Department of Health

Best Practice Guidance

Specification for adult medium-secure services

Health Offender Partnerships 2007

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Best Practice Guidance

Specification for adult medium-secure services

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Contents

Foreword

Modernising mental health services remains one of this Government's core national priorities. Medium secure mental health services are a key element of the forensic mental health system. For patients, these services are an important part of an integrated pathway, when they need care and treatment in a secure environment.

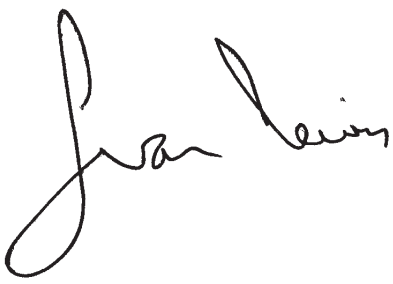
The number of patients who will need this sort of treatment is only a small proportion of patients with mental health problems. However, it is essential for those who do need this treatment that they receive compassionate, beneficial and safe services.

Effective and appropriate commissioning and provision of any forensic services is always complex and sensitive but it is particularly challenging for medium secure services. Patients who require treatment and care in a medium secure facility are nearly always detained under the Mental Health Act. This means that those who commission and provide these services have a defined duty of care to ensure that the services are appropriate and of the highest quality.

The Department of Health with the help of specialist commissioners has produced this suite of documents to provide, for the first time at a national level, a set of quality principles to guide commissioners and those wishing to provide medium secure mental health secure services.

Often not enough recognition and thanks goes to those who work in this very difficult and sensitive area. I would like to take this opportunity to commend all of those involved in ensuring that these patients get the help they so vitally need.

In addition, I am very grateful to all those who were involved, including the Royal College of Psychiatrists for its support, in bringing these documents together. I hope that they will provide a basis to continue to improve services and provide excellent care and treatment for this group of patients.



Ivan Lewis MP,
Parliamentary Under Secretary of State for Care Services

Introduction

This specification relates to medium-secure services as defined in the contract for the provision of mental health, learning disabilities or personality disorder services, of which this specification is a subsidiary and underpinning document. The specification is common to all medium-secure services commissioned across England and Wales whether from the NHS, foundation trusts or the independent sector. It will form part of all contracts/service level agreements (SLAs) for medium-secure provision and will also apply to any services spot purchased, for example as non-contracted activity.

Medium-secure services are part of an integrated care pathway for those who need care and treatment as a result of their mental ill health and/or learning disabilities, and/or treatable personality disorders with a range of potential co-morbidity, including acquired brain injury and deafness.

This specification:

- reflects standards that are in place in high-secure services and supports the throughput of patient care to and from those services;
- builds upon the key elements of the Department of Health's *Standards for Better Health* and the criteria for assessing core standards in mental health and learning disability services published by the Healthcare Commission;
- reflects Department of Health, Home Office and social care guidance;
- draws on local and national work on safety and security developed for medium-secure services and other reports and reviews of services, including independent inquiry reports; and
- sets out the role of the NHS Security Management Service (see Appendix 1).

The quality principles are built around the seven key domains used by the Healthcare Commission and reflect the complex nature of healthcare in a secure environment:

- ***A – Safety***
  Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients. Patients are detained in safe and secure environments, which also protects those they may harm.
- ***B – Clinical and cost effectiveness***
  Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

- ***C – Governance***
  Managerial and clinical leadership and accountability, as well as an organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of a healthcare organisation.

- ***D – Patient focus***
  Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

- ***E – Accessible and responsive care***
  Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

- ***F – Care environment and amenities***
  Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences, in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

- ***G – Public health***
  Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Forensic mental health services

Concept of care

Forensic services serve the public and the criminal justice system by:

- providing medium-secure services within a framework of clinical governance, specialised assessment, treatment, rehabilitation and aftercare services for offenders with mental health problems or those at risk of offending, thereby seeking to reduce the distress associated with mental health problems and their behavioural consequences, with reduction of risk of harm to others;

- promoting better services for the client group by teaching, research and development; and

- working closely with other health, social services and criminal justice agencies to reduce and manage the risk posed to others by the client group.

Models of care

Forensic services are provided within high-, medium- and low-secure hospital settings as well as within community settings. A significant proportion of forensic services are linked to medium-secure units (MSUs). The terms 'medium-secure unit' and 'forensic services' are sometimes used interchangeably; however, they are not the same thing.

MSUs are but one part of a comprehensive forensic psychiatry service and are only one step in the pathway of care for mentally disordered offenders. Most forensic services in the NHS with MSUs provide more than inpatient services: they provide a wide range of forensic services to general psychiatry, prisons and the criminal justice system.

The core tasks of a forensic service include:

- the assessment, management and treatment of high-risk mentally disordered offenders in the community, in hospitals (particularly hospitals using security) and in prisons;
- the assessment, support and treatment of victims, especially those who develop dangerous behaviour;
- the provision of advice to and collaborative working with other psychiatrists, GPs, lawyers, police officers, prison staff, social workers and especially probation officers; and
- the provision of evidence and reports for legal purposes.

Different models of forensic service delivery have developed outside high security since the 1970s. These different models have developed because there is clearly no 'right way' of achieving high-quality service delivery and because of the different provisions for mentally disordered offenders that are available within the forensic service catchment area. Broad service models can be recognised:

- *Integrated model:* Within this model, MSUs provide secure inpatient treatment and, once the need for such security has ended, expect local services to take over longer-term treatment and integrate the patient into local services. Readmission, if necessary, would be to local hospitals. Few services now operate within a pure integrated model because of the special needs of certain patients and the need to provide long-term treatment for the 'critical few' who need intensive, sustained, long-term management by a team experienced in the supervision of high-risk offenders.

- *Hybrid model:* Services using this model aim to run services as an integrated service but utilise 'shared care' in the critical period following discharge and retain long-term responsibility for the critical few who will be high-risk offenders, usually on restriction orders. If readmission becomes necessary, this will usually be to locally based hospitals but, in certain circumstances, return to the MSU (particularly for the critical few who present with exceptional high risk).
- *Parallel model:* Services using this model aim to provide both the inpatient component as well as the community component of the patient's care. Readmission would be to the MSU rather than to local services. The forensic team would expect to provide a full long-term community service to patients under their care. Compared with services utilising a hybrid model, length of stay may be reduced but may be at the expense of more use of readmission to the unit. Arrangements for patients to be followed up by local services are usually made during admission rather than at discharge.

These models have advantages and disadvantages; for example, the integrated and hybrid models attempt to reintegrate patients into regular services and reduce stigmatisation of patients who have progressed. The parallel model, on the other hand, may be better equipped to manage the more high-risk patients in the community and may be providing a service to patients who might not otherwise receive a service. Local circumstances may dictate which model is used. For example, a service to a widely dispersed, mixed urban and rural catchment area may have no option but to use some variant of an integrated service, while a densely populated city catchment area may be better served by a parallel model.

Criteria for care by a forensic service within medium security are probably best calculated on the basis of a matrix of positions on a number of dimensions reflecting qualities such as illness/disorder activity, history of seriousness and frequency of violent or other dangerous behaviour, likelihood of repetition, imminence of that repetition, the extent to which any threat posed is specific or general, capacity to escape, and insight and capacity for co-operating with treatment and supervision to name but a few. Within the different models of forensic service delivery, different MSUs (or different functional areas within an MSU), can cater for patient groups with different needs. These groups include patients who require long-term medium-secure care, those who require therapeutically enhanced care, female patients, adolescent patients, deaf patients, patients with learning disabilities, patients with a diagnosis of personality disorder, patients with significant dependence needs (for example in relation to activities of daily living) and patients in custody because of high-severity risk behaviours. These different patient groups will require different skills and expertise to meet their needs and may require different mixes of environmental, procedural and relational

security to meet their needs (while still compliant with the minimum quality principles identified within this specification for medium security).

Within MSUs, there are two overarching aims in service delivery. One is held in common with all other hospital services – that of delivering high-quality clinical assessments, healthcare and treatment appropriate to the needs of the presenting clientele. The other relates to the forensic service needing to balance the twin factors of treating mental disorder and managing and reducing risk. Risk of harm to others is what distinguishes forensic psychiatry patients from those individuals with mental disorders who present to general psychiatry, and likewise, those in the criminal justice system may only be differentiated from forensic psychiatry patients by the absence of mental disorder requiring hospital treatment.

This specification addresses adult medium-secure inpatient care and recognises that this is one part of a pathway of care for mentally disordered offenders. It is recognised that patients have individual needs, and that patients with a diagnosis of personality disorder will require differing models of care to those with a learning disability. The principle of access to medium-secure services is based on the assessed level of risk and the need of the individual patient to receive care and treatment within a medium-secure environment. Patients who do not require a service that provides a medium-secure specification should not be admitted.

Section A: Safety and security

Security plays a positive and supportive role to the care and therapy provided. It should not be seen as negative or as preventing things from happening but rather as positive, providing the structure within which the clinical agenda can be safely carried out and privacy of patients maintained.

Security should be integral to and supportive of the clinical agenda and will be provided within a threefold concept of relational, procedural and physical security, each element of which will be developed in relation to and with the other two. Physical security alone will not provide safety and cannot operate without appropriate relational and procedural security. Weaknesses in physical security cannot be compensated for by increases in relational and procedural security. The contribution security makes in support of the clinical agenda comes from the synergy that is developed in the interaction of these components of security.

A crucial and central policy underpinning the positive use of all aspects of security as contributors to care will be the development and full implementation of a physical security document (PSD) and a procedural security index document (PSID). Appendices 2 and 3 describe the elements of security required.

Patients in medium security will receive all of their care and treatment within the secure perimeter unless authorised to do otherwise under Section 17 of the Mental Health Act 1983.

(i) Physical security

Physical security is provision, maintenance and correct application of appropriate equipment and technology by appropriately trained staff. It is important but should not be the sole element of the security provided.

The security provided should be such as to protect the privacy and dignity of patients, to prevent others passing contraband items into the unit and to make an escape difficult. There is a range of differing unit designs with physical security provided in differing ways, the principle being a secure/protective envelope to the care facility. Additional supporting advice on physical security is included at Appendix 2.

