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ROYAL COLLEGE OF PSYCHIATRISTS

FORENSIC
QUALITY NETWORK
FOR FORENSIC
MENTAL HEALTH SERVICES

QNFMHS
National Report
Cycle 15-9
2023 - 2025

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Contents

Artwork displayed on the front cover: 'Fishing in the wild' created by a patient at Ridgeway.

FOREWORD

It gives me great pleasure to introduce the seventh National Report published by the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services. The report is based on the data collected from member services who completed their peer-reviews against the Fifth Edition of the Standards for Forensic Mental Health Services in Cycle 15-9 and the first accreditation reviews of services since the opportunity for accreditation was introduced to the Network - held between 2023-2025.

Throughout this review period, we are delighted to report that 18 forensic inpatient wards participated in the new accreditation process, engaging in peer-review cycles that assessed their adherence to QNFMHS standards against a threshold that merits the formal accreditation that we are now awarding. To maintain confidentiality, the wards are represented by anonymised service codes.

We hope that forensic mental health service providers will find this report a useful tool in supporting them to think about how they approach implementing the QNFMHS standards in their services, and how they use their reviews and action plans as iterative means of making positive changes to improve quality and the way services are delivered to the patients in our inpatient care pathways. I applaud those services who have so far signed up for the challenge of achieving accreditation. Huge congratulations to our successfully accredited wards; I hope that others will be inspired to stretch themselves in this way and achieve this recognition of their hard work in the years to come.

The Quality Network would not be able to operate, or to support meaningful change and quality improvement in secure services, without the input of people who have accessed services, and their carers, who are generous in sharing their experiences and views as to what excellent care should look and feel like. We are immensely grateful to be able to include this perspective throughout this report.

As ever, I would like to express my sincere thanks to the QNFMHS team, my colleagues on the Advisory Group, the members of the Network, the patient and carer representatives who have committed their time and energy to working tirelessly for the Network to ensure its smooth running and support our development work. I am extremely grateful for the support they give me, and for their dedication in promoting our values and commitment to excellence and continuous improvement in quality of services and outcomes.

Lastly (and I seem ever to say this) in times of stretched resources, it is more important than ever that we use those we have as effectively as possible, and that we prioritise and focus on quality, in order to safely and sustainably provide effective care for people who need mental health care in secure services, their families, and their friends.

Dr Jude Deacon,

Chair of the QNFMHS Advisory Group

Within my role as chair of the Quality Network for Forensic Mental Health Services (QNFMHS) accreditation committee for secure services, it feels particularly rewarding to see services achieve their goals using the framework. We are seeing services improve local patient safety and experience processes which is exactly what the system is designed to achieve.

As we reflect on the past two years, it is evident that our commitment to excellence, collaboration and continuous improvement remains at the heart of all that we do. Our

efforts have resulted in measurable improvements in quality, safety and service delivery, thanks to the hard work and passion of our staff, carer and patient groups. The Network's success is a testament to the strength of our collaborative approach, where sharing best practice and learning from one another is central to our success.

I would like to extend my thanks to everyone involved in the Quality Network. Your ongoing commitment to quality improvement ensures that we continue to deliver positive outcomes for the communities we serve. The stories and insights contained within this report not only celebrate our accomplishments but also highlight areas for further development and innovation.

Jo Faulkner

Chair of the QNFMHS Accreditation Committee

It's a real pleasure to have been asked to write the foreword for this report, which demonstrates the Network's commitment to recognising carers and fully involving them in the process. There are a number of things which stand out for me in the report.

I'm impressed with the clarity and accessibility of the report making it a document which usefully explains the standards to someone unfamiliar with them. Add the section on "How to use your Developmental Report," and the door is open for more involvement of patients and carers in the process. I welcome this approach; last year I visited a service that involved patients in writing the feedback for the workbook thereby giving them a sense of ownership. They also had patients proudly showing the review team round and they clearly understood why we were visiting the service.

Looking at the Standards Compliance, it's helpful to see where services are achieving and where work needs to be done. It provokes questions- have ward environments improved as a result of reducing restrictive practices? Why do the domains requiring people to speak face to face and relate, have a lower compliance rate? Questions stimulate conversations which lead to improvements. Even identifying the most commonly unmet standards is helpful as recommendations are given for improvement which of course is what the Network is all about.

It's always a privilege to be part of any review where my perspective, as a carer allows me to see things differently and to offer gentle challenges. At times I'm overwhelmed by the kindness I see in services which is why the patient, carer and staff spotlight was the most interesting. Despite the continued struggle to maintain the workforce it's reassuring to hear that the majority of patients feel listened to and can identify a trusted member of staff they can talk to. The number of patients who don't feel involved in developing their care plan is concerning, though it doesn't take away from the positive, person centred care I've witnessed on reviews.

Many staff now have access to reflective practice and have a dedicated staff room which feels a really important step forward though I'm saddened that less than half the staff can take their breaks, generally because of workforce pressures. During the reviews, we've spoken to many committed staff, where conversations reveal how creative their thinking is regarding the welfare of the patients, and the way they support each other as a team.

With less than one carer questionnaire being returned per ward it's difficult to see how carers really feel about the services. When we speak to carers during a review they are generally grateful for the care their relative receives and the support they are given. While there are pockets of excellent carer engagement it's clear from the report that there is still

much more to be done. The newly formed Carer Lead Network is therefore a hopeful addition to the Network.

I love the work I do with the Network as I meet so many dedicated and thoughtful people. There are always highlights from each cycle, the staff member looking for something for a patient to do “so he feels valued”, the patient who sang in the corridor mesmerising the people around her and the carers who continue to support and love their relatives in these services.

So, finally, to anyone who is connected in anyway with the Network a heartfelt thank you for all the work you do.

Sheena Foster

Carer Representative QNFMHS

I am someone that likes to get stuck in when it comes to most aspects of my life, maybe because I am nosey and I don’t want to miss anything. Also, it is something I do when on a peer-review, and yes again, because I’m nosey and I don’t want to miss anything. Also, because every piece of the puzzle makes the end result. So, for these 2 years, this document is the end result and without every piece of the puzzle being part of the report it would be left with a missing piece and not completely complete. So, I’m not going to just solely focus on what the patient’s experience has been just because I’m a patient representative and not because I don’t think that it is not important because I feel the patients perspective is paramount to the peer review process, but co production is also paramount to a patients recovery process. In this foreword, because I like to get stuck in, I will focus on all aspects of this document and my experience of the many units I have visited over this period. The staff at the Royal College of Psychiatrists have taught me that my input in all the areas is important and key to the peer review process (I hope they don’t change their mind after this foreword).

I will start with the patient perspective. When you're in hospital against your will nothing is going to 100% perfect. In fact, when I was in my forensic unit everything was 110% NOT perfect, and everybody is different.....so let’s just get it over with now..... the food....everyone, even if it was the most famous chef in the country was cooking the food, everyone has different tastes so although this standard isn’t always met, what matters is that the food is nutritious and healthy and let’s face it that’s not what we always want- so maybe this is why.

When you have 88% of patients feeling they are treated with compassion, dignity and respect, yes we still want to worry about food but to me this 88% is amazing. What I always say to patients is that I feel this is one of the most important questions and considering I would have been one of the 12% at the time, then I think you’re doing an awesome job. Having spoken to many patients and hearing comments like “the staff really care and always have time for me” is just so refreshing to hear and I’ve heard similar comments from patients from different units across the country.

As it points out in the report, units are struggling with providing meaningful activities for patients, especially on the evenings and weekends and I think this is often down to lack of staff, as the staff have brought this up within the frontline staff meetings I’ve been in.

I also think this links in with care plans and that only 33% are getting a copy or being involved in their care plan. I think this is vitally important and I think it would be great if we could get this percentage up in the next aggregated report, so if you’re reading this then

maybe try one small thing that could make a massive difference to your patients, such as engaging in a short one to one to specifically talk about their care plan.

Some of the things I've seen staff doing with patients and things I have heard on the review days just whilst doing the walk around, such as the rapport that staff have with patients and just the general attitude (that you CAN'T fake just for a review day) is inspiring and knowing that wards have some seriously amazing people working on them makes me feel really proud of you all!

I know there are things that staff struggle with because we are all human. Things such as post incident support. This is so important for staff as it's not just the patients that feel traumatised after an incident. As I said we're all human and staff care and will be affected. Having things like reflective practice that is attended regularly and is not always on the same day and time so that everyone has an opportunity to attend is so important. But specifically having someone available or access to a debrief or some kind of post incident support for not just patients but the staff as well, as I know things I have done in the past on a ward would have had an effect on the staff and to avoid burn out and just to make sure your staff are cared for as well post incident support is really important.

I'm only going to say one thing about carers because I've gone over my suggested word count and I do not want to tread on Sheena's toes as she put things so eloquently. But carers MUST be included even when consent to share has been withdrawn. Staff can still listen to what the carer has to say and you ARE allowed to tell the carer that their loved one is safe. I ask that all staff be aware of the consent to share rules because there is nothing worse than not knowing if your loved one is safe or not.

