Review Summary

Medium and Low Secure

Brockfield House

Essex Partnership University NHS Foundation Trust

Review Date: 03 April 2024
Editor: I/S

Artwork titled ‘A scene from the west of Ireland’ displayed on the front cover of this report was created by a patient at Central Mental Hospital.

This report has been quality checked by I/S Project Officer.

If you have any queries about any aspect of this report please contact:

I/S
Programme Manager
QNFMHS, CCQI
Royal College of Psychiatrists
21 Prescot Street
London E1 8BB

Email: I/S rcpsych.ac.uk

Contents

Introduction

Brockfield House has successfully completed the self and peer-review components of the Quality Network for Forensic Mental Health Services' annual review cycle (a full description of the process can be found at www.rcpsych.ac.uk/QNFMHS). The service was reviewed against Standards for Forensic Mental Health Services: Low and Medium Secure Care – Fifth Edition (CCQI, 2023).

The main value of being a member of the Quality Network for Forensic Mental Health Services is taking part in a formative process of honest self-evaluation, supported by the involvement of peers.

At the beginning of the review cycle, the service completed a self-review whereby they rated their practices against the published standards. The service was also encouraged to distribute questionnaires to team staff, their patients, and family and friends in order to collate feedback.

This was followed by a peer-review on 03 April 2024. As part of the review, information was collected through interviews with senior managers and clinicians, frontline staff, patients and family and friends. A tour of the service was conducted. The review was an opportunity for the peer-review team to validate the service's self-assessment. At the end of the review, the peer-review team provided feedback to the service on their achievements and areas for improvement; suggestions for service development were also provided. The details of the visiting team are provided below.

This Report

This report summarises the views of the service staff, patients, carers and the peer-review team about the service's strengths and weaknesses. It begins with a profile of the service and is followed by a summary of the key findings, identifying areas of achievement, areas for development and providing recommendations for service development.

Within the appendix of this report the full scoring recorded as part of the self-review and peer-review can be found (appendix 1 for medium secure and appendix 2 for low secure), along with the survey responses provided by patients, service staff and family and friends (appendix 5). Also in the appendix, where a service has previously engaged in the Network, a review summary from that cycle is available (appendix 4).

The full set of standards are aspirational and it is unlikely that any service would meet all of them. To support their use, each standard has been categorised as follows:

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

Who should see the report?

Reports are sent to the key contact for the service and should be disseminated to all team members. We recommend that teams share their report with their commissioners. Teams may also wish to share their report with their trust's chief executive, patients and carers.

The review team

The following individuals participated in the peer-review on 03 April 2024:

I/S General Manager, The Humber Centre

I/S Deputy Charge Nurse, The Humber Centre

I/S Security Lead, The Humber Centre

I/S Occupational Therapist, Rohallion Secure Care Clinic

I/S Head of Nursing Medium Secure, Rohallion Secure Care Clinic

I/S Practice Development Nurse, Rohallion Secure Care Clinic

I/S Project Officer, CCQI

Statement of limitations

This report summarises the views of the service's staff, patients, carers and the peer-review team. The findings presented here should be viewed in the context of the range and number of staff interviewed and the number of patients and carers interviewed. This report is not a definitive statement of performance. Such judgements could only be made by a much more detailed process than that used by QNFMHS.

About the Medium Secure Service

The following information has been provided by the service:

Brockfield House is a 98 bedded mixed medium and low secure facility for men and women located near Wickford in south Essex. The building was opened in October 2009 which replaced and enhanced existing provision as part of the Trusts improvement plans. Forensic Mental Health Services are provided for those between 18 and 65 years old, detained under the Mental Health Act or Court Order.

The service cares for patients in conditions of low and medium security including those who:

- Need inpatient assessment and treatment
- No longer require high secure care but need ongoing treatment in secure services
- Can no longer be cared for within mainstream services because of their behaviour and the level of risk this represents to them and others
- Require step down from high secure services

Referrals usually come via the East of England collaborative which EPUT leads on. The service also accepts referrals from the prison service, courts and the police.

Brockfield House has five Medium Secure Wards:

Alpine Ward (Male) 13 Beds
Aurora Ward (Mixed Sex) 12 Beds
Forest Ward (Male) 15 beds
Fuji Ward (Female) 12 Beds
Lagoon Ward (Male) 15 beds

And two Low Secure
wards:

Causeway (Female) 16 beds
Dune (Male) 15 beds

Service Profile

Address of service
Kemble Way, Wickford, SS11 7FE

Catchment area

East of England

Names of ward included in the review
Aurora, Forest, Fuji and Lagoon. Please note that Alpine Ward was under refurbishment on the day of the review and was not observed by the review team.