(ii) Procedural security

Procedural security is the proper application of set procedures, routines and checking. Appendix 3 sets out the requirement for a PSID and offers advice.

Establishing a comprehensive range of effective procedures across the service anchors the application of therapeutic activity to structure and routine. This serves a dual purpose in that staff are able to quickly and efficiently establish clear boundaries across the service but, more importantly, procedures reinforce in patients and staff the requirement to balance the needs of the individual against the needs of others. The routine application of procedures also enables safe practices to become ingrained within staff and patients and to be applied in a consistent way. Staff will be trained to not only recognise these procedures but to understand their application and purpose for the individual.

(iii) Relational security

Relational security is the formation of a therapeutic alliance between staff and patients centred in continuing risk assessment and detailed knowledge of the patient and the use of personal and professional skills by each member of staff to ensure that they support and offer appropriate treatment for patients.

Relational security is the key provider of security within a healthcare setting. It is not always helpful to set a definitive staff/patient ratio but it is more useful to recognise that there is a need to provide a high ratio of experienced staff to allow for optimal intervention with patients, provide a high quality of treatment, and maintain policies related to security and patient confidentiality.

At the centre of relational security is the individual patient care treatment plan. This plan commences at the assessment stage and the admission process. Within the plan there is a collation of information, an assessment of what has occurred and what is occurring. Regular, usually weekly, reviews provide the opportunity to set and monitor treatment, activity programmes and to monitor and reset objectives as necessary. Security input into these plans can be helpful. Security should be seen as facilitating treatment safely, enabling therapeutic gains for patients by judicious and planned risk taking within a controlled environment. Good security can therefore provide the opportunities to test out patient care plans.

Observation and assessment needs to take place in a variety of settings and it is therefore essential that treatment programmes, occupational therapy, work, education, activity and leisure are structured into the day over a seven-day week. Each offers the opportunity to assess and support the patient's recovery. A planned care programme is also essential in maintaining the patient's quality of life.

Staff will be encouraged to develop good quality relationships with patients that motivate and encourage them to use the therapeutic milieu that is provided and to understand the constraints that are present.

In all areas, there will be a system in place for the notification of serious and untoward incidents. This will be in line with *Guidance on the discharge of mentally disordered people and their continuing care in the community* (Health Service Guidance (HSG)(94)27 as amended by Department of Health guidance on *Independent investigation of adverse events in mental health services*, published in June 2005) and is to ensure that there is systematic collection, collation and follow-up of incidents, including an examination of trends and issues requiring further action. This issue is important within the organisation where the incident has occurred and for those responsible for commissioning or performance managing the service. Ensuring that a system is in place to analyse critical incidents, for example *Organisation With A Memory* (*Building A Safer NHS For Patients: Implementing Organisation With A Memory*, published 2001). Learning from incidents should be used to make improvements in practice and be based on local and national experience. This will form part of the work of the National Secure Commissioners Group which will agree mechanisms for sharing learning and disseminating this to all MSUs so that they are aware of problems and potential solutions from events that have happened.

Ref	Quality principle	Measure	Evidence	Review frequency
	(i) Physical security			
A1	The provider will have a PSD (see Appendix 2), which defines the physical security including the perimeter creating the secure area.	Provider policy on physical security (PSD)	Policy addresses all the quality principles identified	Annually
A2	The MSU will have a secure perimeter of: • a 5.2-metre fence of welded mesh surrounding the whole unit; • a 5.2-metre fence of welded mesh joining reception and surrounding the remainder of the unit; • integral design formed by the building creating the enclosed secure area. Building design and specification must be as detailed in this specification, particularly windows and climb points; or • integral buildings forming the perimeter with a 5.2-metre fence around the sports area/field.	Escapes from within the secure area PSD	Inspection of the perimeter Record of escapes from within the secure area	Annually
A3	Patients in medium security will receive all of their care and treatment within the secure perimeter unless they have authorised leave from the secure perimeter under Section 17 of the Mental Health Act 1983.	PSD	Patients receiving treatment and care within the secure perimeter Use of Section 17	Annually
A4	There will be a daily recorded inspection of the perimeter.	Recorded daily inspection	Record of inspections and incidents with actions taken	Quarterly
A5	The perimeter security will not be hampered by the presence of shrubbery close to or growing on the perimeter fence or buildings that form the perimeter.	PSD Maintenance programme for the perimeter	Recorded inspection	Quarterly