I just want to say a heartfelt thank you to all the staff, patients and carers that took the time to speak to me on a review days and just to amplify what an amazing job you are all doing.

And to any patient reading this (because it would be really good if patients were to have the opportunity to read this report) that one saying that got me through my time is secure care and to this day "it isn't about waiting for the storm to pass but learning to dance in the rain". There is hope!

Hannah Moore

Patient Representative QNFMHS

ACKNOWLEDGEMENTS

The QNFMHS team are grateful for the continued support received from both governance groups, the Accreditation Committee and the Advisory Group. Thank you to our valued lived experience representatives (both current and previous) for all of their perspectives and involvement on the programme from its inception to date. Also, thank you to the services who are members of QNFMHS and included in this report, we hope that this provides a useful benchmarking tool and to highlight good practice examples. We would also like to thank previous members of the QNFMHS team and other CCQI colleagues for support with the development of this report, including Ella Hibbs-Newman.

INTRODUCTION

WHO WE ARE

The Quality Network for Forensic Mental Health Services (QNFMHS) was established in 2006. It is one of nearly 30 quality improvement initiatives, research and audit projects within the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). Member services are reviewed against the Network's published specialist standards for forensic mental health services.

WHAT WE DO

We adopt a supportive, multi-disciplinary approach to quality improvement in forensic services. We serve to identify areas for improvement through a culture of openness and enquiry, adopting a model of engagement rather than inspection. QNFMHS facilitates quality improvement through a comprehensive peer-review process, celebrating and sharing good practice as identified by staff, patients and carers.
For more information on the Network and our processes, please visit our QNFMHS website.

AIMS OF THIS REPORT

This national report serves several key aims:

- **Explore Trends**: By presenting aggregated data, this report seeks to identify patterns across member wards, shedding light on compliance rates with QNFMHS standards, and highlighting both strengths and areas for improvement within the wards.
- **Encourage Continuous Improvement**: Through detailed analysis, the report aims to promote continuous quality improvement in forensic mental health services by identifying good practices, providing feedback, and offering guidance to wards engaged in or considering the accreditation process.
- **Support Best Practices**: The report not only benchmarks performance but also offers practical recommendations and showcases quality initiatives to help wards on their journey towards providing higher standards of care.
- **Facilitate Peer Learning**: By sharing the experiences of QNFMHS services, the report aims to foster collaboration where member wards can learn from each other's successes and challenges.

JARGON BUSTER

QUALITY IMPROVEMENT:
'Quality improvement' throughout this report will refer to the process of working with and supporting psychiatric intensive care units to become effective, safe and patient-centred. We use our quality standards to assess performance and make realistic and achievable recommendations for service improvement.

NETWORK STANDARDS

QNFMHS assess low and medium secure services in accordance with a set of standards. The standards have been developed with extensive consultation with multidisciplinary professionals involved in the provision of forensic services, and with experts by experience who have used services in the past.

The standards are used to generate a series of data collection tools for use in the self- and peer-review processes. Participating teams rate themselves against the standards during their self-review. Standards are for service providers and commissioners to help them ensure they provide high quality patient-centred care to people with enduring mental illness and their carers.

STANDARD TYPES

QNFMHS standards are divided into three types:

Type 1 Standards: Standards that encompass criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment.

Type 2 Standards: Criteria that a ward would be expected to meet.

Type 3 Standards: Criteria that are desirable for a ward to meet, or criteria that are not the direct responsibility of the service.

STANDARD DOMAINS

QNFMHS standards are grouped into 15 domains:

1) Admission and Assessment
2) Physical Healthcare
3) Treatment and Recovery
4) Medication Management
5) Patient Experience
6) Family, Friends and Visitors
7) Ward Environment
8) Physical Security
9) Procedural Security
10) Relational Security
11) Safeguarding
12) Workforce
13) Workforce Training and Support
14) Reducing Restrictive Practices
15) Governance

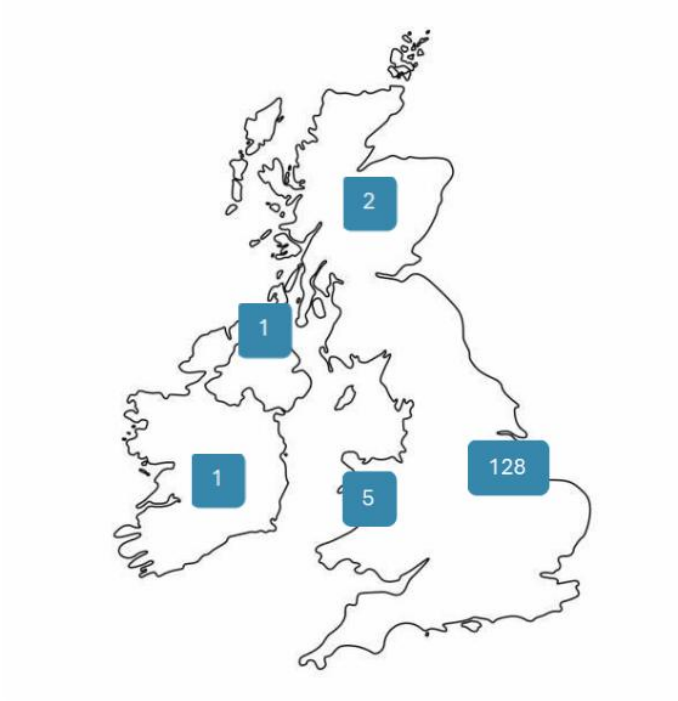
To achieve every standard is aspirational, and it is not expected that a service would meet every standard on the day of their peer-review visit.

MEMBERSHIP

DEVELOPMENTAL

In Cycle 15-9, there was a total of 97 Developmental Reviews, 77 Full Reviews, 15 Open Discussions and 12 cancellations.

An Open Discussion is an opportunity for services to meet with a review team for two hours online to discuss service priorities, achievements and challenges. These sessions are an option for services who do not have the capacity to complete a full or developmental review.



ACCREDITATION

Between 2023-2025, 18 accreditation reviews took place.

BENEFITS

All services signed up to QNFMHS will have access to a range of membership benefits. These are summarised below:

DATA COLLECTION

811
Carers completed questionnaires

2,460
Patients completed questionnaires

7,929
Staff completed questionnaires

379
Wards

79
Trusts and Organisations

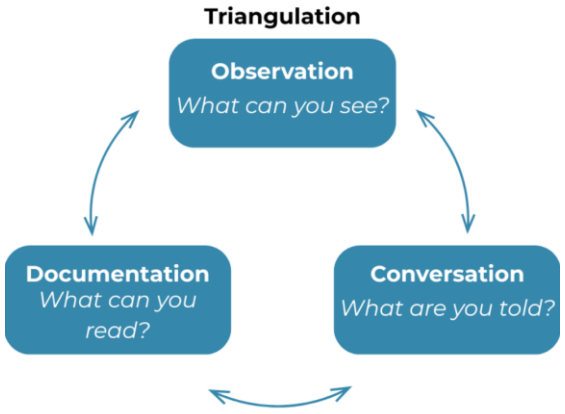
Contextual data was obtained from the information completed by services at the beginning of their self-review period.

How is a standard scored 'Met'?

We base the decision to score a standard as 'Met' on both the self-review findings and the evidence gathered during the peer-review day.

We collect evidence in three primary ways: through observation, conversation (including surveys) and documentation review (accreditation reviews only). If most of this information shows that the ward is meeting the standard's requirements, we mark it as 'Met'.

This approach, known as data triangulation, helps us balance any weaknesses in one set of data with the strengths of others, resulting in more dependable and credible results.



CONTEXTUAL DATA

This section provides an overview of the contextual information gathered from services reviewed against the QNFMHS standards between 2023 - 2025. We collect this information during the self-review process to help gain an overview of the forensic services, such as waiting times, referrals and staffing numbers. The data has been collected from those services that provided this information. Where the data has not been provided or is unclear, this has not been included in the figures.

