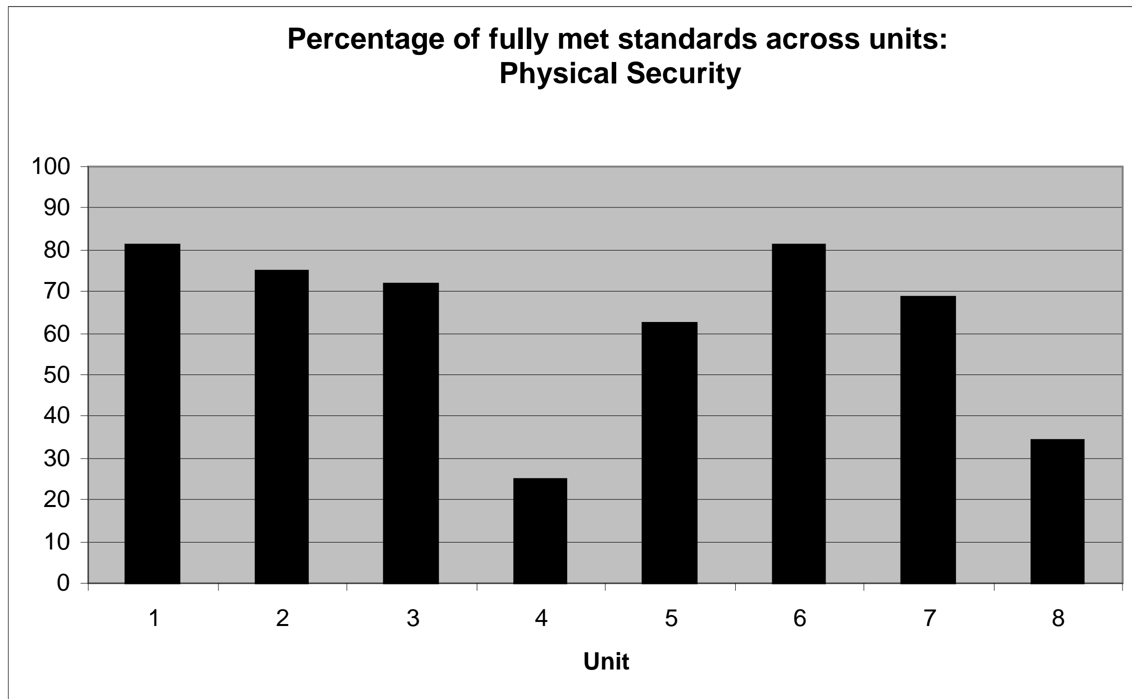
Areas for Improvement

- Only five of the eight units fully meet the standard for being well designed and having the necessary facilities and resources for people requiring medium secure care (see text below for detail on the variability and shortfalls in physical security).
- Only five of the units conduct planned and recorded daily inspection of the perimeter to detect damage and/or contraband
- Only half of the units have a way for patients to raise an alarm in an emergency.

Solutions

- In units where the design of the physical environment and facilities are not meeting standards the services need to continue to implement and monitor action plans for the improvement of the environment, and ensure that this is not delayed or postponed, particularly due to possible future relocation of the service.
- All units to conduct planned and recorded daily inspection of the perimeter. The appointment of security coordinators and/or implementation of clinical governance structures to monitor systems of conducting and recording inspection may be useful.
- In consultation with patients, all units to consider the implementation of systems to enable patients to raise an alarm in an emergency.

Figure 5.



It is particularly notable that there is a great deal of variance across the units with regards to the levels of physical security. As Figure 4 above shows, two of the units fully meet less than 35% of standards.

Achievements

Achievements in physical environment are evident within individual services. For example, three of the units are commendable, having been designed to provide a therapeutic environment in the context of medium security. Individual achievements include the separation of residential and treatment areas and innovative design to allow flexibility in accommodating different patient needs, for example male and female.

Looking at the overall picture, achievements are modest. Seven of the eight units issue all staff who work in the secure unit with a personal alarm. All but one of the units check secure keys a minimum of once a day, three quarters of the units doing so twice daily.

The area of restraint and seclusion is well addressed in general across the units. All of the units operate within the appropriate legal framework in relation to the use of physical restraint and three quarters of the units demonstrated that where seclusion is used, there is a designated seclusion facility available, designed to minimise risk of injury and continually monitor the patient. One of the units does not use seclusion at all.

Areas for Improvement

Three quarters of the units fully meet the standard for a defined perimeter. Those units meeting standards for perimeter security have 5.2m to 5.8m single weld mesh fences and/or perimeter security designed into the unit by way of connected buildings creating a secure area. Those units failing to fully meet the standard have low buildings surrounding the perimeter or low fences and walls constituting the perimeter. Only five of the units conduct planned and recorded daily inspection of the perimeter to detect damage and/or contraband

Regarding secure locking systems, three quarters of units fully meet standards. These locking systems consist of either manual, electronic, magnetic or a combination of these, with backup replacement in the event of a compromise or failure, and a separate locking suite for doors/locks within the perimeter or providing access to it. The remaining units currently rely on deadlock style key systems.

Only half of the units have a way for patients to raise an alarm in an emergency. There is concern in a number of units that an electronic alarm system for patients would be open to abuse. Those units that have implemented such systems have reported that they are generally used appropriately by patients.

Just five of the eight units fully meet the standard for being well designed and having the necessary facilities and resources for people requiring medium secure care. The main difficulty for those units not meeting the standard is that the physical environment is compromised by the inherent limitations of older buildings.

4: Personal Dignity

Key Findings

Number of standards in Personal Dignity	26
Average percentage of criteria fully met by the 8 units	72%

Achievements

- In all units staff demonstrate respect for patients
- Seven of the units fully meet standards for providing daily access to fresh air and indoor and outdoor space for recreation in a secure perimeter.
- Seven of the units fully meet the standard for enabling patients to sleep in privacy and in areas separate from patients of the opposite sex.

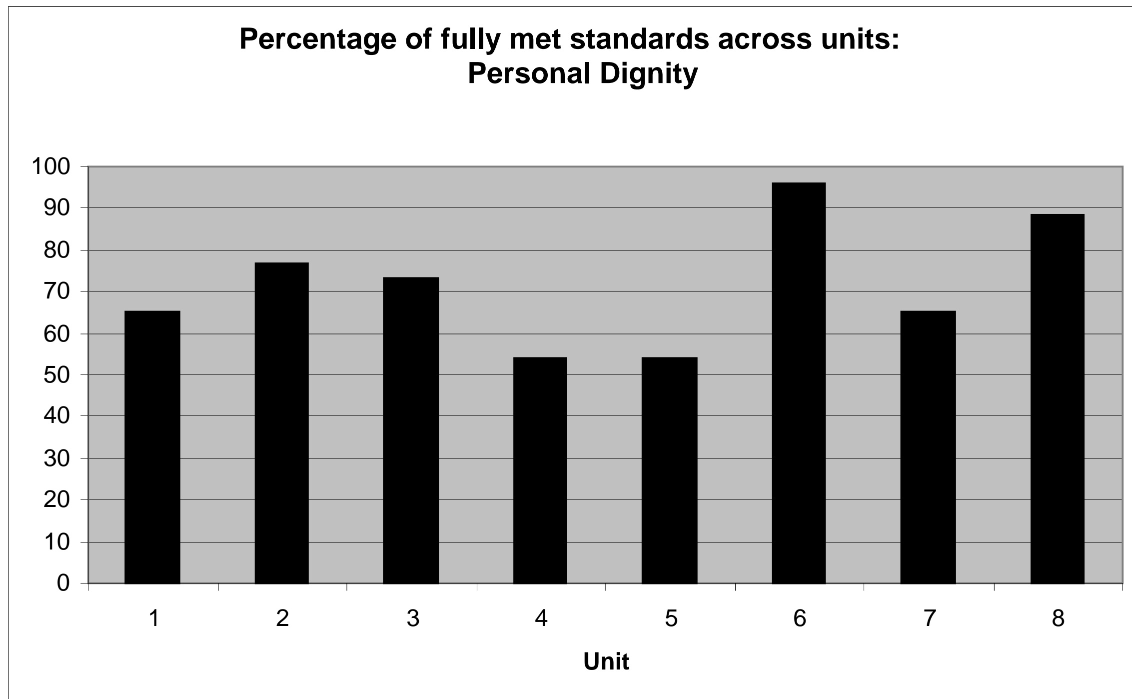
Areas for Improvement

- A quarter of units do not fully meet the standard for ensuring basic patient needs are met for personal dignity, due to constraints of the physical environment.
- Only half of the units provide a good quality and well maintained environment.
- Five units failed to meet standards for general practitioner services
- In the majority of units there is a lack of clear guidelines on sexual issues

Solutions

- Where there are constraints to the physical environment, continue to implement and monitor action plans for the improvement of the environment, and ensure that this is not delayed or postponed, particularly due to possible future relocation of the service.
- Units to ensure that the environment is well maintained, for example, good quality domestic teams are important.
- All units to consider meeting primary health care needs through GP Services and providing Well Woman and Well Man Clinics.
- Units to develop clear guidelines on sexual issues. Sharing policies and training that have been implemented in some units will be useful. The quality network email discussion group will be a useful tool here.

Figure 6.



Achievements

Interviews with over seventy service users found that in all of the units staff demonstrate respect for patients. Indeed, patients consistently spoke of how highly they value their relationships with staff, particularly ward staff such as healthcare assistants, who are often proactive in addressing patient requests.

Seven of the eight units fully meet the standard for enabling patients to sleep in privacy and in areas separate from patients of the opposite sex. Seven of the units also fully meet standards regarding daily access to fresh air, and indoor and outdoor space for recreation in a secure perimeter. Several of the units have developed excellent recreational spaces such as gardens containing art work.

Areas for Improvement

Just half of the units fully meet standards for providing a good quality and well maintained environment. Those not fully meeting the standard require major refurbishment or relocation of the service. Further, a minority of the units do not maintain a satisfactory level of cleanliness. Only three quarters of the units fully meet the standard for ensuring basic patient needs are met for personal dignity. There are good facilities on site in some services, such as shops and hairdressers. However, a quarter of services do not fully meet the standard, for example due to the inadequate provision of bathroom facilities.

There is variable access to primary healthcare services. The majority of services identified this as an area for improvement and do not have

dedicated services on site. Five units failed to meet standards for general practitioner services, although other services, such as dental and laboratory, are met by all of the units. Patients are generally satisfied with the physical healthcare they receive, often from the in-house medical team.

Across the units there are a lack of clear guidelines on sexual issues. This standard is unmet in half of the units. For the most part, staff and patients interviewed lacked an understanding of such issues and reported needing guidelines for their day to day work.