Ref	Quality principle	Measure	Evidence	Review frequency
A6	The lighting within the secure area of the perimeter should be such as to provide good observation during the hours of darkness and, particularly, to allow an appropriate and safe response to an incident.	PSD Checks on clarity of observation during the hours of darkness	Recorded checks	Quarterly
A7	There will be a maintenance programme in relation to the perimeter. Any identified weakness or compromises will be identified with an action plan for remedy.	Record of maintenance programme and actions taken to remedy deficits Escapes	Maintenance programme record and actions taken	Quarterly
A8	The fencing posts will be placed on the non-patient side of the fence.	PSD	Inspection of the fence Estates report	Annually
A9	Reception must be within the secure area or form part of the perimeter. Where reception is part of the perimeter, the rear of the building within the secure area must be protected against climbing.	PSD Escapes	Examination of report Inspection of reception	Annually
A10	Where the fence meets buildings or other fences, action must be taken to reduce the potential to breach perimeter security by ensuring there are no gaps between the joins and no climbing aids.	PSD Escapes	PSD Inspecting the perimeter	Annually
A11	Only essential gate entry points are allowed within the perimeter.	PSD Escapes	Escapes Usage of each gate	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A12	Gate entry points will conform to the following quality principles with either: • an air-lock system; or • double-locked gate accessible only by manual control by authorised individuals.	PSD Escapes	Escapes Inspection checks recorded List of authorised individuals	Annually
A13	Gate entry points must be on a separate locking suite with keys issued, accounted for and controlled by reception.	PSD Escapes	Reception audit Inspection checks recorded	Annually
A14	Gate locks must be integral to the gates. The locks must not be accessible from the external side of the perimeter.	PSD Escapes	Inspection checks recorded	Annually
A15	Gates must not be such as to provide an opportunity to breach the perimeter security. Lock design and secure ground bolt fittings must not be capable of being used to aid climbing. Gates should be fitted to prevent egress under the gate. Double skinning of gates assists in the prevention of climbing (see Appendix 2).	PSD Escapes	Escapes Inspection checks recorded	Annually
A16	Action must be taken to ensure that the gate housings do not provide a climbing aid with adjoining buildings.	PSD Escapes	Inspection	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A17	Where building roofs form part of the perimeter, they must be protected against climbing. This is of particular importance where the roofs are low and provide access either to the reception roof or other roofs, which give access to the outside of the unit. The roofs can be protected by a number of means. The following are acceptable: • a gooseneck capping; • a flexible secure topping (FST); • welded mesh fence – with or without FST – fixed from below the eaves to a height of 5.2 metres; • infrared alarm on the roof (in combination with one of the above); and • hanging eaves with projection a minimum of 1,200mm from the face of the building. The following are not acceptable for use: • revolving spikes; • razorwire/barbed wire; or • other protections intended to cause injury.	PSD Escapes	Inspection Response programme to roof alarm	Annually
A18	Where the building roofs surround courtyards or patient access areas, it must be ensured that there are no climbing points, eg poor siting of light fittings, trees, unprotected window sills, water drain pipes or air-conditioning units.	Planned/actioned reviews PSD Escapes	No escapes over roofs Inspection	Quarterly
A19	Furniture must be fixed in all courtyards. Courtyards will be checked before use to remove any items presenting a security hazard. Action must be taken so that access doors, doors to stores or facilities, lighting postings, fixings, CCTV fixings, sports fixings etc do not provide a climbing aid. Gardening and recreational equipment will be kept securely when not in use.	PSD Ward audit record	Inspection	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A20	Window frames and their fixings must be described in the PSD and have a maintenance programme considering wear and tear over time and weakness of fittings.	PSD Maintenance programme Escapes	Maintenance programme Escapes	Annually
A21	Part of the perimeter may be buildings and may include patient areas such as bedrooms or communal areas and, therefore, these external windows must prevent the passage of contraband.	PSD	Maintenance programme Escapes	Annually
A22	Where windows form part of the perimeter, they should not open more than 125mm and should be capable of being locked open as well as locked shut. Where restraining bars are in use, these must not provide a climbing aid to the roof.	PSD Escapes	Maintenance programme	Annually
A23	Windows and frames must be set within the building masonry.	PSD	Maintenance programme	Annually
A24	Ceiling designs should be such that patients cannot access the ceiling/roof void.	PSD Maintenance programme Escapes	Maintenance programme Report from estates of inspection of roof voids	Annually
A25	There will be a secure locking system in place, either manual, electronic, magnetic or a combination of these.	PSD	Maintenance programme	Annually
A26	Reception should be managed by a senior member of staff.	Management structure	Management profile	Annually
A27	Reception should be staffed 24 hours per day every day. Night cover may be provided by ad hoc deployment from the wards.	Staff structure	Staff structure	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A28	There must be a key-management system in place which accounts for **all** secure pass keys – those in store, those issued, those held in reception – every shift change and twice per day as a minimum. • Spare replacement keys must be under the control of a senior manager and kept secure away from reception. • Secure keys must be on a sealed ring – only secure pass keys will be on this ring. • Secure keys will be issued, returned and accounted for in reception. • Secure pass keys will not be taken out of the secure perimeter • Estates' secure area access keys will be kept in reception.	Key-management system and included as part of PSD Audit of keys takes place at the end of each shift	Audit report	Annually
A29	All staff entering the secure area can only obtain keys upon production of a valid identity card/tally. Staff must not be issued with keys until they have undertaken security induction.	Key-management system	Inspection – audit six staff at random	Annually
A30	Secure keys will be attached to staff at all times, including when used in the lock; a belt, lanyard and pouch should be provided to all staff with secure keys. Where electronic cards are in use and where they provide automated access, they must be secured to staff.	Key-management system	Audit six staff at random within the secure area	Annually
A31	Reception should have an electronically controlled air lock operated by reception. There must be no entry to the reception office/control room from within the air lock. Entry to that office must be controlled by reception.	PSD Key-management system	Reception audit	Annually
A32	When the electronic air lock system fails, there must be a back-up system and the default position for doors is that they will lock on failure of the electronic system.	PSD	Inspection	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A33	Locks within the secure area that provide access to courtyards or open areas within the perimeter must be on a separate suite from internal pass doors. These keys must be issued, controlled and accounted for by reception.	PSD Key-management system	Reception audit Inspection	Annually
A34	All other non-secure pass keys may be controlled, issued and accounted for on the wards. These keys should be kept in locked cupboards and the number of keys on one bunch or within a cabinet should not be such as to make accounting for them difficult. Staff should not keep ward keys and secure pass keys together.	Key-management system	Ward inspection	Annually
A35	Keys to medication storage must always be attached to a qualified member of staff and issued and accounted for within the ward.	Key-management system	Ward inspection	Annually
A36	Alarms may be hardwired alarms or personal issue alarms and must: • have the capacity to identify where the alarm that has been activated is located; • be tested daily; • be available in sufficient numbers to allow for replacements; • be controlled, issued, returned and accounted for by reception; and • be secure to staff at all times.	Reception audit	Reception audit Inspection	Annually
A37	Where CCTV is in use, reception will monitor coverage of the perimeter, reception frontage and access from the secure area to reception.	PSD	Inspection	Annually
A38	Ward staff will monitor CCTV in relation to visits.	PSD	Records of visits	Annually
A39	Visiting areas for children will be covered by CCTV.	PSD	Inspection	Annually
A40	Each unit will have a security committee chaired by the forensic services director or equivalent.	Management structure	Committee minutes	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A41	Each unit will have a security lead as a full-time role.	Management structure	Staff profile	Annually
	(ii) Procedural security			
A42	The provider will have a PSID, which lists the procedural policies.	Provider policy on procedural security (PSID)	Policy addresses all the indexed policies	Annually
A43	There will be a policy that includes patient searching, bedroom searching, ward and off-ward areas, and the searching of visitors if necessary. It will define the quality principle of person search normally as a rub-down search.	Policy document Number of patient searches per month	Policy document Contraband finds	Annually
A44	There will be a policy on management of violence and aggression (National Institute for Health and Clinical Excellence (NICE) guideline 25).	Policy document	Policy document	Annually
A45	Policy on use of seclusion.	Policy document	Report on use	Annually
A46	Policy on use of forced medication including rapid tranquillisation.	Policy document	Policy document	Annually
A47	Policy on observation.	Policy document	Policy document	Annually
A48	Policy on bullying – this should meet the needs of those who are bullying and those who are bullied.	Policy document	Policy document	Annually
A49	Policy on prevention of suicide and management of self-harm.	Policy document	Policy document Number of self-harm/suicide incidents	Annually
A50	Policy on transportation of patients, eg to court or acute hospital.	Policy document	Escapes	Annually
A51	Policy on the use of handcuffs.	Policy document	Number of uses of handcuffs per calendar month	Annually
A52	Policy on escort procedures.	Policy document	Policy document	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A53	Policy on leave of absence including Section 17 leave.	Policy document	Number of leaves of absence Number of failures	Annually
A54	Policy on the control of illegal substances.	Policy document	Number of incidents of discovery of illegal substances	Annually
A55	Policy on substance misuse.	Policy document	Number of incidents	Annually
A56	Policy on the control of prescribed medication and drugs.	Policy document	Number of incidents	Annually
A57	Policy on the prosecution of offences within the unit, which is agreed with the police and Crown Prosecution Service (CPS).	Policy document	Number of referrals to police and CPS Number of those prosecuted	Annually
A58	Policy on patient possessions.	Policy document	List of items allowed	Annually
A59	Policy on smoking for patients, visitors and staff.	Policy document	Evidence of action to reduce smoking	Annually
A60	Policy on management of patients' monies.	Policy document	Policy document	Annually
A61	Policy on the censorship of material including pornography.	Policy document	Policy document	Annually
A62	Policy on the control of mail and use of telephones.	Policy document	Record of incidents of stopped mail and interrupted calls	Annually
A63	Policy on the control of tools used in therapy or education or ward areas.	Policy document	Number of misplaced tools	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A64	Policy on prohibited items and a clear statement of these in reception and provided to all visitors, patients and staff; as a minimum, this will include mobile phones, cameras, firearms, weapons, chewing gum, blue-tack.	Policy document	Number of prohibited items found within the secure area	Annually
A65	Policy on the use of computers and access to the internet.	Policy document	Use of internet/ computers	Annually
A66	Policy on visiting procedures including child protection issues.	Policy document	Policy document	Annually
A67	Policy on patient confidentiality.	Policy document	Policy document	Annually
A68	Policy for managing critical incident reviews.	Policy document	Audit of reviews	Annually
A69	Policy on patient roll checks.	Policy document	Audit	Annually
A70	There will be contingency plans in place agreed with the police as a minimum.	Agreed contingency plans in place	Signed document that is in date Document signed by unit and police	Annually
A71	The contingency plans should be tested by desktop exercises at least once a year. Ideally, there should be a live exercise involving one or other of the emergency services at least once every two years.	Emergency planning systems in place	Evidence of testing and that procedures are effective in managing an emergency situation	Annually
	(iii) Relational security			
A72	Pre-admission multidisciplinary team assessment for all patients, admitting only those in need of care and treatment in a medium-secure setting as part of their care pathway.	Number admitted compared with number referred Assessments have taken place and results shared with referrers along with advice	Case notes Referrers' opinion of response received	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A73	Plan the workforce, including reference to appropriate ratios of qualified to unqualified nursing staff and appropriate numbers of staff on duty per individual unit within the provider, and reflecting the complexity of patient need and the risk associated with that patient group.	Workforce plan in place	Evidence of appropriate staffing levels	Annually
A74	The Royal College of Psychiatry recommends the ratio of consultant psychiatrists to patients to be in the range 1:13–16 for acute MSU and 1:20 for longer-stay patients.	Number of consultants per patient	Evidence of staffing levels	Annually
A75	Enhanced Criminal Records Bureau (CRB) checks for all staff. Where there are delays, staff may be employed on a temporary basis where previous references validate their record, eg employment in another MSU.	Policy in place	All staff with enhanced CRB checks	Annually
A76	Regular individual patient care reviews and assessments led by Responsible Medical Officer (RMO) and including a multidisciplinary approach.	Policy Care Programme Approach (CPA) audit	Frequency of patient reviews by multidisciplinary teams CPA audit report	Annually
A77	A programme of clinical supervision, continued professional development (CPD) and personal development plans (PDPs) for all staff.	CPD audit PDP audit	CPD audit report PDP audit report	Annually
A78	There will be a training and development strategy including how training on security will be addressed.	Strategy in place	Evidence of training Annual report	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A79	A staff training programme including a security input and annual security awareness training.	Training programme Annual security awareness programme	Evidence in PDPs	Annually
A80	There will be a risk management strategy incorporating assessment and management of risk.	Strategy in place	Serious incidents CPAs	Annually
A81	There will be a minimum of 25 hours per week per patient of structured activity. This will be a planned programme of treatment, education and work, taking into account: • week and day routine; • range of therapy programmes including occupational therapy; • psychological sessions; • structured activity programmes; • structured leisure time; • unstructured free time; • access to real opportunities to work; • substance misuse; and • offence-related therapy.	Programme in place	Evidence Sampling clinical notes CPAs	Quarterly
A82	All patients will have an initial plan in place within 24 hours of admission.	CPA	Care plans	Quarterly
	(iv) Serious and untoward incidents			
A83	The provider will have a serious and untoward incident policy.	Policy in place	Evidence of policy	Annually
A84	Clear system in place to identify, record, report and follow up serious and untoward incidents.	Reporting and management of follow up to incidents system in place	Evidence of system Appropriate follow-up Outcomes of serious incidents	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
A85	System in place to report incidents to the relevant commissioners in line with the lead commissioner's reporting policy on serious and untoward incidents. This will include initial notification within 24 hours of the incident. There will be a full, detailed serious and untoward incidents report within seven days of the incident.	Incidents reported appropriately	Review of incidents benchmarked against other similar services	Annually
A86	Untoward incidents will be continually monitored to identify trends and learning points. The provider will ensure that mechanisms are in place to share learning beyond the immediate service/provider and will share this with the relevant commissioner.	System in place to monitor trends and identify learning	Shared learning/ events/ dissemination of advice on outcomes	Annually
	(v) Safeguarding children and child visiting policies			
A87	Policy and visiting facilities in place for children (18 years of age and under) to visit MSU patients, which is external to the ward area but within the secure area appropriately supervised by staff with suitable play areas and facilities (Health Service Circular 1999/222: Local Authority Circular (99)32).	Policy in place Visiting facilities in place	Evidence of policy No incidents involving child visiting No complaints about facilities	Annually
A88	Policy on safeguarding children which complies with national quality principles.	Policy in place	Policy in place and in date	Annually
A89	Policies and protocols in place for safeguarding children and child visiting underpinned by staff awareness training.	Policy in place	Policy in place and in date	Annually
A90	Designated lead for safeguarding children in the MSU.	Identified lead	Name of lead	Annually
A91	Designated lead in place in the provider unit (recommendations of the Victoria Climbié Inquiry, January 2003).	Identified lead	Name of lead	Annually

Section B: Clinical and cost effectiveness

The development of a modern mental health service is based on a clinical assessment, planning and treatment process in which the differing perspectives, including that of the patient and carer of the needs of the patient, must form the basis of the care plan under the Care Programme Approach (CPA).

Considering the spectrum of each individual's need, particularly where the patient is detained for significant periods, requires the exchange of concepts, a shared analysis and practical application of the range of bio-medical, sociological and psychological frameworks offered by the different mental health professions. This will also include the patient's perspective.