Figure 1: Number of wards per security type

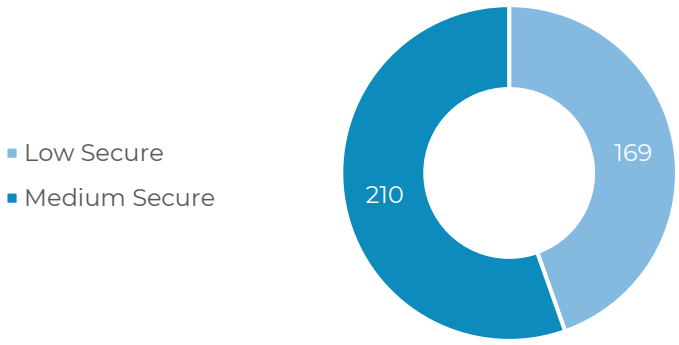
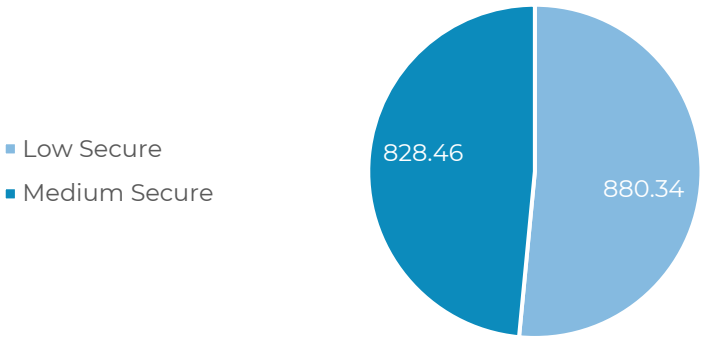


Figure 2: Average length of stay (in days) per security type



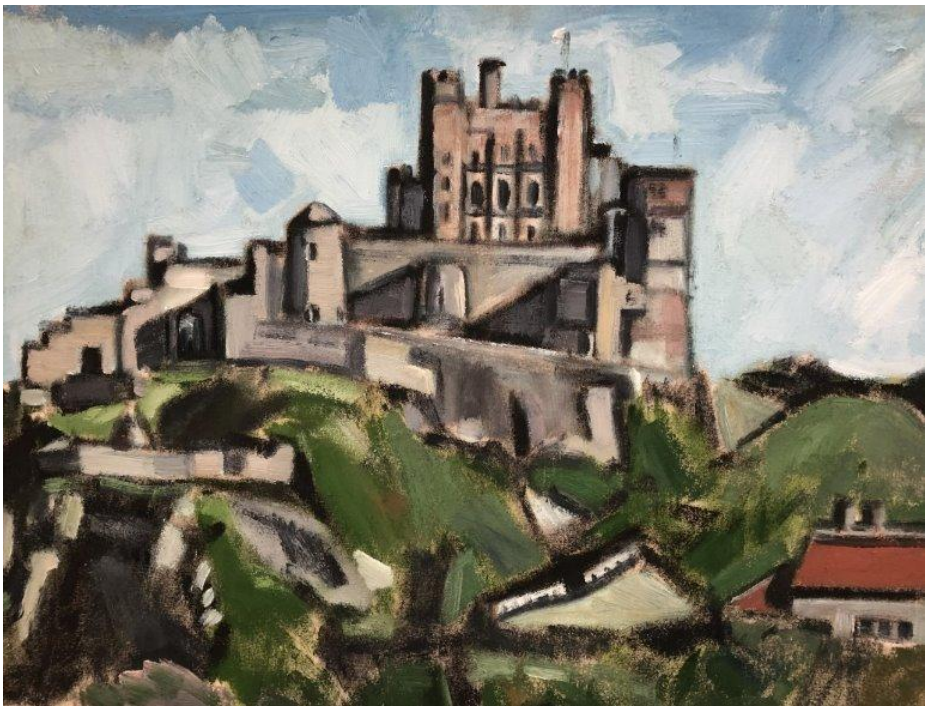
Category	Low Secure	Medium Secure	Total
Beds	2,152	2,785	5,190
Average Length of Stay (in days)	880.34	828.46	858.77
Referrals (in the past 12 months)	2,229	2,261	4,700
Admissions (in the past 12 months)	648	851	1,579
Referrals Accepted	29.07%	37.63%	33.60%

STAFFING BREAKDOWN

Data was collected on the staffing whole time equivalent (WTE) of each service. The average staffing numbers can be seen on the table below:

Profession	Average Low Secure WTE	Average Medium Secure WTE	Total Average WTE
Consultant Psychiatry	1.88	4.73	2.97
Non-consultant medical input	1.51	3.43	2.30
Psychology	2.50	5.35	3.71
Occupational Therapy	3.06	7.82	4.87
Social Work	1.34	3.28	2.08
Ward Manager	2.07	4.82	3.12
Nursing	19.78	51.66	31.51
Healthcare Assistants	31.62	78.66	48.76
Education Staff	0.43	0.76	0.55
Dietician	0.35	0.53	0.41

Some services highlighted having other staff as part of their team. Those who completed this information highlighted having access to roles such as, activity co-ordinators, fitness instructors, CBT therapist, drama therapist, music therapist, art therapist, speech and language therapist, addiction recovery worker, discharge co-ordinator, dual diagnosis nurse, co-production lead, inequalities lead, peer-support worker, carer liaison worker and engagement co-ordinator.



'Bamburg Castle' created by a patient at Thornford Park Hospital.

STANDARDS COMPLIANCE

All services were assessed on their compliance with the fifth edition of the QNFMHS standards (2023). Accreditation review data has not been included here as member services must meet approximately 90% of standards to be accredited.

On average, Cycle 15 members fully complied with 61% of QNFMHS standards.

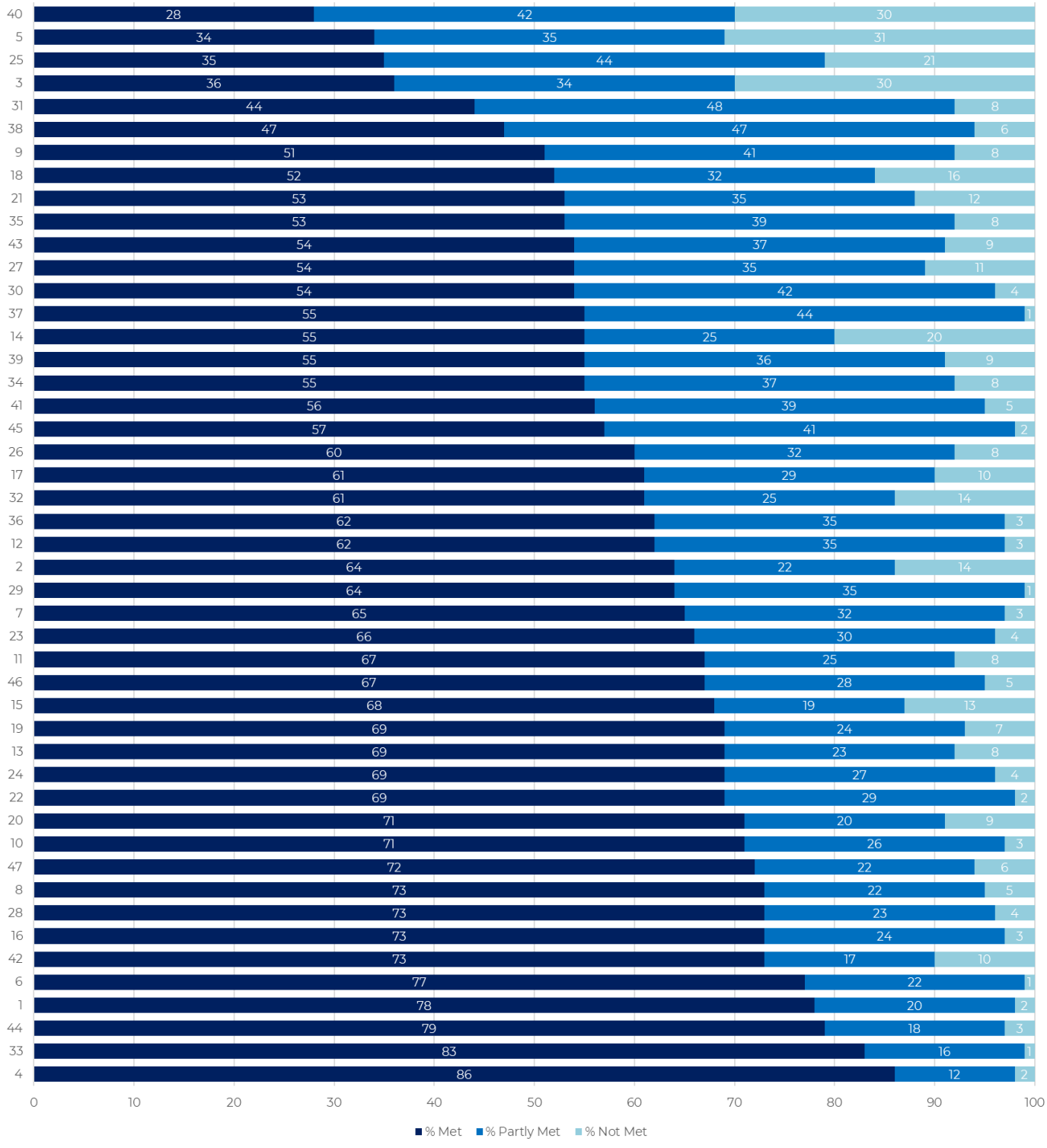


Figure 3: Percentage of met criteria by medium secure services

On average, Cycle 9 members fully complied with 63% of QNFMHS standards.