The provision in the units for facilities appropriate to the patient group is variable. Gym and sports facilities are generally good, although in a number of units ward-based facilities are limited. Often a television or games console is the only ward based resource. This is particularly a concern for patients with limited leave from the ward.

5: Core Interventions

Key Findings

Number of standards in Core Interventions	24
Average percentage of criteria fully met by the 8 units	68%

Achievements

- In seven of the eight services, wherever possible, the treatment provided is evidence-based.

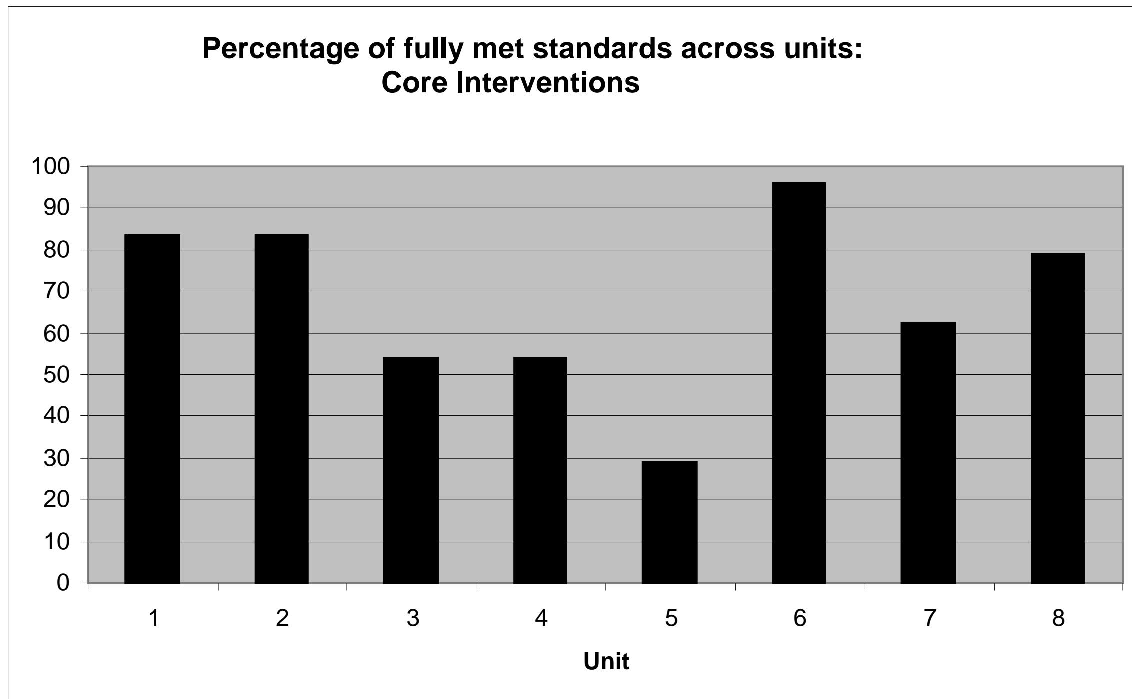
Areas for Improvement

- The majority of services do not provide access to an adequate range of interventions; three of the units fully meet less than 60% of standards.
- Three of the units do not fully meet the standard for the identification and regular reviewing of care pathways.
- Only two of the units contain an adequate number of large and small rooms, adequately designed for individual and group work.
- Half of the units fully meet the standard for involvement in research and development.

Solutions

- All units to review access to core interventions in reference to the standards. It is recommended that a health and social care needs assessment is conducted for the patient group in each service and an action plan compiled based on the needs assessment, including any training and recruitment to meet the needs.
- Implement structures for regular review of care pathways
- Units to review room use in reference to facilitating interventions.
- Units to develop structures for research and development to ensure there is service led approach, disseminated to staff at all levels.

Figure 7.



Achievements

In seven of the eight services, wherever possible, the treatment provided is evidence-based. In the remaining service staff interviewed were unable to answer whether or not this is the case. In the majority of units frontline staff are not aware of the evidence-base for their practice, therefore increasing frontline staff understanding of the care and treatment provided is recommended.

Areas for Improvement

Only three units fully meet 80% or more of standards in this area, with three fully meeting less than 60% of standards. Overall the majority of units are not meeting standards adequately in relation to core interventions

This standard area is characterized by variability across services. Seven of the eight units stated in self and peer-reviews that a range of clinically effective treatments, therapies, recreational and life skills training and support are provided. However, subsequent standards show that the access to these and the specific interventions that are available varies. For example, five of the units fully meet the standard for art therapy, six for cognitive therapy, and three for drama therapy. All of the units fully meet the standard for providing pharmacological interventions. Only two of the units contain an adequate number of large and small rooms, adequately designed for individual and group work and this can limit therapeutic activity.

Three of the units fully meet the standard for providing regular opportunities for patients to work. There is some good practice in this area, with facilities

on site in some services such as shops employing service users, cafes and horticulture opportunities.

In regards to research and audit, findings again vary. Half of the units fully meet standards for involvement in relevant research and development, although all of the units have written research and development policies and procedures. In a number of the units there is not a clear service led approach to research and development; it relies on proactive individuals and a majority of staff, particularly frontline, are not involved.

The identification and regular reviewing of clear care pathways is sufficient to fully meet the standard in five of the eight units. In the remaining units there is good work occurring within the framework of care pathways, however this work is not formalised. Patient pathways in a number of services are structural, that is the pathway concerns progress through the service (i.e. from ward to ward), rather than with a view to independent therapeutic goals.

6: Workforce Development and Training

Key Findings

Number of standards in Workforce Development and Training	11
Average percentage of criteria fully met by the 8 units	65%

Achievements

- All of the units performed highly for standards related to mandatory training and induction programmes.
- Seven of the eight units fully meet standards for workforce training and development strategies.

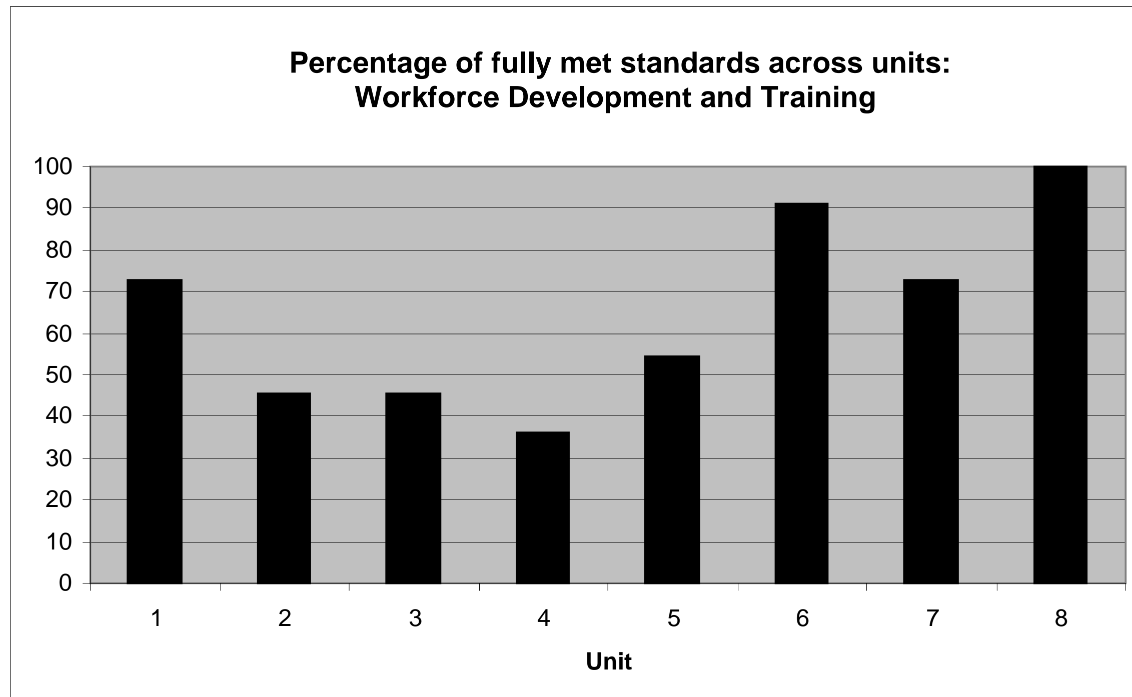
Areas for Improvement

- There are gaps in individual personal development plans for staff and the annual update of these. Nursing staff particularly have a lack of formal structures to implement personal development plans.
- Only a quarter of units fully meet standards for informing training needs through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems.

Solutions

- Implement personal development plans that are updated annually for staff across ALL disciplines.
- All units to consider a unit wide assessment of training needs informed by the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems.

Figure 8.



Achievements

All of the units performed highly for standards related to mandatory training and induction programmes, for example all units fully met the standard for training in the management of imminent and actual violence, breakaway techniques and restraint measures. Inductions across the units are lengthy and comprehensive. Seven of the eight units fully meet standards for workforce training and development strategies.

Areas for Improvement

There are gaps in individual personal development plans for staff and the annual update of these. Only three units fully meet this standard. The majority of units are implementing the Key Skills Framework, although the practical implementation of the guidelines and monitoring is not in place yet in several units. Nurses in particular do not have personal development plans in many units. Further to this only a quarter of units fully meet standards for informing training needs through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems. In the majority of units there is an informal approach, for example proactive individuals approach management with requests for training. There is a lack of formal structures to inform training needs; this is variable across disciplines and is particularly true for nursing staff.

As discussed in Personal Dignity above, units are generally not meeting standards regarding guidelines and training in sexual issues. Only two units fully met the standard for training in the issue of touching and the problem of sexual attraction between staff and patients.

7: Equality and Diversity

Key Findings

Number of standards in Equality and Diversity	3
Average percentage of criteria fully met by the 8 units	79%

Achievements

- All of the patients interviewed reported that issues of equality and diversity are addressed by unit staff.
- All of the units fully meet the standard for providing equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence.
- Seven of the units fully meet the standard for ensuring that telephone numbers for external agencies, such as the Citizens Advice Bureau are available for patients.