Each patient will receive high-quality care and treatment which meets their needs and supports their recovery. Professionals will collaborate as multidisciplinary teams with each patient and their carers as appropriate, to balance their differing perspectives and understandings of need, and together agree how the patient's needs will best be prioritised, met and reviewed by the service.

Ref	Quality principle	Measure	Evidence	Review frequency
B1	The provider should have a clearly identified care pathway with other services that enables patients to move to the most appropriate level of care.	Care pathway developed identifying action from assessment to discharge/transfer	Diagram and report with key decisions identified which links to care pathways in other services, eg high-secure services	Annually
B2	The provider should provide effective care co-ordination for all patients in line with national guidance on the Care Programme Approach (CPA).	CPA system in place All patients to have an individual care plan which meets CPA requirements	Evidence of system in place and operating Individuals' care plans reviewed as a peer audit or spot assessment	Annual peer review Ad hoc checks on a sample of plans
B3	The designated lead medium-secure unit(s) (MSU(s)) for an area, as identified by the relevant lead commissioner, will act as gatekeeper for all potential referrals to high security.	Gatekeeping policy agreed between commissioner and provider	Operation of policy High-secure hospital (HSH) referrals subject to gatekeeping by MSU	Annually; quarterly
B4	All patients from a designated area (defined by the lead commissioner) requiring an MSU will be treated in the MSU designated as the lead for that area unless there are issues of capacity or needs of the patient which mean that the service is not appropriate.	The designated lead MSU will be the gatekeeper for non-contract referrals or any patient who is not admitted to that unit but requires an MSU	All patients placed out with the local MSU have had a gatekeeping assessment	Quarterly
B5	Designated MSUs will work with commissioners as part of the contract to review all patients for whom that MSU is the relevant unit and who are placed elsewhere for reasons such as lack of capacity or security or due to the need for a specialised service.	System to monitor out-of-area patients	Evidence of system Number of those placed elsewhere	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
B6	Commissioners should maintain contact with patients placed out of area and may require the "home area unit" to review patients' progress. Where this is the case, the "home MSU" and the relevant case manager from the commissioning team will attend CPAs or visit the patient as required to ensure co-ordinated and agreed through care unless agreement has been reached for formal transfer to the new area.	Review of needs incorporated into plans	Names/needs identified and discussed with the lead commissioner	Quarterly
B7	The provider should agree clear admission criteria with commissioners as part of the Service Level Agreement and share this with potential referrers.	Clear written admission criteria	Criteria shared with referrers	Annually
B8	Each provider should have a clear written policy for referrals, admissions, transfers and discharges.	Policy with clear timescales	Evidence of policy Adherence to timescales	Quarterly
B9	The provider should identify the responsible primary care trust (PCT) for every individual planned admission, even where the service user is known to the service.	The provider has details of the person's GP and responsible PCT	All patients with an identified responsible PCT	Quarterly
B10	All patients should have a link person/care co-ordinator from their home area services whose responsibilities will include the facilitation of ongoing links and the patient's care pathway.	Identified local co-ordinator and responsible local provider	All patients have an identified local co-ordinator	Quarterly
B11	The provider should facilitate links to the home area services of each patient in terms of local statutory (health and social care) and voluntary services and maintain these to ensure timely and appropriate discharge/transfer arrangements are put in place.	Reports to home area services; invitations to CPAs; attendance by home area team	Attendance at CPAs Delayed discharges	Quarterly
B12	Where patients from the MSU catchment area are in high security, the MSU will develop and maintain links with the high-secure team and will participate in all CPA meetings to ensure timely transfer of the patient when they are ready to leave high security.	All high-secure patients have an identified link MSU and lead clinician	Attendance at CPAs by the MSU Delayed discharges; delays to patient care pathway	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
B13	All patients should have an individual care plan, drawn up in collaboration with the patient, from the assessment of their needs. There will be a preliminary plan drawn up on admission and a first CPA review held within three months of admission.	Care plan in place for each patient which sets out a range of therapeutic, recreational and rehabilitative plans to address their needs using evidence-based approaches.	All patients have a fully developed CPA within three months of admission	Annually
B14	Adhere to Home Office requirements in respect of annual statutory returns and reports on restricted patients required to facilitate the care pathway.	Reports provided on time and covering key areas required by the Home Office	Feedback from the Home Office	Annually
B15	The provider should ensure there is a multidisciplinary assessment to determine readiness for discharge/transfer as part of the patient's care pathway in order to ensure patients are supported to move on without delay when they no longer need an MSU.	Discharge/transfer protocol in place to ensure timely/ appropriate transfer	Delayed discharges Difficulties in moving patients on	Quarterly
B16	The provider should maintain a list of the interventions available within the hospital and a list of resources that can be provided from external sources and will provide a range of evidence-based and clinically effective treatments and therapies, and recreational and life skills training, and support that is appropriate to meet the needs of patients admitted to that service. The information will be made available to service users.	Provider to report range of therapies available	Appropriate range of therapies available	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
B17	The provider should operate effective, patient-centred multidisciplinary working, and ensure there is clear and agreed clinical leadership and governance arrangements.	Demonstrable evidence of effective, patient-centred multidisciplinary working, with clear and agreed leadership	Description of multidisciplinary teams; governance report	Annually
B18	The provider should ensure there are adequate numbers of suitably trained staff to support the ward/service on any given day taking into account fluctuations in individual patient needs. The staff complement, both clinical and non-clinical, should be sufficient in terms of grading, experience, skills, numbers and diversity to ensure the service is appropriately staffed at all times, delivers a full multidisciplinary service and meets the needs of the current patient population.	Range of professions and skills and sufficient numbers of staff	Establishment and numbers in post Staffing profile	Annually
B19	The service should contribute to best practice from evidence-based research, published best practice and clinical guidance.	Each service to have an identified clinical lead with responsibility for R&D	Name of R&D lead	Annually
B20	The service should seek to be involved in R&D relevant to the service development.	R&D plan; clear and written R&D governance policies and procedures which form part of a clinical and social care governance process	Plan in place in context of governance structure	Annually
B21	The service should ensure there are regular reviews for patients transferred from prison (a) on remand or (b) on sentence to assess suitability for return to prison.	Review programme	Number returned against number held	Annually

Section C: Governance

The provider will have clear managerial and clinical leadership and accountability and will ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the provider.

Work in medium-secure units is demanding, complex and difficult. It is important that staff are well trained and provided with training that will develop their skills. The provider will ensure that its training strategy incorporates the future needs of the secure service and changing workforce.

Within a medium-secure unit interpersonal skills are as important as technical skills. The importance of these and their contribution to the atmosphere, culture and security of the unit should be emphasised in staff training.

Medium-secure units are a part of the communities they serve. Patients come from these communities and will return to them. Patients have often been dealt with by a range of agencies and on return to the community may continue to be supported by community-based agencies.

Local authority social services are major stakeholders in the provision of services to mentally disordered offenders and for their follow-up care. Social workers are key members of the multidisciplinary team providing treatment to the patient and have a crucial role in ensuring that links are maintained with the patient's home area to facilitate the care pathway, and in the support and protection of safeguarding children.

It is important to ensure that there are good quality relationships, including meetings with and visits from agencies, and services that are part of Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

Ref	Quality principle	Measure	Evidence	Review frequency
C1	The provider should have a clear complaints procedure and should ensure that complaints are continually monitored to identify trends and learning points.	Procedure in place with mechanisms for follow-up and resolution of complaints	Satisfactory resolution of complaints Trends in number and type of complaints Evidence of action in response to complaints	Quarterly
C2	The provider should ensure that systems are in place to ensure that patients (particularly those vulnerable to exploitation, eg financially, emotionally or sexually) are not subject to bullying by other patients, visitors or staff and that this is managed effectively.	Policy in place to prevent bullying/ exploitation within the unit	Review of incidents Evidence of management of the policy	Quarterly
C3	The provider should implement a risk management strategy.	Strategy in place	Evidence of strategy Review of incidents	Annually
C4	All staff should understand the security policy and how to operate within the policy, ensuring the safety and security of the patients, staff and public at all times, and should be aware of their own role.	All new staff should be given an initial induction course including a security induction. Keys should not be issued prior to completion of this course	Records of induction training Review of incidents	Quarterly
C5	All staff should receive basic security procedure induction training on their first day at the unit.	Staff induction	Records of induction training	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
C6	The provider should ensure that all staff are kept up to date on issues of security awareness and policy implementation.	Annual security update/awareness training; updates when new security arrangements are being introduced	Records of training Review of incidents	Quarterly
C7	The provider should ensure that all mandatory training is undertaken and regularly updated (eg first aid, fire, Control of Substances Hazardous to Health Regulations (COSHH).	Programme in place for uptake of mandatory training	Records of training	Annually
C8	The provider should ensure that all staff are trained in the management of aggression and violence (National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 25(2005)).	Programme in place for uptake of training in the management of aggression and violence	Records of training	Annually
C9	The provider should ensure that staff understand their legal position in relation to leave of absence and the use of restraint and/or force.	Training for all staff to understand the implications of leave of absence and also of the use of restraint and/or force	Records of training	Annually
C10	The provider should ensure that issues relating to diversity are addressed, leading to understanding and sensitivity in meeting patients' ethnic, cultural and gender needs, and should include anti-discriminatory practice training.	Regular training addressing inequality issues and developing cultural competence	Records of training	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
C11	The provider should have clear policies (which may be trust policies in the NHS or whole organisation policies for other providers) that cover disciplinary and grievance procedures, whistle-blowing, discrimination, harassment, bullying and violence, and the provider should ensure that staff understand the policies and have confidence that they are applied satisfactorily.	Policies in place	Evidence of policies Records of training	Annually
C12	The provider should ensure that each member of staff is supported to train and develop their needs and skills appropriate to the patient group, and should develop the service to ensure an appropriate, motivated and skilled staff base.	All staff to have a personal development plan (PDP)	Evidence of PDPs signed and agreed each year between the provider and each staff member	Annually
C13	The provider should ensure that there is clear guidance for staff on the management of relationships between patients and between patients and staff and that staff are supported to understand the user perspective and participation.	All training will include the user perspective and user participation as appropriate	Records of training	Annually
C14	The provider should ensure accreditation for pre-registration training in all relevant disciplines, that there are links and communication channels with higher education institutions, and that the service is recognised as providing a learning environment.	Training systems in place	Links to external training organisations	Annually
C15	The provider should ensure that clinicians participate in regular clinical audit and reviews of clinical services.	Audit programme	Report from audit programme	Annually
C16	The provider should ensure that it has a strategic approach to planning its staffing to meet service needs and should have a current strategic plan for training, encompassing all known initiatives and subject to regular review.	Workforce training and development strategy in place and updated regularly	Up-to-date strategy	Annually
C17	The provider should comply with Improving Working Lives (IWL) requirements and should maintain records of: • the knowledge skills framework; and • professional registration.	System in place to review adherence to IWL	System and compliance with IWL	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
C18	The provider should ensure that there is robust clinical supervision within the medium-secure unit to ensure safe practice, including clear clinical supervision guidelines and a list of supervisors, and that adequate time is made available to enable this to be delivered.	System of clinical supervision in place which is monitored and audited	Clinical supervision records and system	Annually
C19	The provider should ensure that clinical teams and service/provider managers contribute to relevant local networks, including strategic, operational and mentally disordered offender meetings.	Participation of clinical teams and service/provider managers in networks	Identified leads for each network/ meeting	Annually
C20	The provider should ensure that clinical teams and service/provider managers actively participate in developing and maintaining liaison links with key agencies, including prisons, the courts, local authority social care, primary care trusts, the strategic health authority, education and housing providers, employers and voluntary agencies, to facilitate the care pathway and the provision of a comprehensive mental health service.	Clear links established	No operational difficulties due to lack of clarity about contacts; feedback from networks	Annually
C21	Clinicians and managers should maintain good links with the Home Office and ensure that their target deadlines/requirements are met.	Timely reports and annual statutory returns submitted	Feedback from the Home Office Completion of annual statutory returns	Annually
C22	The provider should adhere to the guidelines for repatriation of foreign nationals.	Reports	Repatriation of foreign nationals	Quarterly
C23	Clinicians and managers should link to high-secure services in respect of assessment and transfers within forensic services, to ensure timely, smooth access to services, and should adhere to the timescales set out in the care pathway (Appendix 4).	Networks and liaison links in place	Delayed discharges from high-secure hospitals Time from referral to transfer	Quarterly

