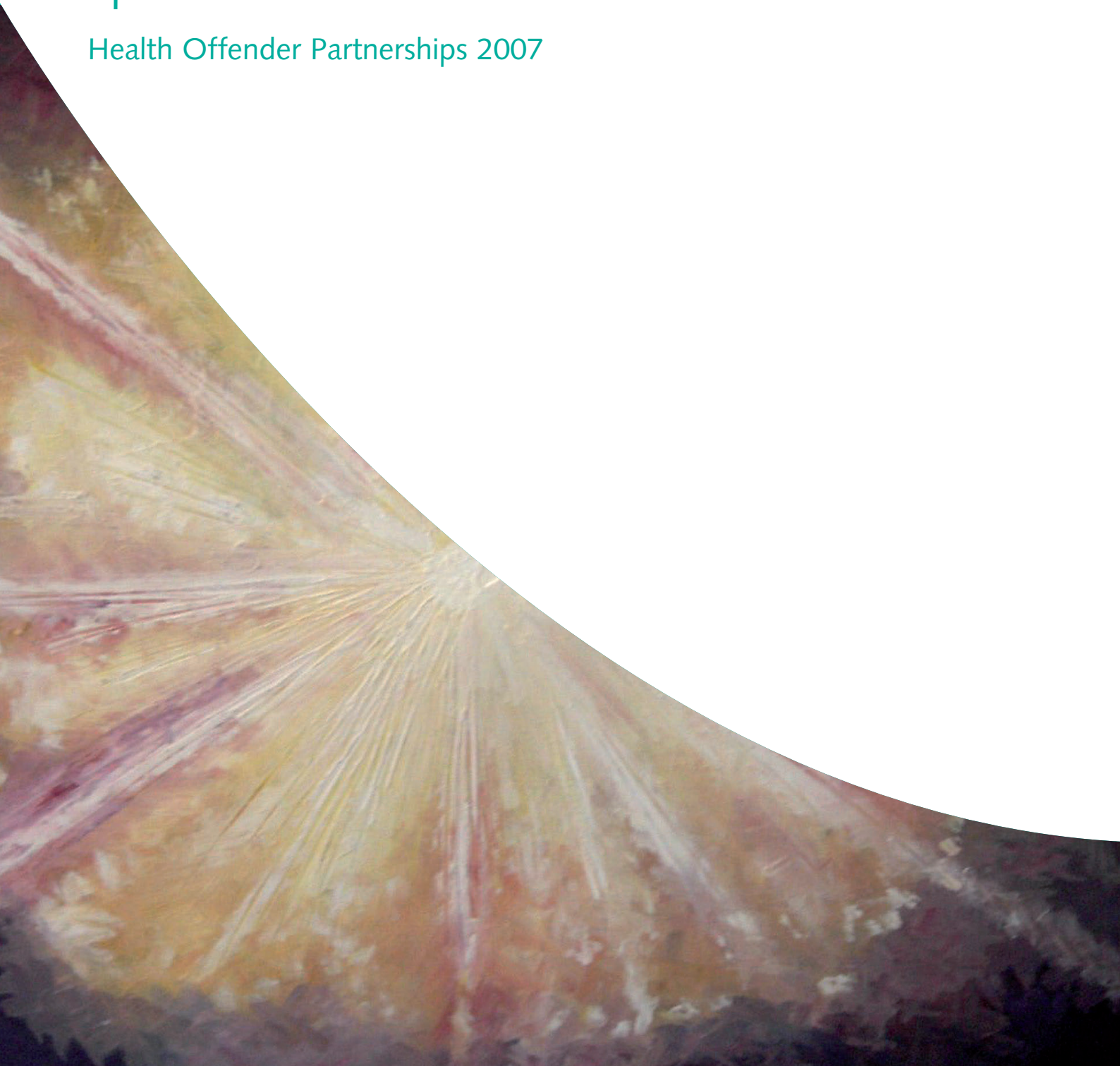


# Executive summary

## Best Practice Guidance: Specification for adult medium-secure services

Health Offender Partnerships 2007





Front cover by Daniel Jones.  
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Daniel is a service user of Mersey Care NHS Trust Secure Services.