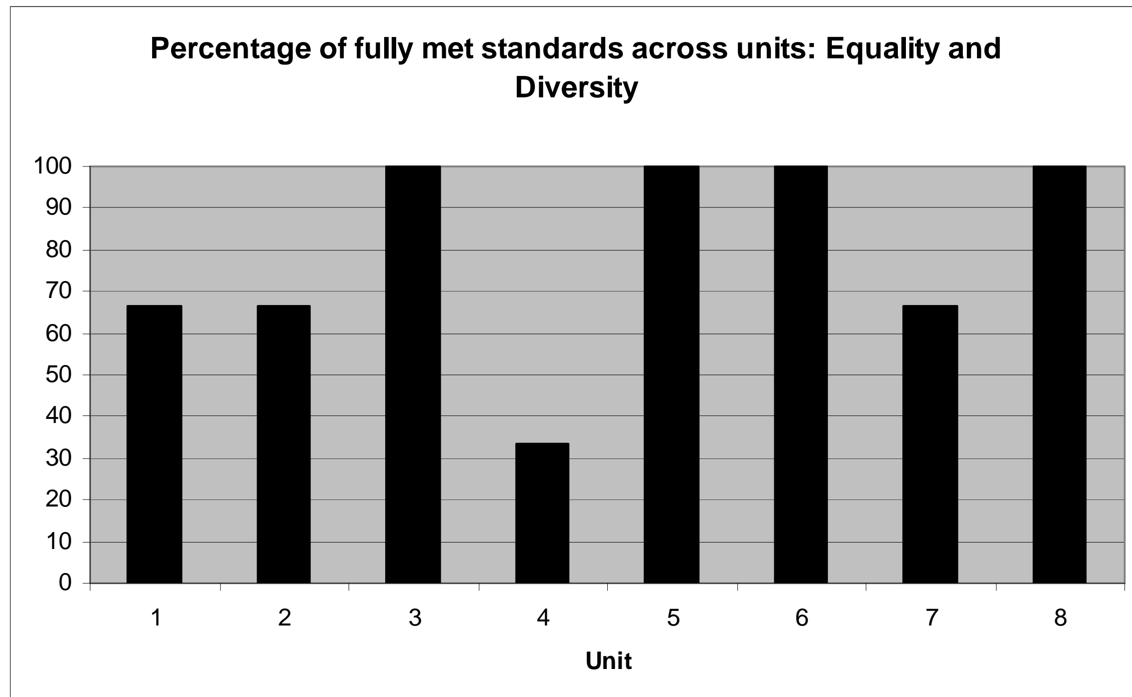
Areas for Improvement

- Addressing issues surrounding the age of patients, for example suitable activities to cater for a range of ages, and particularly older patients, is an area for development generally in the units.
- Generally, unit wide structures for addressing equality and diversity need improving.

Solutions

- Units to address the issue of diversity in the age of patients, for example by providing appropriate activities for older patients.
- Review unit wide structures to address equality and diversity and ensure that this is disseminated to all levels of staff.

Figure 9.



Achievements

In general, patients interviewed expressed satisfaction with how issues of equality and diversity are addressed. Gender issues are addressed across the units, either through providing independent female wards or ensuring that female privacy is maintained in mixed accommodation. Where women only wards are not available, patients provided positive reports; in the majority of these cases mixed wards were reported to be a preference for women. Developing gender specific care is a priority in a number of the member units and there are some good examples of practice in this area (see appendix c).

Units have good resources to meet religious needs, for example all of the units facilitate visits from religious leaders from multi-faith backgrounds and several of the units have multi-faith rooms for prayer and reflection.

All of the units fully meet the standard for providing equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence. Seven of the units fully meet the standard for ensuring that telephone numbers for external agencies, such as the Citizens Advice Bureau are available for patients.

Areas for Improvement

Addressing issues surrounding the age of patients, for example suitable activities to cater for a range of ages, and particularly older patients, is an area for development generally in the units.

More work would be useful in some units to educate staff, given that in two of the units staff interviewed reported that there are no issues to address. This was the case in Unit 4 above, which scored less than 35% of standards fully met in this area.

Meeting patient needs in this area is in some units a result of proactive individuals, rather than unit wide procedure. Several units reported that there is room for improvement to ensure that issues of equality and diversity are fully addressed.

8: Workforce, Recruitment, Retention

Key Findings

Number of standards in Workforce, Recruitment Retention	5
Average percentage of criteria fully met by the 8 units	70%

Achievements

- All of the units have a recruitment policy statement
- All units provide an induction course for all staff prior to any keys being issued.

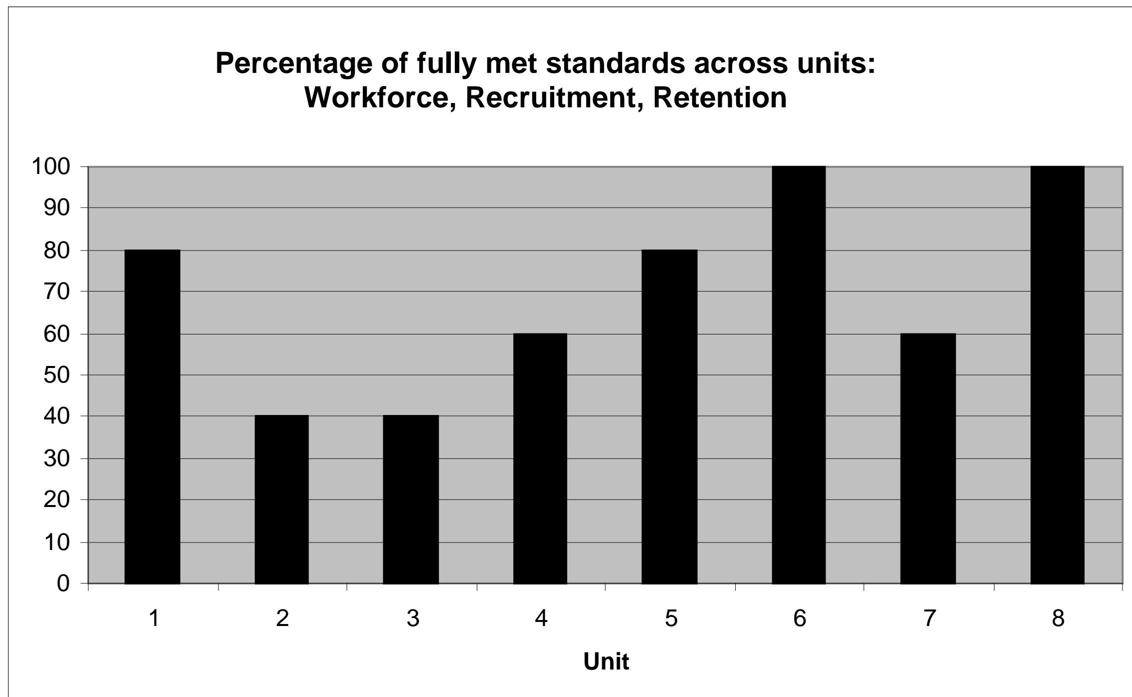
Areas for Improvement

- Only three units provide annual security awareness training
- Only half of the units fully meet the standard for all staff having enhanced CRB clearance.

Solutions

- Ensure security awareness training is implemented for all staff with mandatory updates.
- Where retrospective enhanced CRB checks are limited by funding, units to liaise with the Trust to consider the implementation of a retrospective programme to obtain enhanced CRB clearance for all staff.

Figure 10.



Achievement
All of the units have a recruitment policy statement and all units provide an induction course for all staff prior to any keys being issued.

Areas for Improvement
Only half of the units fully meet more than 60% of standards for workforce, recruitment and retention. Three of the eight units provide annual security awareness training. The units in general are concerned that this standard is not being met, with funding restrictions and the release of staff cited as the major barriers to providing annual updates to training.

Half of the units fully meet the standard for all staff having enhanced CRB clearance. In many units, this is only the case for new employees and is not retrospective. Again, funding issues at Trust level prevent this standard from being met.

9: Supervision and Support

Key Findings

Number of standards in Supervision and Support	7
Average percentage of criteria fully met by the 8 units	20%

Achievements

- Supervision and support structures for the majority of disciplines, such as psychology, occupational therapy, medical and social work generally meet, and indeed exceed, the standards.

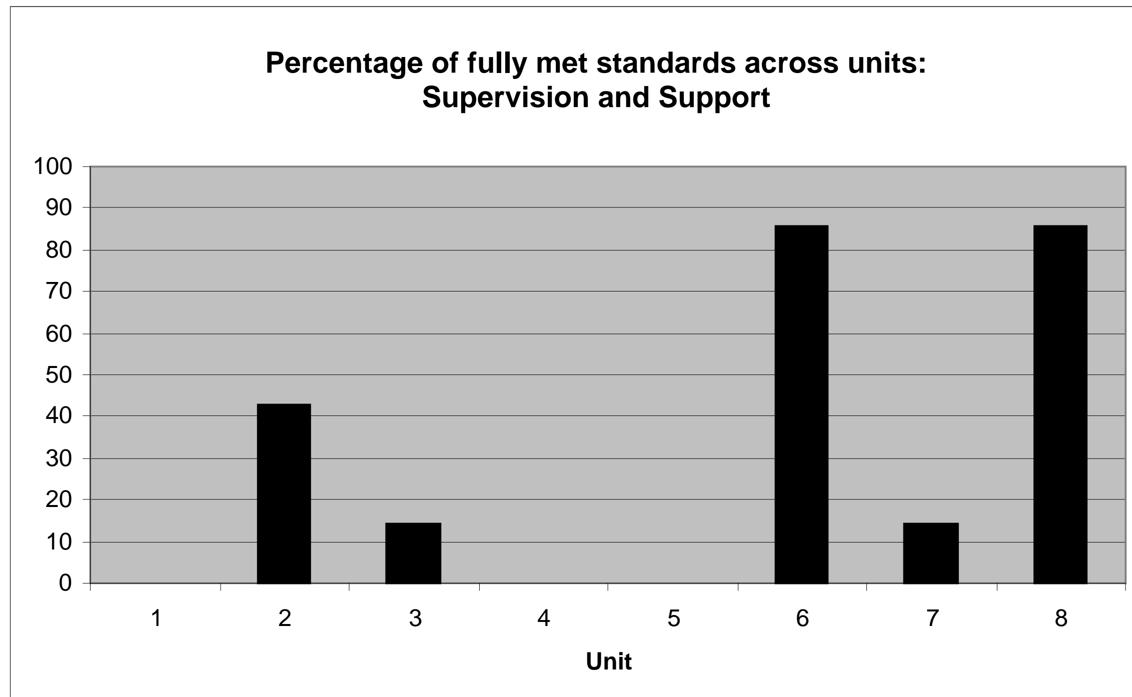
Areas for Improvement

- At present programmes of supervision and support are not meeting the standards for, and subsequently the needs of, nursing staff. Particularly, there is a lack of protected time for nursing supervision, and of regular monitoring and auditing of uptake.
- Group supervision and support for staff is failing to fully meet standards in three quarters of units.

Solutions

- Units to develop structures and strategies to ensure that time for supervision is formally protected for ALL staff.
- Units to ensure that unit wide uptake of supervision and support is regularly monitored and audited.
- Units to introduce regular staff support groups and consider the introduction of reflective practice groups for all staff.

Figure 11.



Achievement

In all of the units, the majority of professions that form the MDT, such as medical, psychology, occupational therapy and social work, have good structures in place for supervision and support and meet standards for a minimum of one hour per month from a colleague with appropriate experience.

Informal support between frontline staff was largely reported to be good and highly valued by the staff.