Ref	Quality principle	Measure	Evidence	Review frequency
C24	Networks of clinicians/professional groups should meet as required, for example to discuss service development, meeting as groups and with commissioners.	Networks in place and clearly described, with clear accountability structures underpinning them	Proposals for change/ modernisation identified and presented to strategic planning groups	Six-monthly
C25	The provider should identify an executive and non-executive director who will take a leadership role and responsibility for secure services. The provider should have clear lines of accountability to the Board and a management structure to underpin this which includes clear lines of accountability for all staff.	Leads identified	Named leads	Annually
C26	The provider should ensure that lead clinicians are involved in the commissioning process.	Identified lead clinicians to attend contract reviews/ Service Level Agreements (SLAs)	Names of lead clinicians	Annually
C27	The provider should ensure that it operates in line with a clinical governance strategy.	Clinical governance strategy in place	Strategy Reports from the clinical governance review group	Annually
C28	The provider should empower all employees to promote openness, honesty, probity, accountability, and economic and efficient use of resources.	Policy in place	Review of issues raised	Annually
C29	The provider should ensure that appropriate management and finance support is provided to the service to manage its budget.	Clear budget in place for the service, with SLAs for other services provided by other departments/ providers	Service achieves budget	Quarterly

Ref	Quality principle	Measure	Evidence	Review frequency
C30	The provider should be supported by high-quality financial management to oversee and manage its use of resources.	Finance lead identified	Attendance at contract meetings	Quarterly
C31	Financial management should ensure an optimised use of public funds, reduce risk to the public and ensure that patients receive appropriate treatment.	Clear systems for financial oversight	Balanced budget	Quarterly
C32	The provider should ensure that systems are in place to manage benefits payments for transferred prisoners.	Systems in place	No delays in allocating benefits	Quarterly
C33	The provider should ensure that the service has information communications technology to support clinical care, for example to manage and monitor referrals, admissions and bed vacancies	IT system in place which addresses key requirements about data management	IT system that meets the need for data management	Annually
C34	Clinical teams should utilise computerised systems for care management records, which in turn feed into the monitoring of services by commissioners.	IT system to underpin the management of clinical records	IT system that meets the need for data management	Annually
C35	The provider should submit information returns to the relevant commissioner in line with the national forensic system.	System in place to record and submit data in line with commissioner expectations	Accurate and timely information to the relevant commissioner	Monthly
C36	The provider should ensure that the requirements of the Race Relations Act are implemented and that the service has undertaken a race impact assessment.	Race impact assessment completed	Outcomes of assessment addressed	Annually
C37	The provider should ensure that all legislative quality principles are maintained, eg Mental Health Act, Human Rights Act, Disability and Discrimination Act, Health and Safety at Work Act, Food Safety Act, Infection Control, Control of Medicines, Race Relations Act, Working Time Directive (this list is not exhaustive).	Quality principles in place	Implementation of quality principles	Annually
C38	The provider of social care services should ensure that it follows current best practice protocols, for example *Protocols for secure services* (NIMHE 2003) and any subsequent best practice guidance.	Social care staff have clear quality principles in place	Report	Six-monthly

Section D: Patient focus

Personal dignity is important for each patient. It is part of the quality of care and it also impacts on issues of security. Those who believe they are respected and have dignity are far more likely to respond to the encouragement of staff within relational security to participate in the therapeutic milieu and accept constraints. A number of factors are important in underpinning this aim.

Patients within a medium-secure unit (MSU) must be given the opportunity to have input into issues that affect them and their lifestyles within the unit. There should be both formal and informal forums or meetings empowering patients to express their views and a response provided taking account of *Involving Patients and the Public in Healthcare* (see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002892).

The aim of commissioning independent civil advocacy services is to promote individual patients' growth towards self-advocacy. Civil advocacy services should be available to all patients receiving care and treatment. This recognises the benefits that can be gained for both patients and provider organisations from having independent, robust, professional civil advocacy services available, as detailed in the *Independent Mental Health Act Advocacy Guide*.

Carers and significant others who have supported and cared for patients prior to admission and may continue the carer role on discharge should be involved in the care process as much as possible, though respecting as appropriate the wishes of the patient, subject to patient consent and within the rules of patient confidentiality.

Service providers should ensure that standard 6 of the National Service Framework for Mental Health and the requirements for the National Strategy for Carers are implemented. The services must ensure that carers are made aware of visiting arrangements, including times, location and any associated requirements, eg limitations on what may be brought in.

All MSUs are repsonsible for ensuring that all patients receive equality of treatment according to need without prejudice to gender, sexuality, disability, age, religious belief or ethnicity.

Ref	Quality principle	Measure	Evidence	Review frequency
D1	The provider should ensure that patients are supported in their personal care including dental hygiene.	All patients should be provided with basic personal care items to enable them to maintain personal hygiene, prevent ill health and to promote health	Report from provider Patient complaints	Annually
D2	The provider should ensure that resources are allocated for patients' clothing and are targeted appropriately and in a way that is mindful of relevant cultural needs, promoting choice and individuality and helping patients achieve a good personal self-image.	Policy in place	Evidence of policy Patients have suitable clothing	Annually
D3	There should be access to personal care facilities including hairdressing.	Policy in place	Provision of toiletries	Annually
D4	Patients should be able to access services that contribute to their overall care package and improve well-being, eg complementary therapies such as aromatherapy.	Policy in place	Access to support services	Annually
D5	The provider should ensure that the individual cultural needs of patients are met.	Policy in place	Patient complaints re cultural and ethnic issues	Annually
D6	The provider should ensure that there are systems in place to allow for translation services and sign language. Written information must be provided in an appropriate number of languages and formats.	Policy in place	Evidence of language translation service, sign language and accessible information	Annually
D7	The provider should ensure that a multi-faith room is available for use by all patients and that it adheres to specific requirements of individual faiths, taking advice from leaders of all faiths.	Policy in place	Multi-faith room Patient satisfaction with facilities	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
D8	The provider should have a policy setting out the consultation and involvement of carers in the care provided.	Policy in line with national guidance on carer involvement	Evidence of policy and its implementation Carer assessments requested from local authorities	Annually
D9	There must be evidence of patient involvement in all aspects of the service including their own care plan and quality monitoring and service improvement programmes at the service.	Policy for patient involvement	Evidence of policy and involvement of patients in overall service planning	Annually
D10	All patients should have access to independent civil advocacy.	Accessible advocacy for all patients	Independent advocacy service in place; reports on issues raised	Annually
D11	The provider will develop systems and support to enable a successful independent civil advocacy service to be operated.	Engagement protocol in place between advocacy provider and the secure service	Reports from advocacy service	Quarterly
D12	The provider will work with patients and families on their health and well-being, eg coping with stress, conflict resolution and sustainable transport plans for visiting.	Policy for providing this support	Record of activities supporting carers, and of carer feedback via nominated lead	Annually

Section E: Accessible and responsive care

Patients should receive services as promptly as possible and have choice in the treatments they access, and should not experience unnecessary delay at any stage of service delivery or the care pathway.

