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FORENSIC
QUALITY NETWORK
FOR FORENSIC
MENTAL HEALTH SERVICES

Standards for Forensic Mental Health Services

Fifth Edition

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Artwork displayed on the front cover of the report:

Butterfly Stitches, created by a patient from Northgate Hospital, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

Contents

Foreword

It gives me great pleasure to be writing this foreword for the 5th edition of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services (QNFMHS) Standards for Medium and Low Secure Care. This 5th edition of the QNFMHS standards has been revised to be consistent with the CCQI core quality standards, subject to considerable stakeholder consultation. Accordingly, there are marginally more standards than previously; however, all have been refined and consolidated to make them accessible as possible, and I am grateful to everyone who has contributed to this process. This 5th edition of the standards represents the first significant review since those published as the 3rd edition in 2019.

The 4th edition of our Quality Network Standards was published two years ago, in 2021. In my foreword to that edition, in 2021, I wrote of my reflections on the challenges under which our member services had been operating since the outset of the Covid-19 pandemic in early 2020, and of my admiration for those colleagues who had worked so hard to ensure our services were safe and mitigate the impact on patients and their families. Whilst we now are adjusting to new approaches to post-pandemic working, and have maximised the benefits of remote working, we have been able to resume some activities in person.

Notably, we held the 2023 Annual Forum in person, and it was a particularly vibrant occasion, with interesting and engaging presentations, from which themes around communication, inclusion and creative expression emerged. In the July 2023 – June 2024 cycle (cycle 15-9 part 1), we will continue with our approach in which half of our member services receive a face-to-face full review visit and the other half receive a virtual developmental review visit.

It now feels that we are looking forward again, and, over the last year, we have also been working with our members to develop the option for an accreditation membership to offer choice, development and new opportunities for those services who would like to work towards accreditation. A steering group, informed by a membership survey, has been supporting us with this, and we will be working with a number of services who have expressed an interest in piloting this approach.

In the UK, there are now 15 Adult Secure Provider Collaboratives, representing a shift in the approach to commissioning specialised mental health, learning disability and autism services, to ensure the best quality of care for their local populations. As we innovate in the development of community services for forensic service users, we must also focus on the quality, uniquely specialist nature and role of inpatient services. In this context, it is important that we consistently retain the fundamentals of high-quality care, working with Provider Collaboratives to maximise their potential to further develop quality, governance, co-production and shared learning in their networks and partnerships.

Although it feels like we are in a very different place than we were in 2021, I am very mindful of the continuing challenges faced by our services, notably in the unprecedented difficulties experienced by many of our member organisations in recruiting and retaining staff of all disciplines. Many services have taken a strategic approach to this, developing skill mix and creating excellent supportive training environments. However, this remains a very sustained and, arguably, the most significant challenge to quality, relational security and culture of our inpatient environments - critical to our ability to provide safe, purposeful and well-led services. I am, therefore, delighted that we have recently published the 3rd edition of "See Think Act" that can be found on our website here. It has been revised to reflect a trauma-informed approach, and a focus on leadership, and is an invaluable tool for exploring and understanding relational security as practitioners and in teams.

Finally, I would like to express my sincere thanks to the QNFMHS team, my colleagues on the Advisory Group, and those members, patient, and carer representatives who work tirelessly to ensure the smooth running of the Network and support our development work. I am extremely grateful for their dedication in promoting our values and commitment to continuous improvement in quality of services, and excellent outcomes, for people who need secure mental health care, their families and friends.

Dr Jude Deacon

Chair of the Quality Network for Forensic Mental Health Services

Introduction

The standards act as a framework by which to assess the quality of forensic mental health services. This is the fifth edition of the standards, which were first published in 2016 for combined Low and Medium Secure Services. These standards have been developed in consultation with the member services of the Quality Network for Forensic Mental Health Services (QNFMHS), patients, family and friends, and other key stakeholders.

Categorisation and themes

Each standard has been rated to define whether it is essential, expected or desirable in relation to patient care.

All criteria are rated as Type 1, 2 or 3

> **Type 1:** Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
>
> **Type 2:** Expected standards that all services should meet.
>
> **Type 3:** Desirable standards that high performing services should meet.

To support the identification of key themes between the standards, a key has been devised. Throughout the document, the following icons will denote where a standard represents one of these themes.

Involving family, friends and carers

The following standards uphold the principle that we wish to ensure positive engagement, support and collaboration from all those who are part of a patient's life, whether family, friends or carers in the pathway of care.

These standards do not supersede the patient's right to privacy. The sharing of confidential information and/or contact with family, friends or carers must uphold the patient's wishes and occur only with their informed consent.

This does not reduce the responsibility of services to support carers where required, ensure access to statutory carers' assessment and provide general information regarding the service. The need to uphold public safety is not affected.

Sustainability Principles

The fifth edition of the QNFMHS standards have been mapped against sustainability principles developed by the Royal College of Psychiatrists' Sustainability Committee.

Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

For more information on the Sustainability Committee, please follow this link: https://www.rcpsych.ac.uk/improving-care/working-sustainably

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, telehealth clinics instead of face-to-face contacts). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic

value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective team working facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

A range of guidance reports and papers has already been developed by the College to help improve the sustainability of mental health care. Please see below for further information:

- Guidance for commissioners of financially, environmentally, and socially sustainable mental health services https://www.jcpmh.info/good-services/sustainable-services/
- Choosing Wisely – shared decision making http://www.rcpsych.ac.uk/healthadvice/choosingwisely.aspx
- Centre for Sustainable Healthcare https://sustainablehealthcare.org.uk/
- Psych Susnet https://networks.sustainablehealthcare.org.uk/network/psych-susnet

Standards for Forensic Mental Health Services

Admission and Assessment		
No.	**Standard**	**Type**
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
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
3	The service provides information to referrers about how to make a referral.	1
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
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
6	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for); • Arrangements for pets.	1
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

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
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
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
11	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	1
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

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
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
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
16	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	1
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
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
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

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
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
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
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
24	The team and patient jointly develop a leave plan, which is shared with the patient, that includes: • 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.	1
25	Staff agree leave plans with carers where appropriate, allowing carers sufficient time to prepare.	1
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

27	The team supports patients to access support with finances, benefits, debt management and housing needs.	1
28	Patients and their carer are invited to a discharge meeting and are involved in decisions about discharge plans.	2
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
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
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
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
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

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
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
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
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
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
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

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
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
42	Patients and carers and prescribers are able to meet with a pharmacist to discuss medications.	2
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
44	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates).	1
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
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
47	Patients feel listened to and understood by staff members.	1
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

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
50	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics.	2
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
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
53	The service facilitates access to a peer support service.	3
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
55	Patients know who the key people are in their team and how to contact them if they have any questions.	1
56	Patients receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.	2

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
58	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.	1
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
60	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness, physical health and treatment.	1
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
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
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
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

65	Carers feel supported by the ward staff members.	2
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
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
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
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
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
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
72	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	1
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

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
75	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff 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.*	1
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
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
78	Patients are able to personalise their bedroom spaces. *Guidance: For example, by putting up photos and pictures.*	2
79	Furnishings minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.	1
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
81	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	2
82	The ward/unit has a designated room for physical examination and minor medical procedures.	2
83	The service has at least one bathroom/shower room for every three patients.	2
84	All patients have single bedrooms.	2
85	Every patient has an ensuite bathroom.	3
86	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.	3

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
88 	Ward/unit-based staff members have access to a dedicated staff room. **Sustainability Principle: Empowering Staff**	2
89	Patients are consulted about changes to the ward/unit environment.	2
90 	Patients have access to safe outdoor space every day. **Sustainability Principle: Consider Carbon**	1
91	All patients can access a charge point for electronic devices such as mobile phones.	3
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
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
94	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	2
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
96	Patients and staff members feel safe on the ward.	1

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
Physical Security		
98	The service manages physical security according to the standards stated in the QNFMHS Physical Security in Secure Care guidance.	1
Procedural Security		
There are formalised policies, procedures and guidance which have been co-produced where possible on:		
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
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
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
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

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
104	The service has a co-produced strategy to respond to requests from victims, patients or carers to participate in restorative justice.	3
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
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
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
108	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.	1
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
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
111	There is dedicated sessional input from arts or creative therapists.	3

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
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
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
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
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 day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	1
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
118	All staff members receive individual line management supervision at least monthly.	2

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
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
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
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
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
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
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
122.5	Recognising and communicating with patients with cognitive impairment and learning disabilities.	1

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
122.7	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	2
122.8	Recovery and outcomes approaches.	2
122.9	Assessing and managing suicide risk and self-harm.	2
122.10	Prevention and management of aggression and violence.	2
122.11	A patient's perspective.	2
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; • When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this.	1
124 	All staff members who deliver therapies and activities are appropriately trained and supervised. **Sustainability Principle: Empowering Staff**	1
125 	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. **Sustainability Principle: Prioritise Prevention**	1
126	Patient and/or carer representatives are involved in delivering and developing staff training.	2
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
128	The team uses seclusion only as a last resort and for the minimum possible period only.	1
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
130	When restraint is used, staff members restrain in adherence with accredited restraint techniques.	1

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
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. *Guidance: If a patient declines to have their vital signs monitored, this should be recorded in patient records and re-offered again as appropriate.*	1
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
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
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
Governance		
136	The ward team use quality improvement methods to implement service improvements.	2
137	The team actively encourages patients and carers to be involved in quality improvement initiatives.	2
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
139	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.	1
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

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
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
143	Services are developed in partnership with appropriately experienced patients and carers who have an active role in decision making.	2
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

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Should you require further information about a source for a standard, please contact the Quality Network.

Appendix 1: Acknowledgements

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- Members of the QNFMHS Advisory Group.

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