Areas for Improvement

As shown in Figure 10 above, supervision and support is an area of poor performance for the majority of units. Only three of the eight units fully meet the standard for providing a programme of clinical supervision and support to meet the needs of all staff. In the five units not fully meeting this standard, it is supervision for nursing staff that is inadequate.

The majority of services are failing to provide the recommended minimum of one hour per month supervision for frontline staff. Only a quarter of the services currently meet this standard.

Looking at the factors contributing to inadequate supervision and support, only a quarter of units fully meet the standard for the provision of adequate time to enable staff supervision and support to be delivered. This is particularly true for nursing staff, for whom time is often not formally

protected, and when time is designated, incidents on the ward take priority and the time is simply 'lost'. Another contributing factor to the problem is the lack of regular monitoring and auditing for staff take up of supervision.

In addition to inadequate individual supervision, wider support structures for staff are also failing to meet standards. Again, only a quarter of services are fully meeting standards regarding regular forums for all staff to reflect on their experience of the work and regular staff support groups.

Across the units, frontline staff interviewed expressed enthusiasm for engaging with a programme of supervision and identified it as a key need. It is also true that in some of the units there is work to be done in changing the nursing culture to introduce supervision as an integral component of the role. It was a general consensus across the units that the difficulty in meeting standards for supervision and support for nursing staff is due to cultural resistance. In some cases this is enforced by management, for example supervision may be mandatory for members of the multidisciplinary team, but is 'flexible', and not enforced, for nursing staff.

10: Patient Involvement

Key Findings

Number of standards in Patient Involvement	6
Average percentage of criteria fully met by the 8 units	54%

Achievements

- The services demonstrated evidence of patient involvement across all aspects of the service. Patient involvement is a key area of focus for development in the units.
- Three quarters of units fully meet standards for patient consultation into the unit environment. The majority of units hold regular community meetings.

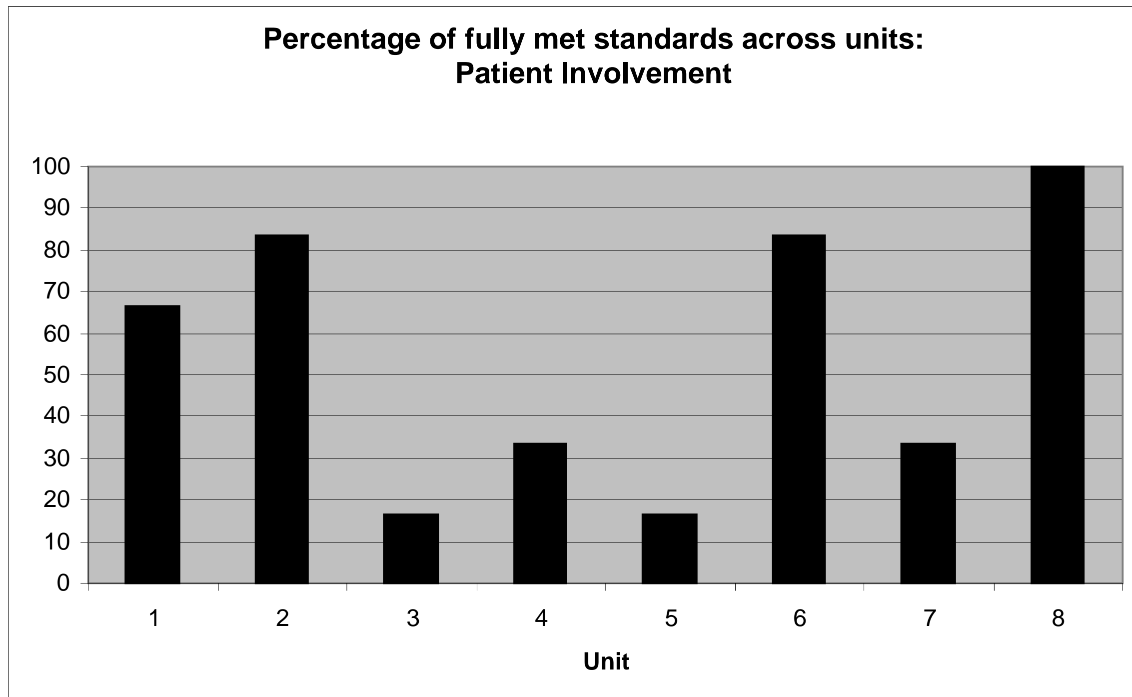
Areas for Improvement

- Only a quarter of the units fully meet the standard for unit wide consultation on policy and procedures; patients are rarely involved.
- The majority of structures in place for patient involvement are new and at a developmental stage. Frontline staff have not been trained in how to implement the structures and solicit meaningful patient involvement, particularly in regards to care.
- The approach to patient involvement in care is fragmented, for example not all patients have access to their care plan, with variance evident within units.

Solutions

- Units to consider implementing a forum or stream of communication for disclosing policies to patients and consulting on the development of policies where possible. Patient representation in clinical governance is a potential solution.
- Units to develop existing structures for patient involvement, for example, train staff in how to implement structures.
- Ensure that all patients have access to their care plans, for example, via a primary nurse or CPA co-ordinator.

Figure 12.



Achievement

The services demonstrated evidence of patient involvement across all aspects of the service. Half of the units fully meet this standard and half partly. In general, patient involvement is an area of focus across the units and many of the structures in place are new and at a developmental stage. There are several examples of good practice (see appendix c). Patient involvement is an area in which sharing practice across units will be particularly useful as structures are developed.

With regards to care, all of the units demonstrated patient involvement to some extent, half of the units fully meet the standard regarding involvement in the development of care plans, and half partly meet it. Primary nurses and care coordinators are particularly valued in ensuring that patients have access to care plans and are consulted on decisions regarding care. An example of good practice in patient involvement in care is units that involve patients in the development of treatment and activity programmes via formal meetings.

The majority of units hold regular community meetings, usually ward based, to discuss the environment. In some units patients reported that the forums in place result in tangible action, for example, new items of furniture; in others that they are tokenistic. All of the units encourage patients to personalise their bedrooms, although the limits imposed are variable. Newer services have sought patient consultation in their design.

Patient views are sought as part of service development, for example feedback from patients and carers is used to improve the quality of the unit, with half of the units fully meeting this and half partly meeting it. Methods for doing so include user and carer forums including representatives across wards and patient meetings with senior management. How much action these forums result in is variable.

Areas for Improvement

There is a need for structures for patient involvement in care to be formalised. Within units the approach is often fragmented, for example, in some cases patients do not have access to their care plan if they do not have a primary nurse that is proactive. Patients attend case reviews and ward rounds across the units. It is widely the case that patients attend the meetings at the end only, and thus many patients find the process somewhat tokenistic and do not feel they can make any meaningful contribution to decisions regarding their care.

Only a quarter of the units fully meet the standard for unit wide consultation on policy and procedures, including patients. Generally policies are not readily accessible to patients and patient input is not sought in the development. Those services that do seek patient input have patient representatives in clinical governance and/or patient reference groups via which policy and procedures are disseminated to patients.

11: Advocacy

Key Findings

Number of standards in Advocacy	3
Average percentage of criteria fully met by the 8 units	96%

Achievements

- Seven of the eight units fully met every standard in this area. Every unit provides access to an independent advocacy service and patients are actively encouraged and given support, to contribute to their care.

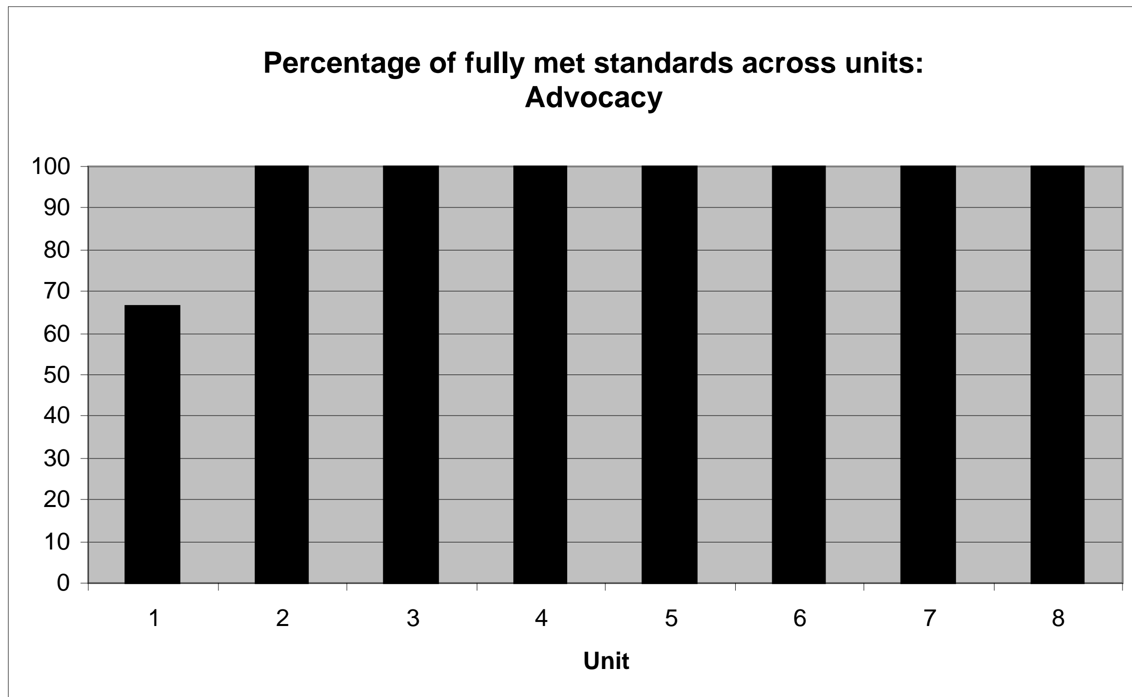
Areas for Improvement

- Patients interviewed at the admission level often had a limited awareness and understanding of the role of advocacy.

Solutions

- Provide information tailored to patients' need at the admission level to explain the role of independent advocacy.

Figure 13.



Achievements
All of the units performed highly against the standards relating to advocacy. Indeed as Figure 12 shows, seven of the eight units fully meet all of the standards in this area. An independent advocacy service is in place and is easily accessible in seven of the units, with the remaining service partly meeting the standard. Advocates regularly visit patients and also attend meetings with them, for example community meetings. Patients interviewed value the independent service provided by advocates and generally demonstrated a clear understanding of its role.

In all of the units, service users are actively encouraged and given support, including independent advocacy, to contribute to their care and all of the units provide information on how to get independent help and advocacy in making complaints.

Areas for Improvement
It would be beneficial to increase the awareness and understanding of advocacy services at the admission level, as the patients interviewed at this level often have a limited awareness of the service.