Ref	Quality principle	Measure	Evidence	Review frequency
E1	The views of patients, their carers and others should be sought and taken into account in designing, planning, delivering and improving healthcare services.	Evidence of patient fora; ward meetings	Surveys Advocacy reports	Annually
E2	The provider should have clear criteria for admission to and transfer/discharge from services which are agreed with commissioners and communicated to all referrers. The service should ensure that the discharge procedures are operated in line with the pathway (Appendix 4).	Evidence of criteria	Delayed discharges Waiting lists reviewed monthly and quarterly at Service Level Agreement (SLA)/ contract reviews	Quarterly
E3	For urgent referrals, an initial verbal response regarding the appropriateness of a referral should be made within 24 hours of receipt of the referral, and an initial multidisciplinary assessment within seven days. The outcome should be notified verbally within 24 hours of the assessment, and a formal written assessment should follow within seven days.	Audit of waiting times	Reports to SLA/ contract reviews	Quarterly

Ref	Quality principle	Measure	Evidence	Review frequency
E4	For routine referrals, an initial response as to whether a multidisciplinary team (MDT) assessment will be appropriate should be notified within 14 days and an initial MDT assessment within one month. A decision should be made within two weeks and a bed offered within a further six weeks. The service should ensure that systems are in place to offer advice and management support to the referrer while a bed is awaited and, if there is a problem with achieving the timescale for admission, the service should contact the relevant commissioner within 24 hours of a decision that the person needs a bed, in line with the lead commissioner's local system for reporting unmet need.	Audit of waiting times; policy in place to notify the commissioner of unmet need	Reports to SLAs/ contract reviews Review of unmet need	Quarterly
E5	Medium-secure inpatient wards should normally have no more than 15 beds.	Ward sizes with a maximum of 15 patients	Visits to wards	Annually
E6	Medium-secure inpatient facilities should be single sex and adhere to the safety, dignity and privacy policy.	Single-sex wards	Visits to wards	Annually
E7	Access to women-only therapy services should be available.	Availability of therapeutic sessions for women only	Records of therapy sessions	Annually
E8	The provider should provide advice to referrers where they require an opinion on management of a patient, which may then lead to a referral to medium-secure care.	Protocol in place	Views of local services	Annually
E9	The service should ensure that medium-secure units provide advice on the management of complex patients to general mental health services when this will support maintenance of the person at a lower level of security and will prevent inappropriate referrals.	Evidence of support	Adhoc survey of mental health services	Quarterly

Ref	Quality principle	Measure	Evidence	Review frequency
E10	The provider should adhere to Home Office requirements in respect of annual statutory returns and reports required to facilitate the care pathway.	Home Office returns completed; timely and complete transfer requests to the Home Office	Views from the Home Office Delayed discharges	Annually
E11	Systems and SLAs/contracts should be in place with provider(s) of acute care to ensure timely access for patients with physical ill health who require hospital care as an inpatient or outpatient for urgent, acute or chronic conditions.	Evidence of SLA/ contract	Report of access to acute care	Quarterly
E12	Systems should be in place for emergency response to physical ill-health problems, and all staff should receive regular update training on basic first aid skills and CPR. At least one nominated member of staff on each ward and on each shift should be able to use CPR techniques until an emergency team arrives. The provider should ensure that its emergency access systems allow urgent admission of an ambulance if required.	Systems in place; details of emergency access systems	Reports	Quarterly

Section F: Care environment and amenities

The provider should ensure a safe and supportive environment for all patients, in particular protecting the needs of women and vulnerable groups. This will include provision of separate accommodation, daily living and therapy/treatment provision to single-sex groups.

Patients should expect to receive their care in safe and supportive environments, which are maintained to a high level of cleanliness.

The availability of a choice of healthy, appetising and nutritious food and drink is a key component of delivering good quality care for patients who are detained in a secure environment for considerable periods of time and is a basic right.

Ref	Quality principle	Measure	Evidence	Review frequency
F1	The provider should adhere to key policies, including hospital cleanliness and high-quality environments, to enhance the care offered and not increase the risks, for example of infection.	Cleaning programme and Patient Environment Action Team visits	Programme and audit	Annually
F2	The provider should address guidance on safety, dignity and privacy.	Single-sex clinical and living areas, plus single-sex access to therapeutic and other activities	Facility visits Patient complaints	Annually
F3	The provider should ensure that all accommodation is provided in single rooms, with all new builds and upgrading programmes providing en suite accommodation. Facilities should be provided so that patients can wash and use the toilet in privacy, unless clinical risk prevents this. At all times, gender-sensitive practice should be followed.	Single rooms, en suite	Facility visits Examine new plans/upgrade plans	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
F4	There should be zero tolerance of graffiti and damage to the environment, and any that occurs should be removed/cleaned/painted/repaired within 48 hours.	Policy in place to deal with any inappropriate soiling of the environment, with plans to meet the target timescale	No graffiti	Annually
F5	There should be a rolling programme of maintenance of the environment, including furnishings, fittings and equipment.	Physical security document; maintenance programme	Clean environment with furniture and fittings in good order	Annually
F6	The provider should ensure that no damaged furniture is left in patient areas.	Damaged furniture removed without delay and replaced	No damaged furniture	Annually
F7	There should be clean, hygienic and modern bathroom facilities, offering a choice of showers or baths.	Range of facilities in the unit; cleaning programme in place	Choice of facilities available which are modern, clean and do not smell	Annually
F8	The bathrooms and shower areas must be free of ligature points.	All ligature points removed	No adverse events	Annually
F9	There should be a formal assessment of the clinical environment at least every six months to ensure that ligature points are identified and appropriate action taken. In addition, there should be evidence that all staff are responsible for continual vigilance and reporting of environmental safety issues and that reported matters are made safe immediately with prompt follow-up action.	System in place to formally assess the environment; system for staff to report problems they identify	Annual review of assessment of ligature points Register of issues raised by staff and action taken	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
F10	Dietary advice and support should be sought from qualified dieticians, reflecting the value of good quality food on a person's well-being. Patients should be provided with meals that are of a high quality, offer choice, address nutritional/balanced diet and specific dietary requirements, and are also sufficient in quantity, are varied and appealing and reflect individuals' cultural and religious needs (*Better Hospital Food*, Department of Health 2004).	Menu in place that offers varied and good quality meals, which are nutritional and well balanced	Sampling of meals Patient complaints	Annually

Section G: Public health

The delivery of high-quality physical healthcare support to patients is crucial as part of the development of their overall well-being and to ensure that they are dealt with appropriately. This includes screening and preventive inputs as well as regular input for dentistry, general practitioner care, ophthalmology etc, in line with expectations in the general community.

Providers should incorporate the principles of *Choosing Health* throughout services and have in place systematic and managed disease prevention programmes through action on nutrition, exercise, smoking, substance misuse and sexually transmitted infections.

By ensuring that attention is paid to promoting, supporting and facilitating good physical health and well-being as well as psychological well-being, better opportunities are provided for overall health gain.

Ref	Quality principle	Measure	Evidence	Review frequency
G1	All patients should have access to a primary healthcare service.	Patients able to access range of primary care services in same timescales and same range as the general public	Access to GPs, dentists, physiotherapists, optometrists, chiropody Complaints about access	Annually
G2	All patients should have at least daily supervised free access to fresh air outside the building as a minimum.	Access to external areas but still in secure perimeter, eg grounds surrounding unit or courtyards, as part of all care plans	CPAs Complaints	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
G3	All service users have their primary healthcare needs assessed on admission and reviewed at least annually or more frequently if required. The patient's physical healthcare needs are identified in the treatment plan. The plan includes any treatment regimes as prescribed.	Admissions assessment; access to physical healthcare	Record of admission assessments CPA reviews Ad hoc samples of individual care plans	Annually
G4	All patients will have access to physical health checks on admission, which include a review of the currently prescribed medication and a full physical examination.	Policy in place for admission physical health check and availability of primary care service	Evidence of policy Primary care service	Annually
G5	Screening programmes will be available in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health.	Policy identifying range of screening available	Screening available Patients have access	Annually
G6	Support for patients to cease smoking should be available.	Services available to support smoking cessation	Numbers taking part in smoking cessation programmes	Annually
G7	The provider should ensure that it has a policy on patient, visitor and staff smoking in line with government policy.	Policy on smoking	Implementation plan to support policy	Annually
G8	The provider should have guidelines and policies on patient sexuality.	Policy guidelines developed	Policy in place and in date	Annually
G9	The provider should have clear policies and guidelines for staff on patients' sexual behaviour.	Policy guidelines developed	Policy in place and in date	Annually
G10	The provider should have a protocol for dealing with allegations of sexual and serious sexual assault agreed by police and consulted upon by the Crown Prosecution Service.	Protocol in place	Evidence of protocol and review of incidents	Annually

Ref	Quality principle	Measure	Evidence	Review frequency
G11	The provider should ensure that advice and input from dieticians provides patients with good quality, nutritious meals that enhance and support the care and treatment they receive, particularly in respect of addressing potential obesity.	Policy for dietary advice in place; regular access to dietician; dietician input to meal planning	Named dietician Assessment of meals by testing meals	Annually
G12	In line with *Choosing Health* requirements, there will be access to health trainers or equivalent, in line with expectations for people affected by mental health problems in the general community.	Delivery of appropriate implementation plan	Reference in *Choosing Health* implementation plan for local primary care trust and provider	Annually
G13	Consideration of *Healthy Settings* approaches to promoting well-being and physical good health in patients and staff.	Documentation of policy or working group looking at *Healthy Settings* approaches	Identified goals and achievements of *Healthy Settings* activities	Annually
G14	Identification and application of some relevant aspects of the General Medical Services Quality and Outcomes Framework to primary care of patients in secure mental health settings (eg identification and treatment of high blood pressure or diabetes).	Some QOF targets chosen for achievement in the setting	Reporting of QOF attainment	Annually
G15	Health promotion support to individuals and groups in line with expectations in the general community, including alcohol and addictions, physical activity, diet and nutrition.	Supportive policies and delivery mechanisms	Evidence of take-up and behaviour change in individuals	Annually

Appendix 1: NHS Security Management Service

The NHS Security Management Service (SMS) forms part of the special health authority, the NHS Counter Fraud and Security Management Service (CFSMS), which was launched in April 2003 and has a remit that includes policy and operational responsibility for the management of security in the NHS. The remit is broad, but can be defined as protecting people and property in the NHS through the creation of safe and secure environments, so that the highest standards of clinical care can be made available for patients.

The NHS SMS strategy document, *A Professional Approach to Managing Security in the NHS,* which was launched in December 2003, outlines the overall aims and objectives as well as the approach that the NHS SMS will be adopting in relation to security management work. This strategy document also outlines four main areas of specific priority action. These are:

- tackling violence against staff and professionals;
- ensuring the security of property and assets;
- ensuring the security of drugs, prescription forms and hazardous materials; and
- ensuring the security of maternity and paediatric wards.