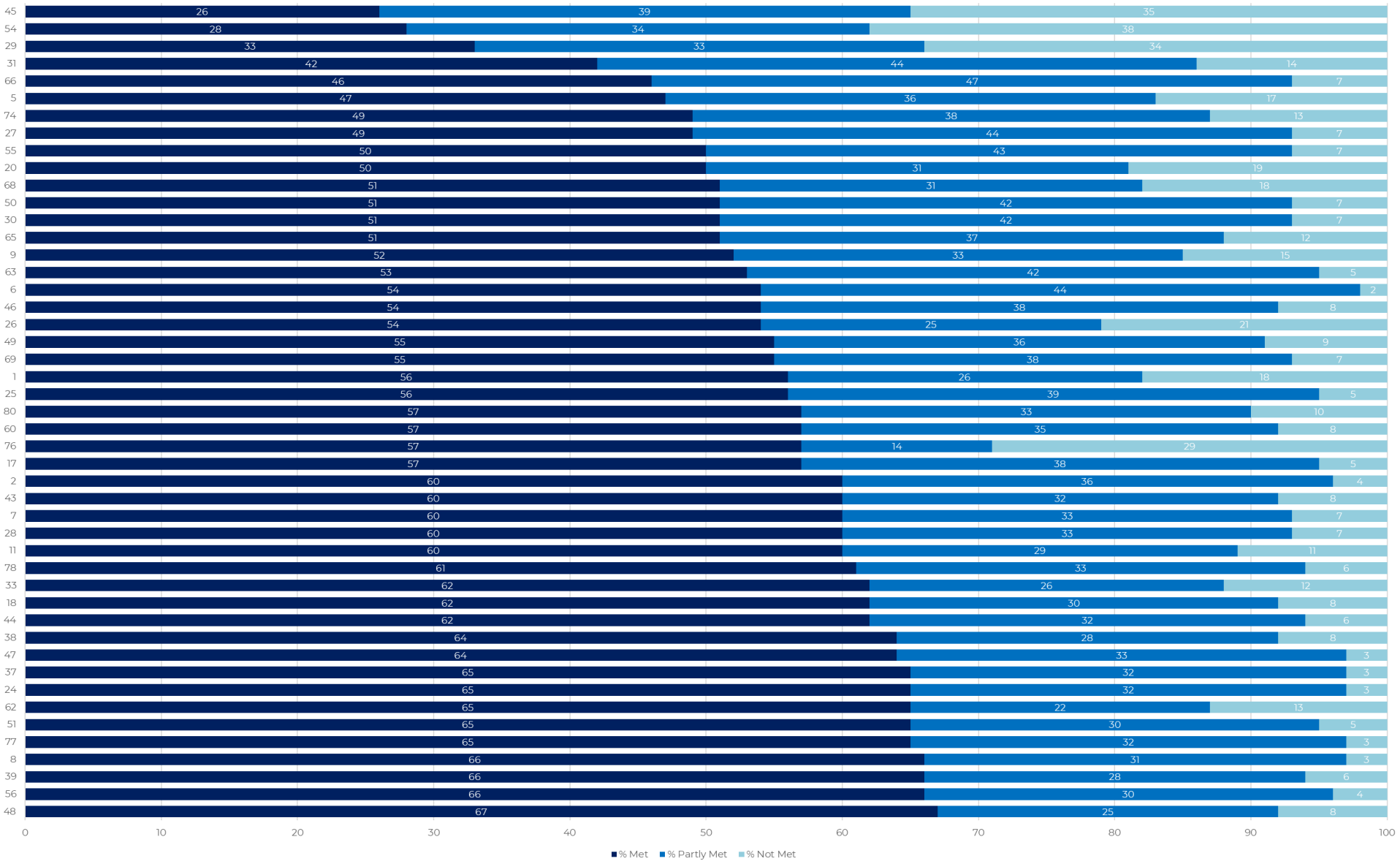


Figure 4: Percentage of met criteria by low secure services (part 1)

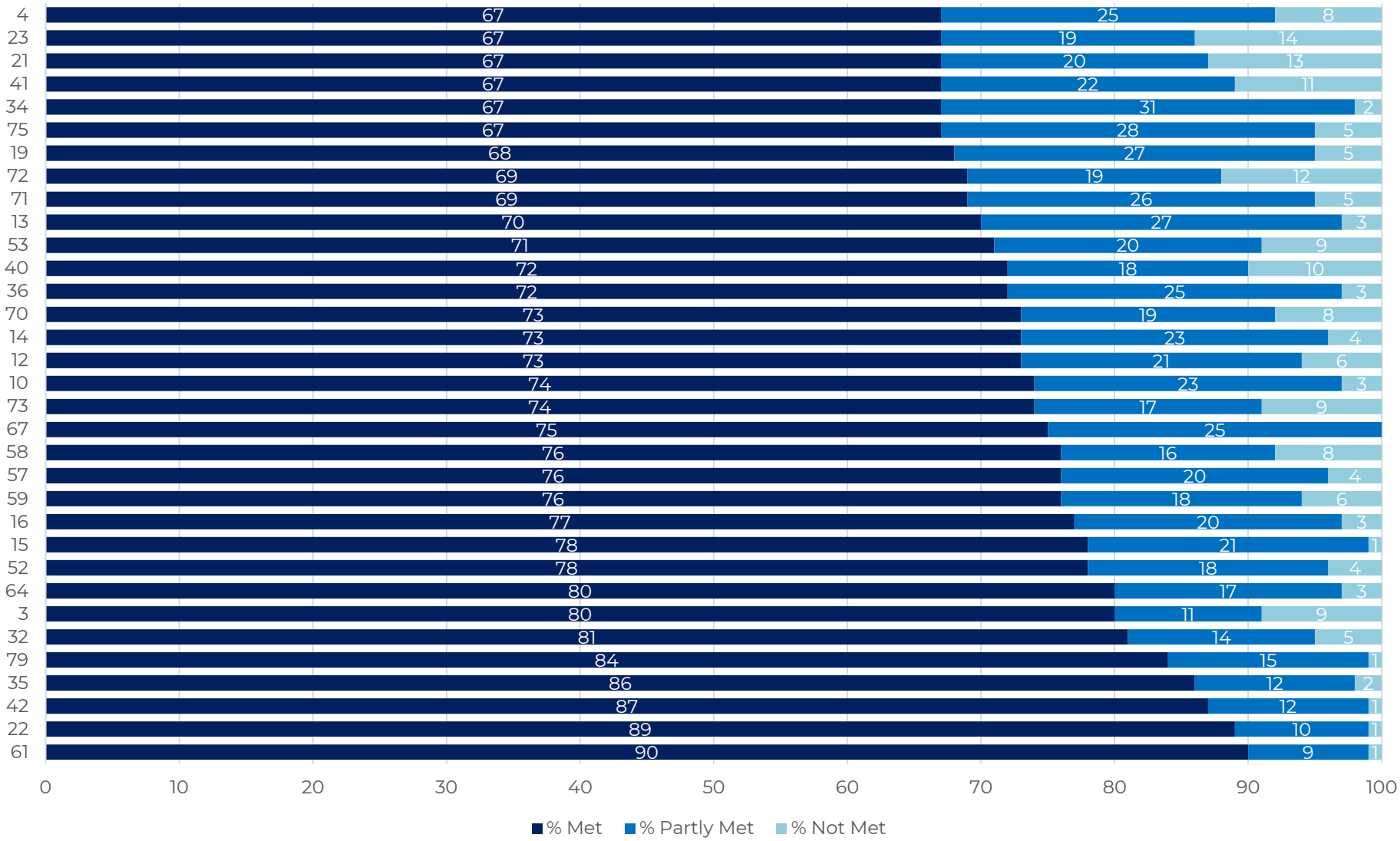
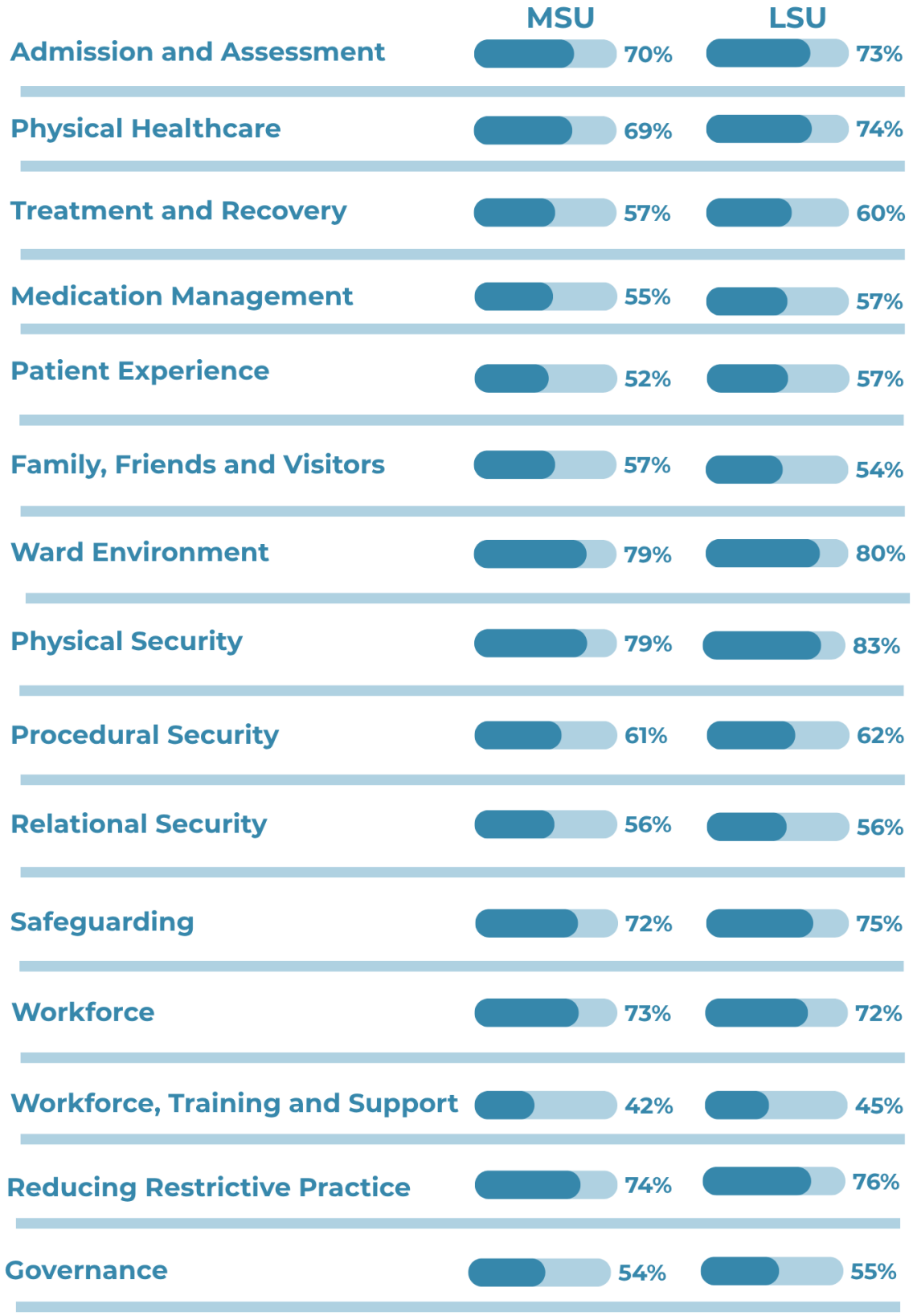