12: Carer Involvement

Key Findings

Number of standards in Carer Involvement	1
Average percentage of criteria fully met by the 8 units	63%

Achievements

- Generally, services have implemented structures to provide, and are seeking to progress, meaningful carer involvement in both individual patient care and the wider service.

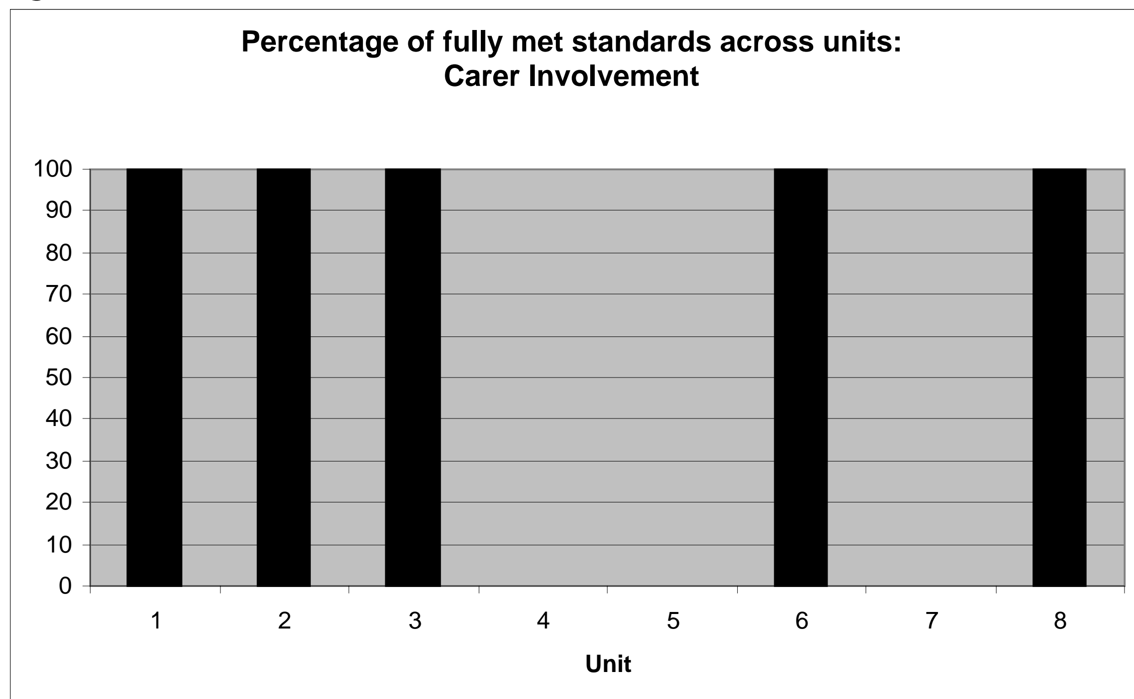
Areas for Improvement

- Three of the services are yet to develop and/or implement a policy covering the consultation and involvement of carers in the care provided.

Solutions

- All services to implement a policy covering the consultation and involvement of carers in the care provided. The email discussion group for the quality network may be a useful tool for services to share such policies.

Figure 14.



Achievements
Five of the eight units fully meet the standard regarding policy for the consultation and involvement of carers in the care provided.

Whether or not there is a policy regarding carer involvement, there are examples of good practice across the units. Carers are invited to attend care reviews and there are a number of carer forums.

Areas for Improvement
The attendance to carer forums has been variable; units reported that there are often constraints imposed by the wide geographical area covered by some of the services. For the majority of services carer groups are a relatively new initiative and there is progress to be made in seeking and obtaining meaningful carer involvement in both patient care and the wider service.

13: Interagency Working

Key Findings

Number of standards in Interagency Working 3

Average percentage of criteria fully met by the 8 units 79%

Achievements

- All of the units are involved in interagency working, most successful is involvement in MAPPA and links with local authorities.

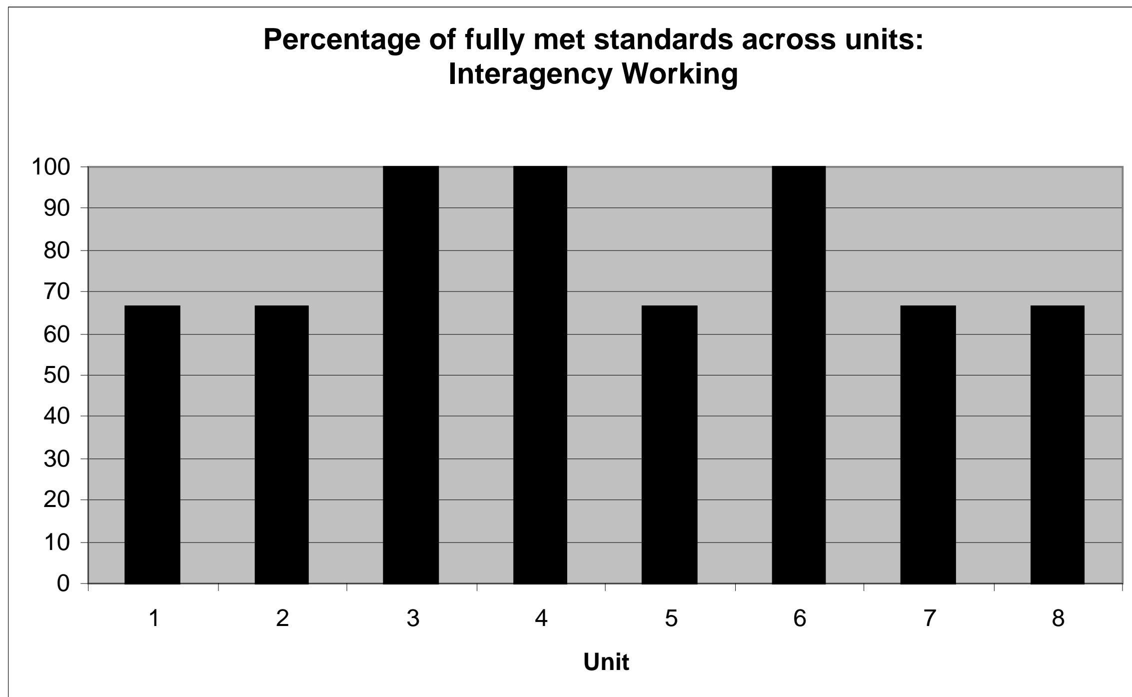
Areas for Improvement

- Only half of the units fully meet the standard for interagency working.

Solutions

- All units to fully develop interagency working and form formal links for interagency working, including meeting regularly with other MSUs, drug action teams, the police, community mental health teams, external probation and local community services.

Figure 15.



Achievements

All of the units are involved in interagency working; half of the units fully meet the standard and half partly. Generally, areas of good practice include regular MAPPA attendance and good links with local authorities. Links with police liaison officers are generally good, however, there were some reports from management staff interviewed that there are difficulties in obtaining an appropriate police response to staff assaults; these are reportedly not taken seriously in some cases.

For the two remaining standards in this area, all of the units facilitate and co-operate with the Mental Health Act Commission visits and seven of the units fully meet the standard regarding an identified duty doctor available at all times to attend the unit.

Areas for Improvement

Although all of the units are involved in interagency working, as stated above. half are not fully meeting the standard. Management staff interviewed reported that forming links when a service covers a wide, in some cases national, catchment area is difficult. It is important that this is improved as interagency working contributes to relational security and has a significant impact on patient care.

In those services that are partly meeting the standard for interagency working it is often the case that there are no formal interagency links in place, but links are formed on a case-by-case basis.

14: Management

Key Findings

Number of standards in Management	4
Average percentage of criteria fully met by the 8 units	88%

Achievements

- Management structures are generally an area of achievement, with three of the four standards in this area fully met in all units.

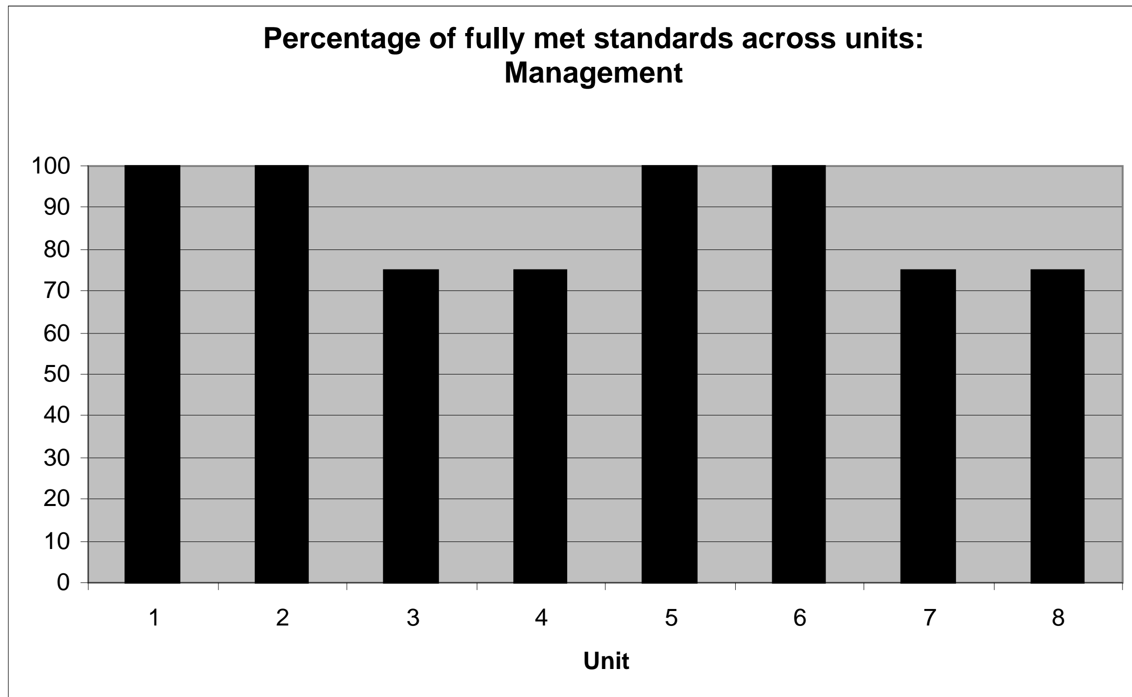
Areas for Improvement

- Only half of the services fully meet the standard for data collection to meet the requirements of the Mental Health Minimum Data Set (MHMDS). This was in part due to unfamiliarity in services with these requirements.

Solutions

- All UK services to familiarise staff with the requirements of the MHMDS and to ensure that data collection meets the requirements.

Figure 16.



Achievements
Three standards in this area are fully met in every unit. All units have clear governance arrangements for secure services at Board level; finance management systems in place which ensure financial probity; and management of patient information compliant with Caldicott.