Two national legal frameworks were introduced, under directions from the Secretary of State, in November 2003 and March 2004 respectively, for taking forward work to tackle violence and general security management issues. The first framework, on tackling violence against staff and professionals who work in or provide services to the NHS, details the requirements for:

- new concise, consistent, legally based definitions for staff to report physical and non-physical assaults;
- a new, streamlined national system for the reporting and recording of physical assaults, which has the capacity to track cases from report to conclusion, allowing for intervention where necessary. The reporting system is designed to achieve consistency across the NHS and to give hard and accurate information on the nature and scale of incidents of physical assault, as well as assuring staff that tough and consistent action will be taken against assailants;

- health bodies to nominate a security management director, a member of the Executive Board, to bear overall responsibility for security management work with particular responsibilities for tackling violence. Representation for security management work at Executive Board level is intended to ensure that responsibilities are taken seriously at the highest level;
- the use of staff from the highly trained NHS Counter Fraud Operational Service – pending the completion of training of local security management specialists (LSMSs) for each health body – to investigate cases of physical assault where these have not been investigated or pursued by the police; and
- the creation of the NHS SMS Legal Protection Unit to provide health bodies with cost-effective advice on a wide range of sanctions that can be pursued, and to work with the police and Crown Prosecution Service to increase the rate of prosecutions including, where appropriate, of those who assault staff in mental health and learning disability settings.

The second framework introduced the requirement for each health body to nominate an LSMS to undergo professional accredited training to ensure that the highest standards can be applied to security management work locally. It is expected that each NHS health body in the acute and primary care sectors will have access to at least one LSMS.

An accredited training course for LSMSs working in mental health and learning disability services commenced in April 2006. The main difference of the mental health/learning disability LSMS role, compared with its generic counterpart, is the emphasis on clinical interface and prevention, recognising that many of the causes of violence in mental health and learning disability settings are environmental and cultural in nature. This rationale is supported by the findings of the recent Healthcare Commission and Royal College of Psychiatrists national audit of violence in mental health and learning disability settings. The LSMS in mental health and learning disability settings will play a key co-ordinating role in relation to providers' strategy, planning and practice relating to all aspects of environmental security, including non-physical aspects such as policy implementation, national guidance implementation, police liaison and cultural change, so areas such as relational security and post-incident analysis are part of the LSMS remit.

In addition to the introduction of these two frameworks, explanatory notes on tackling physical assaults against NHS staff were issued to health bodies in May 2004. Guidance on reporting and dealing with non-physical assaults against NHS staff and professionals was issued to health bodies in November 2004.

An NHS SMS-led expert group developed a national syllabus for non-physical interventions in relation to management of violence training in mental health and learning disability settings, which was launched in October 2005. Called 'Promoting Safer and Therapeutic Services', this mandatory training includes theoretical as well as practical aspects of recognition, prevention and management of violence, and is integrally linked to the work of the National Institute for Mental Health in England (NIMHE) in relation to physical interventions. This project involved the NHS SMS working closely with stakeholders such as the National Institute for Health and Clinical Excellence, NIMHE and the Royal College of Nursing in order to develop the syllabus. The need for quality assurance to guarantee consistently high standards across the NHS, as well as a national system of registration and regulation of trainers who provide this training, is currently under consideration in conjunction with NIMHE.

Since April 2003, a national syllabus for conflict resolution training has been made available for all front-line staff and professionals working in the NHS. Aimed primarily at the acute and primary care sectors, this syllabus is delivered in the form of a one-day training course in non-physical intervention methods in order to equip staff with the necessary skills to be able to identify and de-escalate potentially violent situations from occurring in the first place.

The NHS SMS has published its findings of trials of a mobile phone-based device, *Lone Worker Device – NHS National Trial Evaluation Report*, to see if it can provide better protection for NHS staff, particularly those who work alone, without immediate support from colleagues or others. It has also published *Not Alone*, guidance on the better protection of NHS staff when working alone, including advice on management arrangements, local procedures and training.

The NHS SMS has also agreed a concordat with the Health and Safety Executive to ensure close working between the two organisations, in both policy and operational terms, to deal with violence in the NHS workplace.

A memorandum of understanding has been developed with the Association of Chief Police Officers to clearly define the roles and responsibilities of the police and the NHS, especially around tackling violence against staff and professionals, so that a consistent approach can be achieved.

A memorandum of understanding has been developed with the Crown Prosecution Service to clearly define guidance in relation to prosecution of those who commit offences while they are in secure care.

Appendix 2: The physical security document

The following checklist can be used to support the drawing up of the physical security document (PSD).

Physical security

- There should be a PSD, which sets out details of the perimeter and other physical security provisions.
- There should be a maintenance programme in relation to the perimeter and other physical security provisions. Any weakness or compromises should be identified and an action plan drawn up to remedy them.
- There should be a daily inspection of the perimeter.

Key features of a perimeter

- The perimeter fence should be of weldmesh, 5.2 metres in height, and surround the whole unit.
- The perimeter fence, of weldmesh, 5.2 metres in height, should join reception and surround the remainder of the unit.
- Perimeter buildings with a 5.2 metre fence of weldmesh should surround the sports field.
- Of integral design formed by the buildings creating the enclosed secure area.
- The fencing posts should be placed on the non-patient side.
- Where reception is part of the perimeter, the rear of the building within the secure area must be protected against climbing.
- Where the fence meets buildings or other fences, care must be taken to ensure that there are no gaps between the joins and no climbing aids.

Fencing enhancements

The perimeter fencing can be strengthened by:

- the use of double weldmesh;

- cladding to half its height with metal sheeting – this also provides privacy and dignity for patients where there are footpaths and public access around the outside of the perimeter;
- the addition of an anti-climb topping – either a flexible security topping (FST) or angled weldmesh fence perimeter intrusion devices (PIDs); and
- CCTV coverage with or without alert alarms.

Gates and entry points within the perimeter

Only essential gates and entry points should be allowed within the perimeter because they compromise security.

Essential gates may be for:

- vehicle entry;
- patient reception by vehicle;
- the delivery of goods and services; and
- the estate's ground maintenance.

The following should be taken into account:

- Gates and entry points should, where possible, be of an air lock style and be electronically controlled from reception with CCTV or a video intercom facility.
- Gates and entry points must be on a separate locking suite issued, accounted for and controlled by reception.
- Gate locks must be integral to the gates (not a padlock and chain, which should be used only as an emergency backup).

Gates must not be such as to provide a climbing frame. Locks and secure ground bolt fittings must not be capable of being used to aid climbing. An addition of double skinning or double mesh will assist in protecting the gates from climbing.

Care must be taken to ensure that the gate housings do not provide a climbing aid in conjunction with adjoining buildings.

The value of anti-dash fences, particularly where they have gates within them and when they adjoin the perimeter, should be reconsidered and the risk assessment should be set out clearly in the PSD.

Perimeter roofs

Where building roofs form part of the perimeter, they must be protected against climbing. This is of particular importance where the roofs are low and provide access to either reception roof or other roofs that give access to the outside of the unit.

Roofs can be protected by:

- a gooseneck capping – this may be the most aesthetic solution in healthcare settings;
- an FST – this is much cheaper than the capping;
- weldmesh fencing – with or without an FST – fixed from below the eaves to a height of 5.2 metres;
- alarm systems – these require an immediate planned response; or
- hanging eaves that project a minimum of 1,200mm from the face of the building.

The use of razor wire/barbed wire or rotating spiked toppings is not seen as appropriate within a healthcare setting.

Where the building roofs surround courtyards or patient access areas, there must be a regular planned review, and it must be ensured that there are no climbing points. These can include light fittings, trees, unprotected window sills, water drainpipes, CCTV brackets, lightning conductor tapes or air conditioning units.

Furniture must be fixed.

Football posts should be of lightweight material and be kept secure when not in use. Other equipment, including gardening equipment, must be secured when not in use.

Keys (electronic cards or fobs) and locking systems

Keys

- There must be a key management system in place which accounts for all secure keys – those in store, those issued and those held in reception.
- Spare replacement keys must be under the control of a senior manager and kept secure away from reception.
- Secure keys must be on a sealed ring – only secure pass keys will be on this ring.
- Secure keys should be issued, returned and accounted for in reception.

- Secure keys must be attached to staff at all times – including when being used in the lock. A belt, lanyard and pouch should be provided to all staff with secure keys. (Where electronic cards are in use and where they provide automatic pass, there must be a way of securing them to staff.)
- Secure keys must not be taken out of the unit.
- All other keys may be controlled, issued and accounted for on the wards. These keys should be kept in locked cupboards and there should not be more keys on one bunch or within a cabinet than can be accounted for easily. Spare keys must be available.
- Keys to medicine/drugs cupboards must be secured to a qualified nurse at all times and their handover documented by ward staff.
- Secure access keys for estates staff should be held in reception and used only by estates staff.

Locks

- Reception should have an electronically controlled airlock operated by reception.
- There should be no door within the airlock giving entry to the reception office.
- Doors into reception must be controlled by reception.
- Airlock doors, when they fail, must default to the lock position.
- There must be a backup locking system – manual or battery – for these doors.
- Gates and entry points within the perimeter should be controlled by electronic airlock systems with a video/intercom facility.
- Where gates or entry points are not operated by reception, they must be on a separate lock suite with the keys controlled, issued and accounted for by reception.
- Locks within the secure area, which provide access to courtyards or open areas within the perimeter, must be on a separate suite from internal pass doors. The keys must be accounted for by reception.

Note:
Lockable doors must be treated as lockable doors: for example, lockable doors providing access to the courtyards should not be left open as a means of providing fresh air to the unit.

When a door is locked, the member of staff locking it must test that it has been locked. **This also applies to slam locks. There have been examples of such locks being compromised by patients**.

The locking system should be seen as a way of defining an inner perimeter, which is then supported by the outer perimeter. The outer perimeter only fails after the inner perimeter has failed. Physical security only fails after relational and/or procedural security has failed.