# Executive summary

## Best Practice Guidance: Specification for adult medium-secure services

Health Offender Partnerships 2007

Policy	Estates
HR/Workforce	<b>Performance</b>
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## 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.

A handwritten signature in black ink, appearing to read 'Ivan Lewis'.

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



# Introduction

This document provides an overview of the context within which medium-secure services are delivered together with the high-level performance indicators. The quality principles for medium-secure services are set out in detail in the companion document *Best Practice Guidance: Specification for adult medium-secure services*. The specification sets out the quality principles for use by all secure commissioners to assist them in designating services.

## Forensic mental health services – concept of care

Forensic mental health 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, local authority social services, non-statutory and criminal justice agencies to reduce and manage the risk posed to others by the client group.

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 the 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 the 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.

## 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 agendas 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.

### (i) Physical security

Physical security is the 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.

### (ii) Procedural security

Procedural security is the proper application of set procedures, routines and checking.

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 need 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 should 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 (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.

## 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, form the basis of the patient's identified needs in 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 positively 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.

## 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 and not apart from 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 a major stakeholder 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.

## 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 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 should be provided, taking account of *Involving Patients and the Public in Healthcare* (see [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4002892](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002892)).

The aim of commissioning 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 medium-secure units are responsible for ensuring that all patients receive equality of treatment according to need without prejudice to gender, sexuality, disability, age, religious belief or ethnicity.

## 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.

## 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 and choice of a range 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.

## 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 *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.

# High-level performance indicators for medium-secure services

Name and location of medium-secure unit:

Unit reference:

Specialised Commissioning Group area:

Type of unit: mental health/learning disabilities/personality disorder (delete as appropriate)

Name/location of relevant secure commissioner:

Ref	Quality principle	Indicator	Values
<b>1. Physical security</b>			
1.1	There will be a physical security document (PSD) with supportive inspection and maintenance programme	(a) Evidence of PSD and maintenance schedules, in date (b) No policy and/or no maintenance schedules	(a) = green (b) = red
1.2	There will be a defined perimeter (note: fences below 5.2m are not secure but classified as anti-dash fences)	(a) 5.2m single-weld mesh fence surrounding the whole unit (b) Combination of 5.2m single-weld mesh fence and buildings including reception create a secure area (c) Perimeter security designed into the unit consisting of connected buildings, which meet the medium-secure specification standards, including reception creating a secure area (d) Separate buildings not connected and not creating a secure area	Evidence of (a), (b) or (c) = green (d) = red
1.3	There will be a recorded daily inspection of the perimeter	(a) Evidence of record of daily inspections (b) Inspections less than daily	(a) = green (b) = red
1.4	There will be an electronically controlled air lock operated by the control room to permit access to the secure area	(a) Evidence of the system operating as per the standard (b) No airlock (c) Control by means other than an electronic entry system	(a) = green (b) or (c) = red

Ref	Quality principle	Indicator	Values
1.5	Secure locking system in place	Secure locking system, either manual, electronic, magnetic or a combination of these, with: (a) back-up replacement in the event of a compromise or failure; (b) separate locking suite for doors/locks within the perimeter or providing access to it; or (c) neither in place	Evidence of (a) and (b) = green (b) only = amber (c) = red
1.6	There will be a key management system in place that accounts for all secure pass keys	(a) Evidence of the system (b) Insufficient evidence	(a) = green (b) = red
1.7	There will be an alarm system in place which has the capacity to identify the site of the activated alarm	(a) Alarm system in place which meets standard (b) Alarm system which does not meet the standard	(a) = green (b) = red
<b>2. Procedural</b>			
2.1	There will be a procedural security index document (PSID) which specifies all procedural policies	(a) PSID document and an index of all policies and review dates (b) No index of policies (c) Any policies out of date	(a) = green (b) or (c) = red
2.2	Contingency plans	There are contingency plans agreed with the police and emergency services (National Institute for Health and Clinical Excellence (NICE) guideline 25) covering as a minimum: hostage taking, serious disorder, escape	In place = green Plans in place but not agreed with the police = amber Not in place = red
2.3	There will be a policy on prohibited items and a clear statement of these in reception for all staff, visitors and patients to see	(a) Evidence of policy in place and clear notices in reception (b) Policy in place but items not displayed in reception (c) No policy and no prohibited list in reception	(a), (b) = green (c) = red