Areas for Improvement
Half of the units did not fully meet the standard regarding collection of data to meet Mental Health Minimum Data Set requirements. This was largely because services are not familiar with these requirements, or they are not applicable, for example in non-UK services.

APPENDIX A: AGGREGATED DATA

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	1: Relational Security					
	Relational Security – Admission and Assessment					
1.1	Units have systems and processes in place that ensure good quality multi-disciplinary assessment prior to admission (Please use the comments section to provide brief details)	4	4	0	0	0
1.2	The assessment takes into account relevant history, problems, issues, legal status and risks	8	0	0	0	0
1.3	There is a clearly defined process for the admission of people to the unit	7	1	0	0	0
1.4	There are written referral criteria	6	1	0	1	0
1.5	Staff and patients provide written information about the unit that addresses the need of prospective patients, referrers and other relevant professionals	5	1	2	0	0
1.6	The information provided contains a clear description of the aims of admission, the current programme and modes of treatment	2	4	2	0	0
1.7	Measures are in place to record and audit refusals, terminated referrals and waiting lists	7	1	0	0	0
1.8	Where patients are refused admission to the service, the reasons for refusal are explained to the person and referrer, and they are informed about alternative options	6	2	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
1.9	Those presenting high risk or with more severe conditions are given priority with assessment	7	0	0	1	0
1.10	All patients have an initial treatment plan in place within 24 hours following admission	6	2	0	0	0
1.11	All patients on admission have an initial risk assessment	7	1	0	0	0
	Relational Security - Care and Treatment					
1.12	All patients are managed within the framework of the CPA process	6	0	0	0	2
1.13	The staff team develop a written care pathway in consultation with each patient, within the limits of safety and risk assessment	4	4	0	0	0
1.14	Patients are given a copy of the management or care plan or have ready access to it	5	3	0	0	0
1.15	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)	4	4	0	0	0
1.16	There are regular case reviews in line with good practice ECC/CPA guidelines	8	0	0	0	0
	Relational Security - Care and Treatment					
1.17	There are processes in place which demonstrate an evaluated staffing profile to meet the needs of the patients (e.g. skills assessment and needs assessment)	5	3	0	0	0
1.18	There are clear and effective systems for communication and handover within staff teams	2	6	0	0	0
1.19	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	7	1	0	0	0
1.20	The ratio of Consultant Psychiatrists to medium secure beds is 1: 14	3	2	3	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
1.21	There are multi-disciplinary teams identified as part of the staffing establishment, with each team including psychiatrists, nurses, psychologists, occupational therapists, and social workers	5	3	0	0	0
1.22	There is at least one nurse holding the RMN qualification on duty at all times	8	0	0	0	0
1.23	At least (four) staff hold an appropriate qualification on duty per shift and (two) at night-time (Grade E-H)	5	2	1	0	0
1.24	A typical unit with 10-12 places includes at least one WTE SpR or equivalent	5	1	2	0	0
1.25	A typical unit with 10-12 places includes at least one level two SHO	6	0	2	0	0
1.26	In a typical unit about one WTE clinical psychologist is provided	3	4	1	0	0
1.27	In a typical unit about one WTE Occupational Therapist is provided	6	2	0	0	0
1.28	1.0 WTE social work input is provided in a typical 10-12 bed unit	5	2	1	0	0
1.29	The unit has access to a substance misuse specialist or dual diagnosis specialist either working as part of an integrated or parallel model	4	4	0	0	0
1.30	The unit has access to a range of practitioners offering psychotherapeutic sessions	5	3	0	0	0
1.31	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	4	3	1	0	0
1.32	All staff can demonstrate an understanding of their role in relation to meeting the complex needs of patients	5	3	0	0	0
1.33	The variance between staff in post and establishment is minimised	5	2	1	0	0
1.34	The number of nursing staff on the unit is sufficient to safely meet the needs of the patients at all times	7	0	1	0	0
1.35	Extra nursing cover is available when needed, e.g. there is access to additional on-call staff in emergency	7	1	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
1.36	The unit is staffed by permanent staff and agency staff are used only in exceptional circumstances	5	3	0	0	0
1.37	There are published and monitored plans to deliver therapy and treatments in line with planned programmes	6	2	0	0	0
	Relational Security - Risk and Safety					
1.38	The unit provides an annual report on risks and incidents to enable the unit to learn from risks and provide a safer environment	6	2	0	0	0
1.39	The unit promotes an open, blame-free culture for reporting incidents	8	0	0	0	0
1.40	There is a policy on clinical risk assessment	7	1	0	0	0
1.41	The unit keeps records of the following measures concerning risk assessment:	5	2	0	0	1
1.42	Number of periods of escorted access taken by in-patients	7	1	0	0	0
1.43	Number of periods of unescorted access taken by in-patients	7	1	0	0	0
1.44	Number of abscondings from escorted access as percentage of escorted access taken	5	2	0	0	1
1.45	Number of failures to return from unescorted access as percentage of access	5	2	0	0	1
1.46	Number of escapes within last 12 months	7	0	0	0	1
	Relational Security - Discharge and Transfer					
1.47	The place of discharge is known before admission where possible	4	3	1	0	0
1.48	There is a frequent decision-making forum, e.g. weekly ward rounds rather than monthly reviews, to prevent unnecessary delays to discharge	7	1	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
1.49	Discharge target are agreed as part of the discharge planning process	4	2	0	1	1
1.50	When a patient needs to transfer to services for older people, a joint review is undertaken to ensure effective hand-over takes place	6	0	1	0	1
1.51	A CPA meeting is held for all patients to plan discharge	7	0	0	0	1
1.52	Section 117 meetings are held prior to the discharge of all patients detained under a treatment section of the Mental Health Act	6	0	0	0	2

	2: Procedural Security					
2.1	There are relevant, accessible, authorised, up to date policies (no more than 3 years old) and procedures in place to address the areas of practice identified above.	8	0	0	0	0
	Procedural Security - Care and Treatment					
2.2	There are written admission and discharge procedures	5	3	0	0	0
2.3	There are written policies and procedures that implement the requirements of the Care Programme Approach (CPA)	6	0	0	0	2
2.4	There is a procedure regarding obtaining consent from patients	7	1	0	0	0
	Procedural Security - Risk and Safety					
2.5	There is a policy in place on the management of aggression and violence which is compliant with NICE 25	6	2	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
2.6	The unit has procedures for the management of bullies and for those who have been bullied	6	2	0	0	0
2.7	There is a policy in place for the observation and monitoring of patients who are at risk of suicide	8	0	0	0	0
2.8	The procedure for resuscitation of patients is clearly documented, resuscitation equipment is available and its location is clearly identified	8	0	0	0	0
2.9	There are policies, procedures and guidance for infection control practice	7	1	0	0	0
2.10	There is a searching policy in relation to patients, visitors, bedrooms, and off ward areas	8	0	0	0	0
2.11	There are contingency plans agreed with the police and emergency services (NICE 25) covering as a minimum: hostage taking, serious disorder, riot, escape	6	1	1	0	0
2.12	There is a policy on the control of illicit substances covering (a) treatment of substance misuse; (b) education on the dangers of substance abuse; c) advice to visitors on the dangers of passing illicit/unauthorised substances; (d) a protocol with police for when drugs are discovered; (e) a policy on "searching with cause" for drugs	6	2	0	0	0
2.13	There is a policy for administering drugs at dosages above BNF recommendations	5	2	1	0	0
2.14	There are clear contingency plans in place which meet NICE Clinical Guideline 25 Systems (including: systems to ensure the management of serious incident, systems for review (both internal and external to organisation), methods to ensure learning, audit process of actions with timescales following review, and clear lines of responsibility and accountability)	7	1	0	0	0
2.15	There is a policy for prompt response to staff alarms	8	0	0	0	0
2.16	There is a procedure for evacuation in case of fire which is rehearsed at regular intervals	5	3	0	0	0
2.17	There is a procedure in place to ensure that perimeter fence inspection processes are audited	7	0	1	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
2.18	There is a protocol in place for the risk assessment of patient access to telephones, the internet and cameras	6	1	1	0	0
2.19	Units have in place appropriate procedures to manage the risks created by the movement of patients with the unit and externally (e.g. for hospital/court visits), visitors and staff proportionate to the level of risk posed, and the effect of those measures on the rights of patients, staff and visitors, and the patients quality of life.	6	2	0	0	0
	Procedural Security – Responsibilities and Rights					
2.20	There is a policy in place to ensure issues of equality and diversity are regularly monitored	5	2	1	0	0
2.21	The unit has a written complaints procedure	8	0	0	0	0
2.22	The unit holds data in compliance with legislation (including the Data Protection Act 1984, MAPPA, Caldicott Principle) to ensure maintenance of confidentiality	7	1	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	3: Physical Security					
3.1	The physical security protects the privacy and dignity of patients, facilitates their care and treatment, prevents the passing in of contraband items and offers a protection to the public such as to make escape/abscond difficult. (A number of issues are covered in this statement. It may be helpful to provide a general response here and use the standards below to provide more detail).	7	0	1	0	0
	Physical Security - Perimeter					
3.2	There is a defined perimeter	6	2	0	0	0
3.3	There is EITHER (a) a 5.2m single weld mesh fence surrounding the whole unit (note: fences below 5.2m are not secure fences but anti-dash fences) OR (b) a combination of a 5.2m single weld mesh fence and buildings including reception creating a secure area OR (c) perimeter security designed into the unit consisting of connected buildings, including reception, creating a secure area	6	1	1	0	0
3.4	Where there are separate buildings they are connected and create a secure area	3	1	2	0	2
3.5	The perimeter is inspected	7	0	1	0	0
3.6	There is planned and recorded daily inspection of the perimeter to detect damage and/or contraband	5	0	2	0	1
3.7	There is planned and recorded weekly inspection of the perimeter to detect damage and/or contraband	3	0	1	0	4
3.8	There are longer planned periods between inspections of the perimeter	1	0	1	0	6

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	Physical Security - Access and Egress					
3.9	Access and egress is via reception	6	0	2	0	0
3.10	Access/egress to the secure unit is granted via an airlock controlled from reception	6	0	2	0	0
3.11	Access/egress to the secure unit is granted by a single door controlled from reception	0	0	1	0	7
3.12	Entry is controlled from reception	5	0	2	0	1
	Physical Security - Locking System and Keys					
3.13	There is a secure locking system in place	6	1	1	0	0
3.14	There is a secure locking system - either manual, electronic, magnetic or a combination of these, with backup replacement in the event of a compromise or failure AND a separate locking suite for doors/locks within the perimeter or providing access to it	6	0	2	0	0
3.15	There is a secure locking system - either manual, electronic, magnetic or a combination of these, with a separate locking suite for doors/locks within the perimeter or providing access to it, but with no backup replacement	0	0	2	0	6
3.16	Checking of secure keys takes place	7	0	1	0	0
3.17	Secure keys are accounted for and reconciled by reception twice daily, normally at end of main shift and at night (Note that reconciliation of keys means that all keys held in reception and issued are accounted for in a single check)	6	0	2	0	0
3.18	Secure keys are accounted for and reconciled by reception once daily	1	0	0	0	7
3.19	Secure keys are accounted for and reconciled by reception less than once a day	0	0	0	0	8