It is important for security that staff have confidence in the locking system, but it is also important that they understand that they must test every door they lock.

There must be a maintenance programme for the locking system. Where electronic systems are in place, there must be a backup battery or manual system.

Alarms

- These may be hardwired alarms or personal issue alarms.
- Alarm systems and personal alarms should be tested daily.
- There must be enough personal alarms to allow for replacements.
- Personal alarms must be controlled, issued, returned and accounted for in reception.
- Personal alarms must be secured to staff at all times.
- Alarm systems, when activated, must show the place where the alarm is triggered to allow an appropriate controlled response.

Note:

- There must be a planned response to any alarm.
- There should be a patient numbers check following an alarm.
- Where the reception roof provides the only access to the outside from within the secure perimeter, there should be an immediate staff deployment there.

Reception

- Reception should be managed by a senior member of staff.
- Reception should be staffed 24 hours a day, seven days a week. Night cover may be provided by departments from the wards.

Reception should be responsible for the following tasks:

- the control of entry and egress of all staff, visitors and patients;
- the control of all vehicle entry to the secure area;

- the issue, collection and accountability of all secure keys;
- the issue, collection and accountability of all personal alarms;
- the monitoring of alarms;
- maintaining patient numbers; and
- the main switchboard, which is often located within reception.

CCTV

Where CCTV is in use, reception should monitor CCTV coverage of:

- the perimeter;
- the perimeter fences;
- reception; and
- access from the secure area to reception.

Wards should monitor CCTV coverage of:

- visiting rooms;
- ward areas; and
- off-ward areas.

Facilities

- The design of reception should ensure that it is user friendly for staff working there.
- Where possible, there should be a separate staff entrance.
- There must be a clear display showing what items are not allowed into the unit.
- There should be lockers to hold any visitors' possessions that are not allowed in.
- There should be a search area where patients are searched before entering the secure area.
- There should be a private area for the searching of visitors where such searches are appropriate.

- Staff should have access to a portable metal detector (wand), which may be used to support the searching process.

Windows

Where windows are within the buildings making up the perimeter, they present particular difficulties in terms of maintaining security.

There are many window designs, including various designs providing fresh air.

- Windows should not open more than 125mm and should be capable of being locked open as well as locked shut.
- Where restraining bars are used, they must not provide a climbing aid to the roof.
- Windows and frames must be set within the building masonry.
- Windows that are in buildings that form part of the defined perimeter should be sealed or protected against contraband being passed.

Windows and their frames and fixings become vulnerable over time. When patients break out of them, it is usually due to:

- weakness due to design;
- weakness due to wear and tear;
- weakness due to age; or
- weakness due to workmanship during installation.

There should be a planned inspection every six months of windows and their fixings by estates staff to assess any potential weaknesses.

It would be good practice for commissioners to share information on window design and strengths when new installations or refurbishments occur. It would also be good practice to share examples of how windows have been breached.

Ceilings

There will be many different designs. It is important that:

- there are regular checks of their security and integrity;
- any damage is immediately repaired; and
- patients are not given access to areas where ceilings and/or ceiling tiles are damaged.

Courtyards

- Courtyards should be checked before use to remove any items that present a security hazard or would assist an escape.
- Care must be taken that facility doors, doors to stores, lamp posts, sports equipment and CCTV fittings do not provide a climbing aid.
- Furniture must be fixed.
- Equipment, including gardening equipment, must be secured when not in use.
- The secure area as a whole must be kept clear of broken items, rubble, rubbish and loose materials that could be used as weapons or to assist escape.

Other

- Each unit should have a security committee chaired by the senior manager.
- Each unit should have a full-time member of staff responsible for security.

Appendix 3: Procedural security index document

The provider will have an index of procedural security policies which must include contingency plans.

When drawing up policies units may consider the following issues. The medium-secure unit (MSU) may be part of a wider NHS provider or in the private sector, ie one unit within a provider organisation. The policies and procedures for the unit should be specific and tailored to the needs of the unit. They should be authorised by the provider or provider organisation. It is advisable to have the policies, particularly the searching policy, agreed by legal advisers.

Policies and procedures should include the following:

- searching, including patient searching, bedroom searching, ward and off-ward areas, and the searching if necessary of visitors;
- management of violence and aggression (National Institute for Clinical Excellence (NICE) guideline 25);
- seclusion;
- use of control and restraint;
- use of forced medication including rapid tranquilisation;
- observation;
- anti-bullying policy – this should meet the needs of those who are bullying and those who are bullied;
- prevention of suicide and management of self-harm;
- transportation of patients, eg to court or acute hospital;
- use of handcuffs;
- escort procedures;
- leave of absence;
- control of illegal substances;
- substance misuse;
- control of prescribed medication and drugs;

- prosecution of offences within the unit – this should be agreed with the police and the Crown Prosecution Service (CPS);
- possessions;
- smoking;
- monies;
- censorship of material, including pornography;
- control of mail and use of telephones;
- control of tools used in therapy or education or ward areas;
- control of mobile phones, including camera phones;
- computers and access to the internet;
- visiting procedures, including child protection issues;
- patient confidentiality;
- critical incident review; and
- patient roll checks.

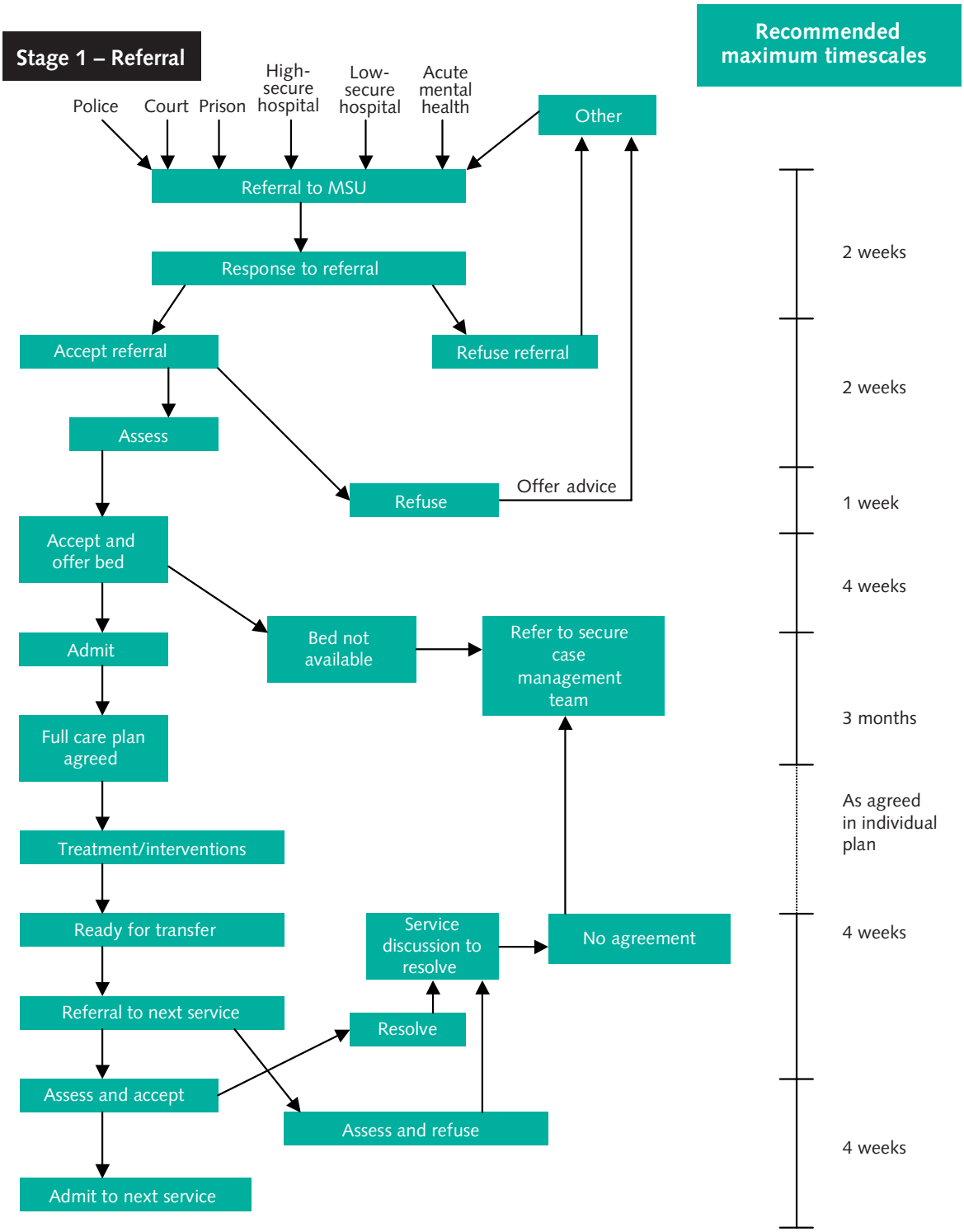
Policies and procedures should:

- be set out clearly;
- have a clearly identified author/postholder with lead responsibility for them;
- be reviewed at least annually and clearly identify the date they were approved;
- be in accordance with the Secretary of State for Health's Code of Practice under the Mental Health Act 1983;
- reflect the ethical standards within society;
- meet NICE guidelines where these are relevant to mental health, specifically in relation to the management of aggression and violence (and their appendix guidelines on security);
- incorporate learning/experience within the service, organisation or external agencies;
- be written to ensure they reflect the needs of the patients;
- be owned by relevant groups and specialists within the organisation;

- acknowledge a need for proportionality;
- acknowledge a need for the exercise of discretion;
- comply with health and safety guidance;
- maintain patient confidentiality;
- consider issues of equality and diversity; and
- be available in a range of languages and in a range of accessible formats.

Appendix 4: Key stages of the care pathway

The following diagram outlines the key stages of the care pathway into, through and out of medium-secure services.



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282364/*Best Practice Guidance: Specification for adult medium-secure services* can also be made available on request in Braille, on audio cassette tape, on disk and in large print.

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