Ref	Quality principle	Indicator	Values
2.4	Control of illicit substances	There is a policy on the control of illicit substances covering: (a) treatment of substance misuse; (b) education on the dangers of substance abuse; (c) advice to visitors on the dangers of passing illicit/unauthorised substances; (d) a protocol with police for when drugs are discovered; (e) a policy on 'searching with cause' for drugs	Evidence of (a), (b), (c), (d) and (e) = green Evidence of (a), (b) and (d) = amber Other = red
2.5	There will be a policy on visiting procedures including child protection issues	(a) Evidence of policy in place (b) No policy in place	(a) = green (b) = red
2.6	There will be a policy on the identification, recording, reporting and system of follow-up for serious and untoward incidents	(a) Evidence of policy in place (b) No policy in place	(a) = green (b) = red
<b>3. Relational security – part 1</b>			
3.1	Ratio of consultant psychiatrists	The ratio of consultant psychiatrists to medium-secure beds at 1:13–16	13–16 patients = green 17–20 = amber 20+ = red
3.2	Multidisciplinary team working	Multidisciplinary teams identified in staffing establishment with each team including psychiatrists, nurses, psychologists, occupational therapists and social workers	Full compliance = green Teams minus one discipline = amber Teams minus more than one discipline = red
3.3	There will be a pre-admission multidisciplinary assessment for all patients	All patients have multidisciplinary assessment prior to admission	100% compliance = green 80% compliance = amber Less than 80% compliance = red

Ref	Quality principle	Indicator	Values
3.4	Treatment plans	All patients will have an initial treatment plan in place within 24 hours following admission	100% compliance = green 80% compliance = amber Less than 80% compliance = red
3.5	Risk assessment	All patients on admission have an initial risk assessment	Yes = green No = red
3.6	Care Programme Approach (CPA)	Every patient is managed within the framework of the CPA process	100% = green <100% = red
3.7	Primary healthcare	Provision of primary healthcare service to all patients including screening programmes	Access within 48 hours = green Within 72 hours = amber Greater than 72 hours = red
3.8	Enhanced Criminal Records Bureau (CRB) clearance	All staff will have enhanced CRB clearance	100% compliance = green Less than 100% compliance = red
<b>4. Relational security – part 2</b>			
4.1	Independent advocacy	Independent advocacy service in place for all patients, which is easily accessible	All offered = green Service available to 80–99% = amber Less than 80% = red
4.2	There will be a workforce plan that references appropriate staffing ratios and skill mix	(a) Evidence of workforce plan in place and agreed (b) Workforce plan being developed and with clear target completion date (c) No evidence of a workforce plan	(a) = green (b) = amber (c) = red
4.3	There will be a programme of clinical supervision, continuing professional development and personal development plans for all staff	Evidence of programmes in place	100% compliance = green 80–99% compliance = amber <80% compliance = red
4.4	Induction training	All staff will receive an induction course prior to any keys being issued	100% compliance = green <100% compliance = red
4.5	Security awareness	All staff will receive annual security awareness training	100% compliance = green <100% compliance = red









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282364/1 *Best Practice Guidance: Specification for adult medium-secure services Executive Summary* can also be made available on request in Braille, on audio cassette tape, on disk and in large print.

[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)