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	Physical Security – Alarms					
3.20	All staff who work in the secure unit are issued with a personal alarm	7	1	0	0	0
3.21	There is written evidence that staff personal alarms are regularly tested	5	1	2	0	0
3.22	There is a way for patients to raise an alarm in an emergency	4	0	4	0	0
	Physical Security - Restraint and Seclusion					
3.23	The unit operates within the appropriate legal framework in relation to the use of physical restraint	8	0	0	0	0
3.24	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	7	1	0	0	0
3.25	If seclusion is used, there is a designated seclusion facility available, which is designed to minimise risk of injury and where the patient is continually monitored	6	1	0	0	1
	Physical Security- Environment and Facilities					
3.26	The unit is well designed and has the necessary facilities and resources for people requiring medium secure care	5	1	2	0	0
3.27	There are areas with clear lines of sight to enable staff to monitor patients who need closer observation	4	4	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
3.28	Entrances and exits are designed to enable staff to see who is entering or leaving	4	3	1	0	0
3.29	Patients have supervised access to computers with relevant risk assessment	6	2	0	0	0
3.30	The unit is managed in line with Health and Safety legislation and guidance	8	0	0	0	0
3.31	All confidential case materials, e.g. notes, are kept in locked cabinets or locked offices	7	1	0	0	0
3.32	There is a policy in place for child visiting/contact with children	8	0	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A

	4: Personal Dignity					
	Personal Dignity - Healthcare Access and Provision					
4.1	There is good access to primary healthcare services	2	4	2	0	0
4.2	There is access to good quality physical healthcare and screening	3	4	1	0	0
4.3	The in-patient team has good access to a range of services, as appropriate to the needs of the patients. These include the following:	4	4	0	0	0
4.4	General practitioner services	2	1	5	0	0
4.5	Laboratory services	8	0	0	0	0
4.6	Neurological, cardiology and dental services	7	1	0	0	0
4.7	Substance and alcohol misuse services	6	2	0	0	0
	Personal Dignity - Responsibilities and Rights					
4.8	Staff demonstrate respect for patients	8	0	0	0	0
4.9	It is explained how complaints may be made without the knowledge and involvement of the person complained of	4	3	1	0	0
4.10	Staff are made aware of complaints that are relevant to their work and the outcome of the complaints process	7	1	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
4.11	Staff ensure basic needs are met to ensure personal dignity (e.g. privacy, clothing etc)	6	2	0	0	0
4.12	Patients may sleep in privacy and in areas separate from patients of the opposite sex, within the limits of safety and risk assessment.	7	1	0	0	0
4.13	The food provided is of a good standard	5	2	1	0	0
4.14	All aspects of food procurement, production, preparation, storage, transportation and delivery comply with current legislation, regulations and guidelines	8	0	0	0	0
4.15	Patients have access to a telephone in a private area, within the limits of safety and risk assessment	4	4	0	0	0
4.16	Patients have regular access to fresh air (usually daily)	7	1	0	0	0
4.17	There is indoor and outdoor space for recreation within a medium secure perimeter	7	1	0	0	0
4.18	There are clear guidelines on sexual issues	3	1	4	0	0
4.19	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	6	1	0	0	1
4.20	Restriction of liberty of the patient occurs within the appropriate legal framework, under the provision of the Mental Health Act	8	0	0	0	0

	Personal Dignity - Environment and Facilities					
4.21	The environment is good quality and well maintained	4	3	1	0	0
4.22	There is a designated dining area	8	0	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
4.23	There are facilities appropriate to the patient group, e.g. a pool table and board/console games are provided	6	2	0	0	0
4.24	There are facilities for patients to make their own hot and cold drinks and snacks	5	2	1	0	0
4.25	Books and magazines are provided in recreation areas for patients	7	1	0	0	0
4.26	Access to media (e.g. TV, video, audio and internet) is monitored with safeguards in place	7	1	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	5: Core Interventions					
	Core Interventions - Care and Treatment					
5.1	There are clear care pathways identified which are reviewed regularly	5	3	0	0	0
5.2	There is a range of clinically effective treatments, therapies, recreational and life skills training and support available A number of issues are covered in this statement. It may be helpful to provide a general response here and use the standards below to provide more detail).	7	1	0	0	0
5.3	A structured therapeutic programme is run during weekdays	7	1	0	0	0
5.4	A comprehensive range of treatments is available at the unit. This will depend upon the nature of the group of patients, but is likely to include:	5	3	0	0	0
5.5	Art therapy	5	1	2	0	0
5.6	Behavioural therapy	6	0	1	0	1
5.7	Cognitive therapy (e.g. CBT, brief solution focused therapy, anger management)	6	2	0	0	0
5.8	Drama therapy	3	1	4	0	0
5.9	Drug therapy	8	0	0	0	0
5.10	Family therapy and family work	3	5	0	0	0
5.11	Group therapy	5	3	0	0	0
5.12	Music therapy	4	1	3	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
5.13	Occupational therapy	7	1	0	0	0
5.14	Offender related treatments (where these are not part of the core programme units have access to specialist offender programme such as SOTP)	4	4	0	0	0
5.15	Social skills training	7	1	0	0	0
5.16	Wherever possible the treatment provided is evidence-based	7	0	0	1	0
	Core Interventions - Environment and Facilities					
5.17	The unit contains an adequate number of large and small rooms, adequately designed for individual and group work	2	5	1	0	0
5.18	There is a room large enough for staff and patients to meet, where everyone can see and hear each other	7	1	0	0	0
5.19	Interactive learning material and software is provided	7	1	0	0	0
5.20	Patients have regular opportunities to work	3	4	1	0	0
5.21	There is effective, patient centred multi disciplinary working, with clear and agreed leadership	3	5	0	0	0
	Core Interventions - Research and Audit					
5.22	The service is involved in relevant research and development	4	3	1	0	0
5.23	There are clearly written research and development policies and procedures which form part of a clinical and social care governance process	7	1	0	0	0
5.24	The programme of activities offered is planned in consultation with patients	4	3	1	0	0
5.25	The unit engages in meaningful clinical quality assurance	4	4	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	6: Workforce Development and Training					
6.1	There is a workforce training and development strategy in place	7	1	0	0	0
6.2	All staff have an individual personal development plan which is updated annually	3	4	1	0	0
6.3	Training has been provided in the following:	4	1	0	0	0
6.4	Clinical governance	4	3	1	0	0
6.5	Culturally sensitive practice, disability awareness, and other equality issues	6	2	1	0	0
6.6	Legal frameworks such as the Mental Health Act 1983 and the revised Code of Practice	7	1	0	0	0
6.7	Management of imminent and actual violence, breakaway techniques and restraint measures	8	0	0	0	0
6.8	Resuscitation	8	0	0	0	0
6.9	The issue of touching in general and the problem of sexual attraction between staff and patients	2	3	3	0	0
6.10	Unit managers who are nursing staff have had further training in management and team leadership	6	2	0	0	0
6.11	Training needs are informed through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems - all have been assessed in the last year	2	6	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	7: Equality and Diversity					
7.1	Issues of equality and diversity are addressed (e.g. issues surrounding gender, sexuality, race, religion and age)	4	4	0	0	0
7.2	There is equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence	8	0	0	0	0
7.3	Telephone numbers for external agencies are available (e.g. Citizens Advice Bureau, statutory regulatory body, Commission for Racial Equality)	7	1	0	0	0
	8: Workforce, Recruitment, Retention					
8.1	There is a recruitment policy statement.	8	0	0	0	0
8.2	All staff receive an induction course prior to any keys being issued	8	0	0	0	0
8.3	All staff receive annual security awareness training	3	2	3	0	0
8.4	All staff have enhanced CRB clearance	4	3	1	0	0
8.5	Reasons for staff leaving are established, particularly where there is a high staff turnover, e.g. exit questionnaires or interviews are used	5	3	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	9: Supervision and Support					
9.1	There is a programme of clinical supervision and support to meet the needs of all staff	3	5	0	0	0
9.2	Adequate time is made available to enable staff supervision and support to be delivered	2	6	0	0	0
9.3	Staff take up of supervision and support is regularly monitored and audited	3	4	1	0	0
9.4	All staff receive regular supervision totaling at least one hour per month from a person with appropriate experience	2	5	1	0	0
9.5	Junior staff have regular supervision totaling at least one hour per week and are able to contact a senior colleague as necessary	3	4	1	0	0
9.6	There are regular forums for all staff to reflect on their experience of the work	2	6	0	0	0
9.7	There is a regular staff support group, ideally weekly	2	4	2	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	10: Patient Involvement					
10.1	There is evidence of patient involvement in all aspects of the service (e.g. regarding care, patients attend review meetings, have access to copies of care plans and give informed consent. Regarding the service, patient views are sought as part of service development, for example via patient involvement groups) (A number of issues are covered in this statement. It may be helpful to provide a general response here and use the standards below to provide more detail).	4	4	0	0	0
10.2	Patients are actively involved in the development of their management or care plan	4	4	0	0	0
10.3	Patients are consulted about the unit environment and have choice when this is appropriate	6	1	1	0	0
10.4	Patients are encouraged to personalise their bedroom spaces. (Must be appropriate. Pictures of nude bodies may be offensive or pictures of children inappropriate i.e. paedophiles)	6	2	0	0	0
10.5	Feedback from patients and carers is used to improve the quality of the unit	4	4	0	0	0
10.6	The unit's policy and procedures are agreed through discussion with the whole unit	2	6	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	11: Advocacy					
11.1	An independent advocacy service is in place and is easily accessible	7	1	0	0	0
11.2	Service users are actively encouraged and given support, including independent advocacy, to contribute to their care	8	0	0	0	0
11.3	There is information available on how to get independent help and advocacy in making complaints	8	0	0	0	0
	12: Carer Involvement					
12.1	There is a policy on consultation and involvement of carers in the care provided	5	2	1	0	0
	13: Interagency Working					
13.1	There is inter-agency working (e.g. meeting regularly with other MSUs, drug action teams, the police, community mental health teams, external probation and local community services)	4	4	0	0	0
13.2	The Mental Health Act Commission visits are facilitated and co-operated with	8	0	0	0	0
13.3	There is an identified duty doctor available at all times to attend the unit	7	1	0	0	0