Figure 5: Percentage of met criteria by low secure services (part 2)

Below is the average percentage of fully met standards on each of the subsections of the standards for Cycle 15-9 (2023 – 2025). Accreditation review data has not been included here.



COMMONLY UNMET STANDARDS

63% of services did not meet the following standard at the point of their peer-review visit:

Standard 104 [3]: The service has a co-produced strategy to respond to requests from victims, patients or carers to participate in restorative justice.

Recommendation

- Liaise with patients, carers and relevant professionals to develop a co-produced strategy. Where available, liaise with restorative justice practitioners to develop this strategy. Services should consider employing restorative justice practitioners. Further resources can be found within the Network of Restorative Practitioners in Mental Health. Further guidance and support can be accessed by contacting Gerard Drennan, Head of Psychology & Psychotherapy, Gerard.Drennan@slam.nhs.uk, and Fin Swanepoel, Restorative Justice Practitioner, Fin.Swanepoel@slam.nhs.uk.

61% of services did not meet the following standard at the point of their peer-review visit:

Standard 122.1 [2]: Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: A patient's perspective.

Recommendation

- Services should liaise with their Trust/organisation's learning team to arrange this training for all staff. Where this is not possible, services could consider developing their own training resources on this topic, with patient input (either from current or previous patients) or a peer support worker. For further support, refer to the QNPICU Staff Training Guidance.

61% of services did not meet the following standard at the point of their peer-review visit:

Standard 122.7 [2]: Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.

Recommendation

- Services should liaise with their Trust/organisation's learning team to arrange this training for all staff. Where this is not possible, services could consider developing their own training resources on this topic, with carer input (either from current or previous carers). For further support on Carer Engagement and Involvement, refer to the QNPICU Carer Engagement and Involvement guidance.

43% of services did not meet the following standard at the point of their peer-review visit:

Standard 123 [1]: All clinical staff undergo specific training in therapeutic observation when they are inducted into a Trust or changing wards. This includes:

- Principles around positive engagement with patients;
- When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this.

Recommendation

- Services should review the current offering of this training so that the above points are included. There should be an internal process to monitor team training compliance and training content to keep it relevant and up to date. This should be part of bank and agency staff inductions, where relevant. Training can be sources externally, such as from NHS Professionals.

41% of services did not meet the following standard at the point of their peer-review visit:

Standard 124 [1]: All staff members who deliver therapies and activities are appropriately trained and supervised.

Recommendation

- Services should develop a local supervision tree that matches senior clinicians to relevant junior clinicians so that staff who deliver therapies and activities are appropriately supervised. During supervision sessions, training needs should be identified and implemented. A contingency plan should be developed to facilitate access to external supervisors where supervisors are not available due to vacancies or periods of long-term sickness. A record of the supervisor/supervisee structures and qualifications should be kept and maintained as relevant. Guidance can be sought from the NHS Workplace Supervision for Advanced Practice.

'Red the Pat Dog' created by a patient at Kedleston Unit.

PATIENT FEEDBACK SPOTLIGHT

We analysed patient survey data from **2,460** individuals and feedback from the patients spoken to during peer-reviews.

Positive feedback

Patient feedback indicates that they **know which member(s) of staff they can talk to if they have any questions and how to contact them**, with **88%** of survey responses supporting this. Patient feedback also expresses **feeling treated with compassion, dignity and respect** as well as **feeling listened to and understood** by staff, with **77% and 73%** of responses supporting both standards respectively.

Good practice examples

Fitness instructors offer personalised gym plans, green walks, and classes like Tae Kwando.

Seasonal ward activities include harvest celebrations, pumpkin carving, and annual Christmas events, along with community trips.

Paid opportunities for patients such as a buddy role to support peers.

Areas for improvement

46% of patients noted that the **meals** provided at their services **are not satisfactory**. Patients feedback also indicates for over **70%** of patients **activities are often not engaging, with limited offering on weekends**. Lastly, most patients shared that they do not **feel involved in their care plans**, with only **33%** reporting that they have a care plan, felt involved in its development, and were offered a copy.

Recommendations

Develop a food group where patient representatives can feed back on the food to the catering team and discuss the food in community meetings. Collaborate on updating menus, consider taster sessions, and use regular surveys for ongoing input. Maintain clear communication and continue supporting self-catering and healthy takeaway initiatives. Meals should always cater for religious, cultural and dietary needs.

Recruit activity co-ordinators to provide activities seven days a week, including evenings and weekends. Identify activities that can be facilitated by nursing staff or external companies during evening and weekends. Liaise with patients to identify what activities they would like on offer and develop an action plan to explore such opportunities. Promote gym access, internal or external, and develop varied group exercise sessions. Where staffing shortages persist, consider introducing a range of self-led activities.

Consider a QI project focused on enhancing patient involvement in care planning. Review resources such as the Social Care Institute of Excellence person-centred care guide, NICE recommendations, Sermo and The Patients.

CARER FEEDBACK SPOTLIGHT

We analysed carer survey data from carers **811** individuals and feedback from the carers spoken to during peer-reviews.

Positive feedback

Carers shared that they **feel listened to and understood by staff**, which is reflected in **72%** of surveys. Carers noted that they are involved in their **loved ones' care planning**, including being invited to key meetings, which is supported by **73%** of surveys.

Good practice examples

WhatsApp group for carers to network and support each other.

Carer Champion (staff supporting role) or Carer Representative (lived experience role) roles are available.

Carer newsletter created in collaboration with carers.

Areas for improvement

Many carers noted that they **have not been provided** with information or support around how to access **a statutory carers' assessment**, with only **24%** of services meeting this standard. Carers also reflected that they have not been provided with **accessible carers' information**, such as a welcome pack, with **28%** of services meeting this standard. Lasty, most carers shared that they were not **offered individual time with staff members, within 48 hours of their loved one's admission to discuss concerns and their own needs**, with **17%** of services meeting this standard.

Recommendations

Carers should be provided with verbal and written information about what a carers' assessment is and its potential benefits, and staff should support carers to access this through an appropriate agency. Written information could be included within the carers' information pack and placed in visiting areas.

Develop a welcome pack with carers which includes local and organisational information, contact details of the ward, information about key staff members and local sources of advice and support. *Advancing Practice: Create a welcome video for carers which shows the ward, shares information about what to expect and could include patient and carer stories/feedback.*

Add 'contact with carers' to the admissions checklist. Regularly audit the timeframe in which this is offered and develop an appropriate action plan to deliver this offering within 48 hours. All contact with carers should be clearly recorded in the dedicated carer notes. *Advancing Practice: Recruit to or develop a Carer Champion role to lead on this process and allocate staff to complete the discussion with carers.*

Explore the QNPICU Carer Involvement and Guidance for further support.

STAFF FEEDBACK SPOTLIGHT

We analysed staff survey data from **7,929** individuals and feedback from the staff spoken to during peer-reviews.

Positive feedback

Feedback from staff highlighted good access to **reflective practice** and **clinical supervision**, with **71%** and **80%** of respondents respectively supporting this. Standard data indicates **93%** of services have access to a **dedicated staff room** and **85%** of staff are able to **report incidents quickly**. Commonly mentioned achievements within services in this area include a range of **training needs being supported**, including in-house bite-size training sessions.

Good practice examples

There are Mental Health First Aiders on the ward.

There is a health and wellbeing lead and champions available.

The Professional Nurse Educator (PNE) is responsible for providing additional support to student nurses, apprenticeship nurses and newly qualified nurses.

Areas for improvement

Standard data indicates nearly **60%** of staff **do not receive post incident support** and only **43%** of staff **can access their breaks**. Commonly mentioned challenges within services in this area highlight **staff not feeling safe**, with **26%** of services meeting this standard. Common reasons for not feeling safe are noted as lack of staff and unbalanced skill mix.

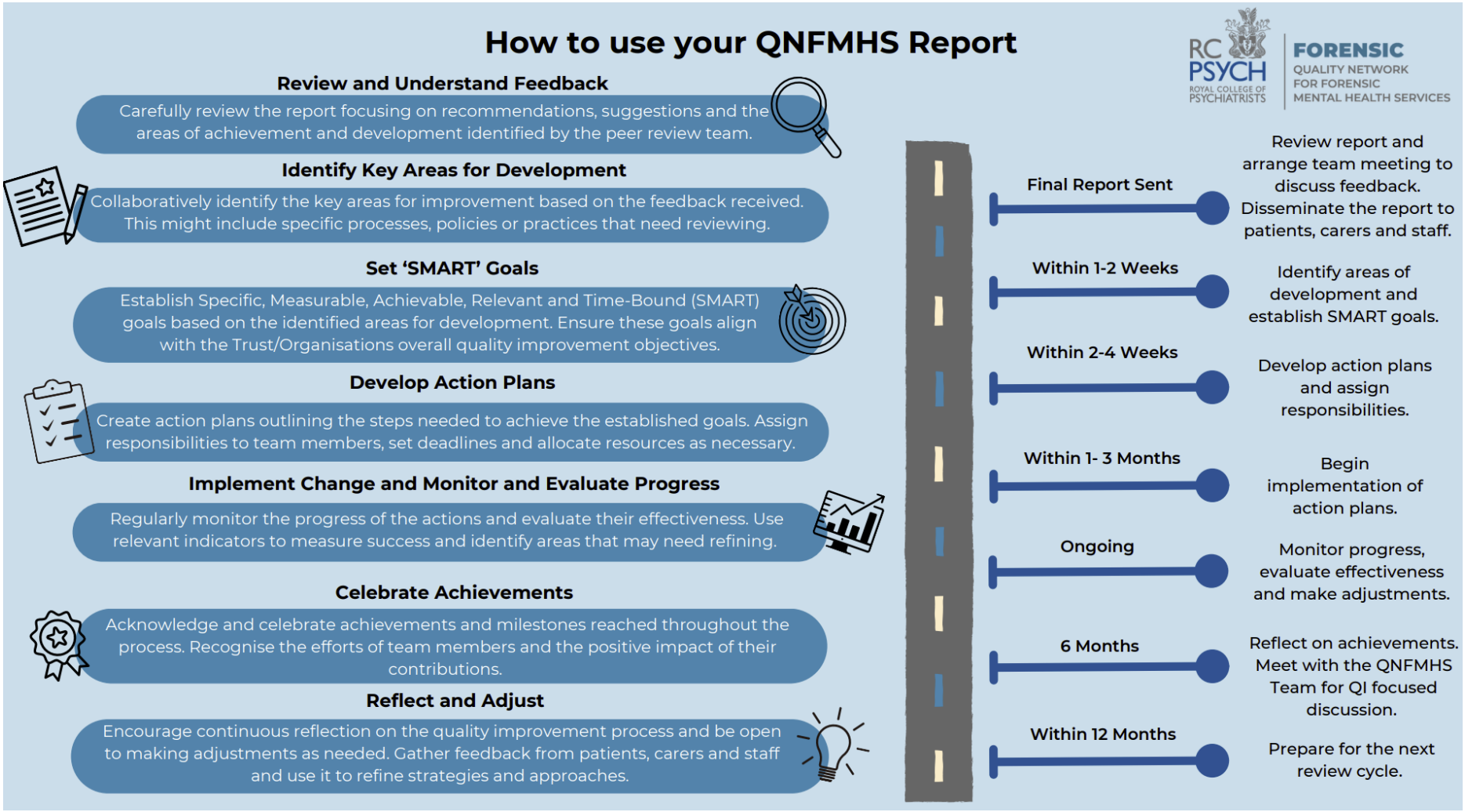
Recommendations

Provide access to Trauma Risk Management Practitioners. Teams should explore the importance of debriefs and providing hot and cold debriefs. Online resources, such as the Australian and New Zealand College of Anaesthetists "How to Hot Debrief" Guide and PIER Network Debrief Tools can be used to develop this provision.

Teams should develop a process for allocating breaks and appropriate cover. Where breaks cannot be taken, reasons should be recorded and audited regularly to identify any actions needed. This should be an ongoing process and, where required, members of the multi-disciplinary team should support covering the ward whilst nursing staff take their breaks.

When needed, services should block-book agency staff that are familiar with the patients/ward processes. Minimum staffing levels should be reviewed to ensure these are still relevant and appropriate to the service provision. Rota setters should consider the skill mix on each shift, ensuring staff appropriately trained to de-escalate patients are always on shift. Explore introducing a ward atmosphere tool.

HOW TO USE YOUR DEVELOPMENTAL REPORT



EVENTS, TRAINING AND PUBLICATIONS

Annual Forums

Two QNFMHS Annual Forums were held during Cycle 15-9. The first took place in person on 02 July 2024, featuring presentations on building relationships and celebrating achievements, flexible paid work opportunities for service users and co-producing a new app in a medium secure hospital. The afternoon was filled with more presentations such as implementing music therapy in forensic services, Patient Safety Incident Response Framework (PSIRF) at Thornford Park Hospital, human factors in forensic mental health care, trauma-informed support for staff through Trauma Risk Management (TRiM), and a final plenary led by carer and patient representatives.

The second Annual Forum took place online on 27 May 2025. The morning sessions featured presentations on patient progress, achieving accreditation, and the role of the CQC in challenging closed cultures. In the afternoon, speakers explored topics such as the positive impact of patient engagement in developing secure mental health services, a documentary and discussion on the importance of arts and co-production in forensic services, and neuro-accessibility within forensic inpatient settings. Further sessions focused on reducing incidents and improving safety on an integrated female learning disabilities ward through engagement and therapeutic relationships, implementing the Patient and Carer Race Equality Framework (PCREF), and promoting co-production in quality improvement initiatives.

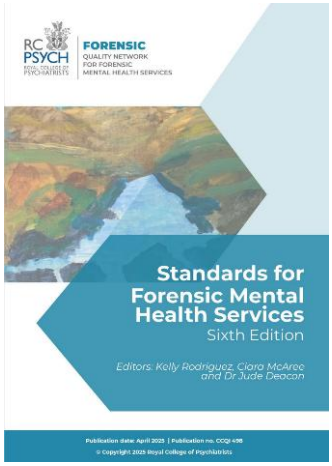
Peer Reviewer Training

Peer reviewer training is a free event for staff from QNFMHS member services. The training prepares clinicians for the role of peer reviewer and build skills in a group facilitation and delivery. It is a great learning experience for those who are interested in participating in peer reviews for forensic mental health services. The

training takes place online via MS teams. Over Cycle 15-9 (2023-2025), eight training sessions were run with a total of 305 delegates.

Standards

The QNFMHS Standards Consultation Event was held in November 2024 which provided member services, the advisory group and patient and carer representatives the opportunity to review the existing standards. The aim was to collect feedback on the standards and whether these were still fit for purpose, reflecting current best practice and measure the quality of care received by patients. The sixth edition of the standards were published in April 2025.



Staff Cultures Webinar

The Quality Network hosted a webinar on the 12 February 2025 to explore the issue of closed cultures within forensic mental health services, as identified through peer reviews. The session provided a platform for professionals to share experiences and explore practical approaches to fostering more open and supportive environments. Topics covered included the use of psychologically informed organisational consultancy, the implementation of restorative practices, and the role of peer support in creating a positive work culture.

Carer Lead Forum

The QNFMHS Carer Engagement Lead Forum is an online meeting for those who lead on carer engagement. It provides a space for carer leads to share ideas, best practice, and gives them the opportunity to network. The forum has been running quarterly since November 2024 and now has over 60 members.

Artwork and Creative Writing

The Network hosts an annual artwork and creative writing competition for patients and carers. All artwork and creative writing submissions are showcased in our bulletins, and the winners of the artwork competition are used on publications such as reports and shared on our social media accounts. Winners of the artwork competition have been used on the cover of this report and throughout. In addition, the Network runs an annual Winter Celebration competition, which also welcomes entries from patients and carers. To support these initiatives, we have developed updated guidance for both the Patient and Carer Winter Celebration Artwork Competition and the Artwork and Creative Writing Competition.