	Standard	Met	Partly Met	Unmet	Don't Know	N/A
	14: Management					
14.1	There are clear governance arrangements for secure services at Board level	8	0	0	0	0
14.2	There are finance management systems in place which ensure financial probity	8	0	0	0	0
14.3	The management of patient information complies with Caldicott.	8	0	0	0	0
14.4	There is accurate information which meets the requirements of the MHMDS	4	0	1	2	1

APPENDIX B: MEMBER UNITS 2006-2007

Central Mental Hospital – Health Service Executive

Fromeside Clinic – Avon and Wiltshire Mental Health Partnership NHS Trust

Humber Centre – Humber Mental Health Teaching NHS Trust

Newton Lodge – South West Yorkshire Mental Health NHS Trust

Ravenswood House - Hampshire Partnership NHS Trust

Shannon Clinic – South and East Belfast Trust

St Andrews Health Care

Three Bridges – West London Mental Health NHS Trust

APPENDIX C: MEMBER UNIT INITIATIVES

Relational Security

Team Name	Achievement	Contact Name	Contact Number	Contact Email
The Central Mental Hospital	Implementation of the Treatment and Care Plan approach (TCP). This is not a statutory requirement in the Irish jurisdiction and CMH is the only service working to this model, which mirrors the UK Care Programme Approach	Professor Harry Kennedy	00353 1298 9266	harry.kennedy@maild.hse.ie
Three Bridges	Established MDT DASS team to cascade substance misuse work to ward level in an integrated model.	Dr Paul Gilluley	020 8354 8755	paul.gilluley@wlmht.nhs.uk
The Humber Centre	Development and implementation of the Integrated Clinical Pathway as overarching clinical strategy for the service, with clear outcome requirements.	Dr Simon Wood Mr. Barrie Green	01482 336200	simon.wood@humber.nhs.uk barrie.green@humber.nhs.uk

Ravenswood House	Development of a Team CPA Handbook to facilitate the implementation of the Care Programme Approach and ensure work is consistent across teams.	Malcolm Campbell	01329 836000	malcolm.campbell@wht.nhs.uk
Shannon Clinic	An Essential Lifestyle Plan is completed for each patient prior to admission	Nichola Goodfellow	028 9091 6800	Nichola.Goodfellow@sebt.n-i.nhs.uk
Newton Lodge	Development of the role of Clinical Nurse Specialists to lead treatment teams. For example, a CNS drug and alcohol abuse specialist.	Mr John Wiggins	01924 328642	John.wiggins@swyt.nhs.uk

Procedural Security

Team Name	Achievement	Contact Name	Contact Number	Contact Email
Central Mental Hospital	Active research programme in patient consent and capacity.	Professor Harry Kennedy	00353 1298 9266	harry.kennedy@maild.hse.ie

Physical Security

Team Name	Achievement	Contact Name	Contact Number	Contact Email
The Humber Centre	Operating under a model of 'gender fluidity'. The physical environment allows flexibility, in accommodating female patients either in a mixed or single sex environment, based on the wishes of the individual.	Dr Simon Wood	01482 336200	simon.wood@humber.nhs.uk
Fromeside Clinic; Shannon Clinic	Recently developed medium secure care in commendable therapeutic physical environment.	Patrick Neville; Noel McDonald	01173784114; 028 9091 6800	Patrick.neville@awp.nhs.uk; Noel.McDonald@sebt.n-i.nhs.uk
Fromeside	Healthcare assistants work rotations to run the exchange and checking of secure keys.	Jenny Tonkin	0117 3784115	Jenny.tonkin@awp.nhs.uk

Personal Dignity

Team Name	Achievement	Contact Name	Contact Number	Contact Email
The Central Mental Hospital	A commendable onsite gardening project.	Professor Harry Kennedy	00353 1298 9266	harry.kennedy@maild.hse.ie
The Humber Centre	Issuing of electronic passes for those patients who have reached an appropriate level of risk assessment to enable independent access to outdoor areas in the secure perimeter.	Mr Barrie Green	01482 336200	barrie.green@humber.nhs.uk
Ravenswood House	Central shared staff/patient dining room	Malcolm Campbell	01329 836000	malcolm.campbell@wht.nhs.uk

Core Interventions

Team Name	Achievement	Contact Name	Contact Number	Contact Email
Three Bridges	Creative therapists occupy a role in the core multidisciplinary team	Dr Paul Gilluley	020 8354 8755	paul.gilluley@wlmht.nhs.uk

St Andrew's Healthcare	Implementation of a 12 week rolling psychosocial multi-disciplinary treatment programme, developed with patient consultation.	Dr Clive Long, Head of Psychology	01604 616311	CLong@standrew.co.uk
St Andrew's Healthcare	Implementation of a financial incentive programme to encourage patient participation in activities. Attendance is audited and feedback given.	Dr Clive Long, Head of Psychology	01604 616311	CLong@standrew.co.uk
Fromeside	Central therapy unit onsite to facilitate specialised therapeutic interventions and work opportunities.	Julie Somerville	0117 3784154	Julie.somerville@awp.nhs.uk
Newton Lodge	Development of joint working between psychology and nursing and a robust and well supported primary nurse system.	Mr Jim Gardner	01924 328642	Jim.gardner@swyt.nhs.uk

Workforce Development and Training

Team Name	Achievement	Contact Name	Contact Number	Contact Email
St Andrew's Healthcare	Provision of gender specific induction programmes in addition to the hospital wide induction.	Men's Service Carol Rooney, Senior Nurse Manager Women's Service Jason Martin, Clinical Development Facilitator	01604 616488 01604 616696	CRooney@standrew.co.uk JMartin@standrew.co.uk
Shannon Clinic	Development of the healthcare assistant role, e.g. encouraging assistants to register their skills and interests and for these to be developed, such as with further training, to facilitate patient activities.	Colette McCorry-Hotchkiss	028 9091 6800	Colette.McCorry-Hotchkiss@sebt.n-i.nhs.uk

Workforce, Recruitment and Retention

Team Name	Achievement	Contact Name	Contact Number	Contact Email
Ravenswood House	Successful recruitment drive, using innovative methods such as CD ROMS about the service and surrounding area, and following up all expressions of interest.	Malcolm Campbell	01329 836000	malcolm.campbell@wht.nhs.uk

Supervision and Support

Team Name	Achievement	Contact Name	Contact Number	Contact Email
Three Bridges	All wards have reflective practice and/ or staff support groups. Further, working groups have been tasked to reviewing how to best meet staff needs for supervision and support.	Dr Paul Gilluley	020 8354 8755	paul.gilluley@wlmht.nhs.uk
Fromeside	A Clinical Supervision Steering Group has generated action points to be taken to staff via ward-based link nurses.	Nikki Churchley	0117 3784142	Nikki.churchley@awp.nhs.uk

Newton Lodge	Supervision and support structures in place to develop the role of primary nurses.	Mr Jim Gardner	01924 328642	Jim.gardner@swyt.nhs.uk

Patient Involvement

Team Name	Achievement	Contact Name	Contact Number	Contact Email
Three Bridges	The unit's policy and procedures are agreed through discussion with the whole unit	Dr Paul Gilluley	020 8354 8755	paul.gilluley@wlmht.nhs.uk
Central Mental Hospital	Implementation of regular meetings between patients and senior management.	Professor Harry Kennedy	00353 1298 9266	harry.kennedy@maild.hse.ie
The Humber Centre	Comprehensive patient involvement structures to function at all levels, from residential areas to wider strategic involvement. Includes a Hospital Managers Visiting Scheme.	Mr Mike Cheeseman	01482 336200	mike.cheeseman@humber.nhs.uk

Ravenswood House	Introduction of a Patient Reference Group, with responsibilities including recruiting patients to attend QNFMHS interviews and developing paid roles.	Malcolm Campbell	01329 836000	malcolm.campbell@wht.nhs.uk
Shannon Clinic	Ward level meetings, either daily or weekly according to ward, to plan the core day in consultation with patients.	Noel McDonald	028 9091 6800	Noel.McDonald@sebt.n-i.nhs.uk
Fromeside	Service User Involvement Worker employed; Carer involvement (Friends and Family work)	Cathy Tunnock; Jeremy Dixon	0117 3784113; 0117 3784128	Cathy.tunnock@awp.nhs.uk; jeremy.dixon@awp.nhs.uk

Advocacy

Team Name	Achievement	Contact Name	Contact Number	Contact Email
Central Mental Hospital	A peer-advocacy service.	Professor Harry Kennedy	00353 1298 9266	harry.kennedy@maild.hse.ie

St Andrew's Healthcare	Access to advocacy services available on a speed dial from private ward telephones. Ward specific clinic times for the advocacy services.	Paul French, Speaking Up Advocate	01604 616552	
Shannon Clinic	Carer advocate employed in addition to the service user role.	Sylvia Cooke	(028) 9056 5656	

Interagency Working

Team Name	Achievement	Contact Name	Contact Number	Contact Email
St Andrew's Healthcare	Hospital placed community beat officer. Training offered to police officers including ward placements	Carol Rooney, Senior Nurse Manager	01604 616488	CRooney@standrew.co.uk

APPENDIX D: PROJECT TEAM

John O'Grady
Consultant Forensic Psychiatrist Ravenswood House, Chair of Forensic Faculty, Royal College of Psychiatrists

Tessa Hughes
Quality Improvement Worker, Quality Network for Forensic Mental Health Services

Paul Lelliott
Consultant Psychiatrist/Director, College Research & Training Unit

Sarah Tucker
Programme Manager, Quality Network for Forensic Mental Health Services

Adrian Worrall
Head of Centre for Quality Improvement

APPENDIX E: ADVISORY GROUP

Malcolm Campbell
Service Manager, Ravenswood House

Lorna Duggan
Consultant Forensic Psychiatrist, St Andrews Health Care

Mike Gatsi
Senior Nurse, Three Bridges Regional Secure Unit

John O'Grady (Chair)
Consultant Forensic Psychiatrist Ravenswood House, Chair of Forensic Faculty, Royal College of Psychiatrists

Tessa Hughes
Quality Improvement Worker, Quality Network for Forensic Mental Health Services

Andrew Johns
Consultant Forensic Psychiatrist, Dennis Hill Unit

Harry Kennedy
Consultant Forensic Psychiatrist, The Central Mental Health Hospital

Paul Lelliott
Consultant Psychiatrist/Director, College Research & Training Unit

David Ndegwa
Clinical Director - Lambeth Forensic Services

Sarah Tucker
Programme Manager, Quality Network for Forensic Mental Health Services

Roland Woodward
Head of PD and Forensic Services, Affinity Healthcare

Adrian Worrall
Head of Centre for Quality Improvement

Charity registration no. 228636

Quality Network for Forensic Mental Health Services
Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor, 21 Mansell Street,
London E1 8AA
Telephone: 020 7977 6665/6661
Fax: 020 7481 4831
Email: msu@cru.rcpsych.ac.uk
Website: http://www.rcpsych.ac.uk/msu

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