"Synchronising Bird Watching" by a patient at Peplaw Ward.

APPENDIX 1: ALL STANDARDS DATA

No.	Standard	Type	Percentage Met
Admission and Assessment			
1	Patients receive a multidisciplinary pre-admission assessment of need and risk which accords with an access assessment for secure care and good practice in relation to mental health measures and CPA/CMHF. *Guidance: An admission tool is available to consider risk and levels of security.*	2	98
2	The multi-disciplinary team make decisions about patient admission or transfer. In making those decisions, they take account of patient mix and the potential to compromise safety and/or therapeutic activity when deciding where a patient will be placed. *Guidance: Decisions to accept or refuse patients are recorded.*	2	100
3	The service provides information to referrers about how to make a referral.	1	87
4	The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. *Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.*	1	61
5	Patients have a comprehensive mental health assessment which is started within four hours of admission. This involves the multi-disciplinary team and includes consideration of the patient's: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. **Sustainability Principle: Improving Value**	1	78
6	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for);	1	74

	Arrangements for pets.		
7	Patients admitted to the ward outside the area in which they live have a review of their placement at least every three months.	1	96
8	On admission to the service, patients feel welcomed by staff members who explain why they are in hospital. *Guidance: Staff members show patients around and introduce themselves and other patients, offer them refreshments and address them using their preferred name and correct pronouns. Staff should enquire as relevant how they would like to be supported in regard to their gender.*	1	76
9	The patient is given an information pack on admission that contains the following: • Admission criteria; • Clinical pathways describing access and discharge; • How the service involves patients; • A description of the service; • The therapeutic programme; • Information about the staff team; • The unit code of conduct; • Key service policies (e.g., permitted items, smoking policy); Resources to meet spiritual, cultural or gender needs.	2	46
10	Patients are given accessible written information which staff members talk through with them as soon as practically possible. The information includes: • Their rights regarding admission and consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to view their health records; How to raise concerns, complaints and give compliments.	1	39

11	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	1	83
12	The ward/unit works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	2	96
Physical Healthcare			
13 	Patients have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. If all or part of the examination is declined, then the reason is recorded, and repeated attempts are made. **Sustainability Principle: Prioritise Prevention**	1	74
14	Patients have access to physical health programmes in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health. *Guidance: Patients are informed of the higher physical health risks for patients in secure mental health, such as diabetes, dyslipidaemia, hypertension, epilepsy, asthma etc. and gender-specific needs.*	2	67
15	Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly, and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.*	1	80
16	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	1	100
17 	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. **Sustainability Principle: Consider Carbon**	1	67
Treatment and Recovery			

18	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy. *Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.*	1	33
19	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	2	43
20	Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. *Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*	2	22
21	There is a documented formalised review of care or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback.	1	59
22	Patients are encouraged and supported to play a key participating role in their formal review meeting (such as Care Programme Approach or equivalent) and the patient's views are clearly documented. *Guidance: Other professionals involved should be routinely invited, and carers in accordance with patient's wishes.*	1	74
23	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Recovery colleges.	2	41
24	The team and patient jointly develop a leave plan, which is shared with the patient, that includes:	1	30

	• The aim and therapeutic purpose of section 17 leave that clearly links to the overarching plan for the care pathway; • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit and crisis numbers.		
25	Staff agree leave plans with carers where appropriate, allowing carers sufficient time to prepare.	1	67
26	When patients are absent without leave, the team (in accordance with local policy): • Activates a risk management plan; • Makes efforts to locate the patient; • Alerts carers, people at risk and the relevant authorities; • Escalates as appropriate.	1	100
27	The team supports patients to access support with finances, benefits, debt management and housing needs.	1	93
28	Patients and their carer are invited to a discharge meeting and are involved in decisions about discharge plans.	2	61
29	The service works proactively with the home area care coordinator and next point of care (including other in-patient services, forensic outreach teams, community mental health teams or prison) to ensure delays to discharge for those medically ready are appropriately identified and steps taken to expedite. *Guidance: Patient discharge plans feature triggers and arrangements for 'recall' to the service if the patient relapses. When patients are transferred between services there is a handover which ensures that the new team have an up to date care plan and risk assessment.*	2	98
30	Mental health practitioners carry out a thorough assessment of the person's personal, social, safety and practical needs to reduce the risk of suicide on discharge. *Guidance: Where possible, this should be completed in partnership with carers.*	1	89

31 	The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge. *Guidance: The plan includes details of:* • *Care in the community/aftercare arrangements;* • *Crisis and contingency arrangements including details of who to contact;* • *Medication including monitoring arrangements;* • *Details of when, where and who will follow up with the patient.* **Sustainability Principle: Prioritise Prevention**	1	70
32	A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent). The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation.	2	38
33	The team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 72 hours of discharge.	1	91
34	Teams provide support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. *Guidance: The team provides transition mentors; transition support packs; or training for patients on how to manage transitions.*	3	59
35	Clinical outcome measurement is collected at two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements where possible. This can include Historical, Clinical, Risk 20 (HCR-20), Short Term Assessment of Risk and Treatability (START), Health of the Nation Outcome Scale Secure (HoNOS Secure), FORensic oUtcome Measure (FORUM), Wales Applied Risk Research Network (WARRN) or Dangerousness, Understanding, Recovery, and Urgency Manual (DUNDRUM).*	1	72
36	The ward/unit/organisation has a care pathway for patients who are pregnant or in the postpartum period. *Guidance: Patients who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.*	1	70

Medication Management			
37	All staff members who administer medications have been assessed as competent to do so. The assessment is completed at least once every three years using a competency-based tool.	1	91
38	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	1	59
39	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually. If a physical health abnormality is identified, this is acted upon.	1	72
40 	Patients have their medications reviewed at least every two weeks. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.* **Sustainability Principle: Consider Carbon**	1	70
41	Every patient's PRN medication is reviewed at least every 2 weeks: frequency, dose and indication. *Guidance: Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.*	1	52
42	Patients and carers and prescribers are able to meet with a pharmacist to discuss medications.	2	17
Patient Experience			
43	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their family or carers, are respected and reviewed regularly.	1	26

44	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates).	1	91
45	Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy. *Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.*	1	87
46	Patients and carers feel treated with compassion, dignity and respect by staff members. *Guidance: This includes respect of an individual's race, age, expressed social gender, marital status, sexual orientation, maternity, disability, social and cultural background.*	1	65
47	Patients feel listened to and understood by staff members.	1	72
48	Patients are involved (wherever possible) in decisions about their level of therapeutic observation by staff. *Guidance: Patients are also supported to understand how the level can be reduced.*	1	41
49 	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. *Guidance: This can include feedback surveys, focus groups, community meetings and patient representatives.* **Sustainability Principle: Empowering Individuals**	1	48
50	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics.	2	30
51	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. *Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.*	2	80

52	The service has a service user and carer involvement and co-production strategy covering all aspects of service delivery along with a designated lead for patient and carer involvement. This individual contributes to the leadership of the service. *Guidance: The strategy is developed through use of the 'Carer support and involvement in secure mental health services toolkit' (NHS England, 2018).*	2	35
53	The service facilitates access to a peer support service.	3	63
54	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	1	54
55	Patients know who the key people are in their team and how to contact them if they have any questions.	1	93
56	Patients receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.	2	78
57 	Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). *Guidance: This assessment considers risk to self, risk to others and risk from others.* **Sustainability Principle: Prioritise Prevention**	1	59
58	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.	1	93
59	Each patient is offered a one-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.	1	50
60	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness, physical health and treatment.	1	20

61 	Patients, according to risk assessment, have access to regular 'green' walking sessions. *Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rainwear.* **Sustainability Principle: Consider Carbon**	2	52
Family, Friends and Visitors			
62	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g., in a carers' pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	2	28
63	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This is an opportunity for carers to discuss what support or services they need, including physical, mental and emotional needs. Arrangements should be made through the carer's local council.*	1	24
64	Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically.*	2	35
65	Carers feel supported by the ward staff members.	2	70
66 	Carers are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents. **Sustainability Principle: Empowering Individuals**	1	54
67	The patient's carer is contacted as soon as possible by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.	2	46

68 	Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns and their own needs. **Sustainability Principle: Empowering Individuals**	2	17
69	The team knows how to respond to carers when the patient does not consent to their involvement. *Guidance: The ward may receive information from the carer in confidence.*	1	54
70	There is a designated visitors' room within the secure perimeter. The space must meet the following requirements: • Suitable to maintain privacy and confidentiality; • Provide a homely environment; • Observations enable private conversations; • Accessible by patients and visitors.	2	87
71	The service is able to safely facilitate child visits and is equipped with a range of age-appropriate facilities such as toys, games and books. *Guidance: The children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit. Sufficient staff should be made available to enable children to visit during evenings and weekends.*	2	91
72	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	1	59
73	The pathway of care takes into account victim issues and is developed in liaison with relevant supervisory agencies e.g. the responsible local authority, offender manager and/or MAPPA.	2	100
Ward Environment			
74	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms. There is an agreed response when the alarm is raised.	1	89
75	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff*	1	74

	members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.		
76	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	1	80
77	Staff members and patients can control heating, ventilation and light on the ward/unit. *Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches, and they can request adjustments to control heating.*	2	89
78	Patients are able to personalise their bedroom spaces. *Guidance: For example, by putting up photos and pictures.*	2	85
79	Furnishings minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.	1	63
80	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g., covered copies of faith books, access to a multi-faith room, or access to groups.	1	89
81	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	2	83
82	The ward/unit has a designated room for physical examination and minor medical procedures.	2	89
83	The service has at least one bathroom/shower room for every three patients.	2	91
84	All patients have single bedrooms.	2	100
85	Every patient has an ensuite bathroom.	3	70
86	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.	3	89
87	Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom. *Guidance: This may be subject to risk assessment including emergencies.*	1	74

88 	Ward/unit-based staff members have access to a dedicated staff room. **Sustainability Principle: Empowering Staff**	2	93
89	Patients are consulted about changes to the ward/unit environment.	2	57
90 	Patients have access to safe outdoor space every day. **Sustainability Principle: Consider Carbon**	1	87
91	All patients can access a charge point for electronic devices such as mobile phones.	3	98
92	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. *Guidance: Hot drinks may be available on a risk-assessed basis.*	2	96
93	All patients can access a range of current culturally specific resources for entertainment, which reflect the service's population. *Guidance: This may include recent magazines, daily newspapers, books, board games, a TV and DVD player with DVDs, computers and internet access (where risk assessment allows).*	2	98
94	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	2	89
95	In services where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and ventilated; • It has adequate lighting, including a window(s) that provides natural light; • It has direct access to toilet/washing facilities; • It has limited furnishings (which include a bed, pillow, mattress and blanket or covering); • It is safe and secure, and does not contain anything that could be potentially harmful; • It includes a means of two-way communication with the team; • It has a clock that patients can see.	1	76
96	Patients and staff members feel safe on the ward.	1	26

97	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.	1	74
Physical Security			
98	The service manages physical security according to the standards stated in the QNFMHS Physical Security in Secure Care guidance.	1	91
Procedural Security			
99	• Anti-bullying (for staff and patients, for those who are bullying, and those who are being bullied). • Supporting patients' use of electronic equipment and safe access to the internet, including specific advice around the appropriate use of social networking sites, confidentiality and risk. • Effective liaison with local police on incidents of criminal activity/harassment/violence and other criminal justice agencies, where relevant (a memorandum of understanding is in place with local police on reporting crime). • Minimising restrictive practices (a process for reviewing restrictive practices is documented with specified timescales. Individual care plans focus on minimisation and restrictive practices).	2	72
100	• Managing situations where patients are absent without leave. • Patient observation and engagement. • Conducting searches of patients and their personal property, staff members, visitors and the environment. • Prevention of suicide and management of self-harm. • Visiting, including procedures for children and unwanted visitors (i.e. those who pose a threat to patients, or to staff members).	1	83
101	Services have an easily accessible business continuity plan that provides guidance for a range of emergency planning eventualities. This includes testing by live and/or desktop exercises at least six-monthly.	1	63

102	There is a process in place to enable patients and their representatives to view policies and procedures critical to their care. These are stored in ways that staff, patients and carers find accessible and easy to use.	2	57
Relational Security			
103	There is a relational security component to the induction programme for all staff that includes the See Think Act framework. This is refreshed annually.	1	74
104	The service has a co-produced strategy to respond to requests from victims, patients or carers to participate in restorative justice.	3	26
105	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. There is a record kept. *Guidance: It is good practice to utilise the relational security explorer wheel.*	1	67
Safeguarding			
106	There is a local designated safeguarding lead who can give advice and ensure that all safeguarding issues are raised and resolved, and links into the safeguarding processes within the organisation/provider collaborative. *Guidance: On admission, a record is made for each patient of any children known to be in their social network, their relationship to those children and any known risks whether or not reflected in convictions.*	1	87
107 	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. **Sustainability Principle: Empowering Staff**	1	46
108	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.	1	96
Workforce			

109	There is a psychologist who is part of the multi-disciplinary team. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.	1	91
110	There is an occupational therapist who is part of the multi-disciplinary team. They work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions.	1	93
111	There is dedicated sessional input from arts or creative therapists.	3	35
112 	The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services. **Sustainability Principle: Empowering Staff**	1	100
113	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency.	1	70
114	The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g., in response to additional clinical need or short term absence of permanent staff.	2	93
115 	Patient or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance: The representatives should have experience of the relevant service.* **Sustainability Principle: Empowering Individuals**	2	74
116	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working*	1	43

	day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.		
Workforce Training and Support			
117	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	1	65
118	All staff members receive individual line management supervision at least monthly.	2	52
119 	Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice. **Sustainability Principle: Empowering Staff**	3	70
120 	The service actively supports staff health and wellbeing. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports, and taking action where needed.* **Sustainability Principle: Empowering Staff**	1	46
121	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met.	1	83
122	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:		
122.1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1	52

122.2	Physical health assessment and management. *Guidance: This could include training in understanding physical health problems, undertaking physical observations, basic life support, and Early Warning Signs.*	1	43
122.3 	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation, or neglect.* **Sustainability Principle: Prioritise Prevention**	1	52
122.4 	Risk assessment and management. *Guidance: This includes assessing and managing suicide risk and self-harm, and the prevention and management of challenging behaviour.* **Sustainability Principle: Prioritise Prevention**	1	30
122.5	Recognising and communicating with patients with cognitive impairment and learning disabilities.	1	37
122.6	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	1	41
122.7	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	2	24
122.8	Recovery and outcomes approaches.	2	26
122.9	Assessing and managing suicide risk and self-harm.	2	37
122.10	Prevention and management of aggression and violence.	2	43
122.11	A patient's perspective.	2	17
123	All clinical staff undergo specific training in therapeutic observation when they are inducted into a Trust or changing wards. This includes: • Principles around positive engagement with patients;	1	37

	• When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this.		
124 	All staff members who deliver therapies and activities are appropriately trained and supervised. **Sustainability Principle: Empowering Staff**	1	35
125 	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. **Sustainability Principle: Prioritise Prevention**	1	80
126	Patient and/or carer representatives are involved in delivering and developing staff training.	2	72
Reducing Restrictive Practices			
127	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. *Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis.*	1	78
128	The team uses seclusion only as a last resort and for the minimum possible period only.	1	93
129	In units where long term segregation is used, the area used conforms to standards as prescribed by the Mental Health Act Code of Practice (or equivalent). *Guidance: This includes patients having access to meaningful and therapeutic activity and outdoor space.*	1	75
130	When restraint is used, staff members restrain in adherence with accredited restraint techniques.	1	93
131	Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018 (or equivalent).	1	96
132	Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs, including respiratory rate, monitored by staff members and any deterioration is responded to.	1	74

	Guidance: If a patient declines to have their vital signs monitored, this should be recorded in patient records and re-offered again as appropriate.		
133	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.	2	70
134	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions.	1	74
135	The service collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. *Guidance: Audit data are used to compare the service to national benchmarks where possible.*	1	57
Governance			
136	The ward team use quality improvement methods to implement service improvements.	2	39
137	The team actively encourages patients and carers to be involved in quality improvement initiatives.	2	50
138	The service supports research and the implementation of evidence-based interventions. There is a local research strategy linked to the needs of patients and workforce.	3	35
139	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.	1	85
140	When serious mistakes are made in care, this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement (or equivalent).	1	98
141 	Staff members, patients and carers who are affected by a serious incident including restraints and/or rapid tranquilisation are offered post-incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection.* **Sustainability Principle: Empowering Individuals**	1	43

142	Lessons learned from patient safety incidents, safeguarding themes/trends and complaints are shared with the team and the wider organisation/provider collaborative. There is evidence that changes have been made as a result of sharing the lessons.	1	100
143	Services are developed in partnership with appropriately experienced patients and carers who have an active role in decision making.	2	54
144	The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan (or equivalent). It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team.	3	17

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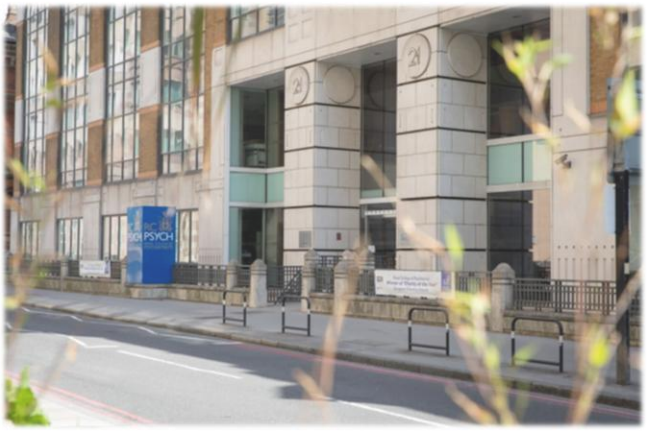

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