Number of beds
98

Average length of stay (days over the last year)
850

Number of referrals over the last year
121

Number of admissions over the last year
31

Staffing information (whole time equivalent)

Staffing	WTE
Consultant psychiatry	6.0
Non-consultant medical input e.g. Staff	8.0
Psychology	8.0
Occupational therapy	6.0
Social work	5.0
Ward manager	7.0
Nursing	45.0
Healthcare assistants	65.0
Security/Control room staff	6.0
Education staff	1.0
Dietician	0.0
Primary healthcare (please list)	GP x 1 RGN's Physical Health Lead
Others (e.g. Drama Therapist, Art Therapist, Family Therapist and Activities Co-ordinator) (please state)	Activity Coordinators Fitness Instructors

Medium Secure Review Summary (Cycle 15)

Brockfield House fully met 54% of standards for forensic mental health services.

The following graph summarises the key findings from the service's participation in cycle 15 of the review process.

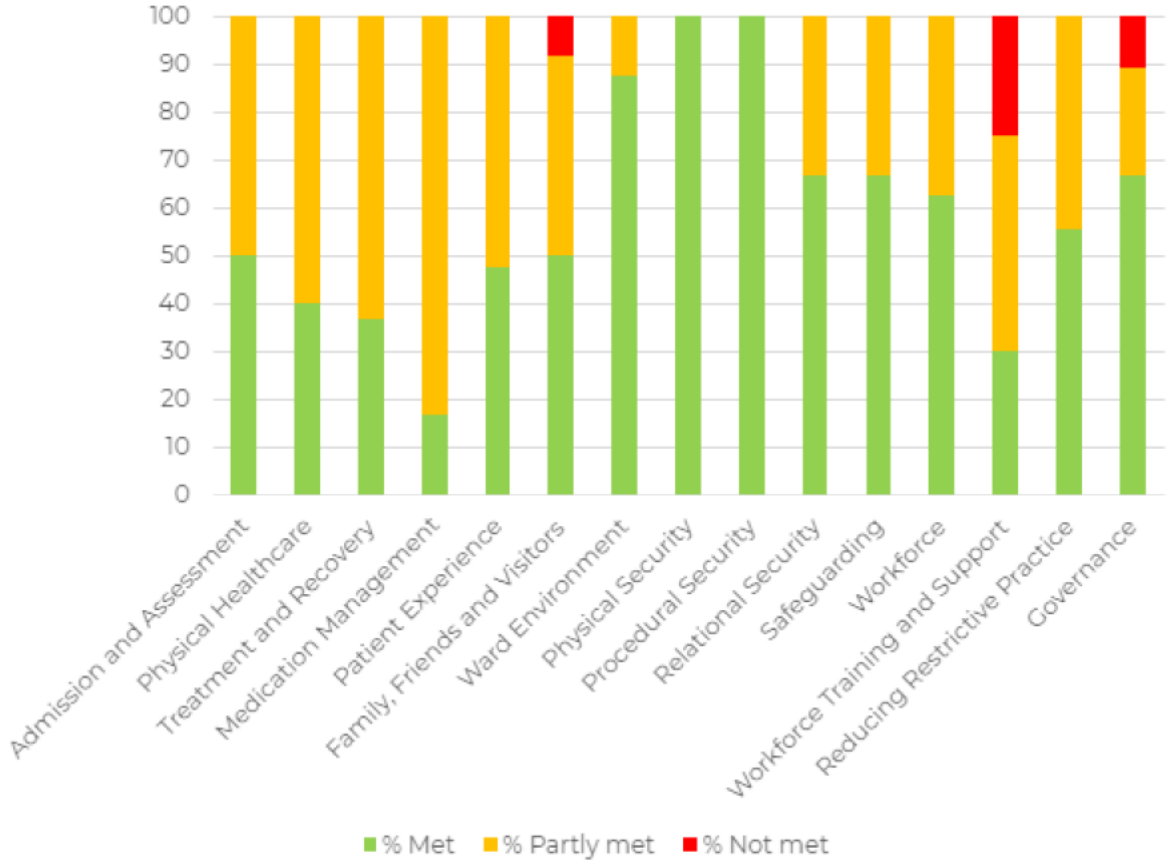

Figure 1: Percentage and number of criteria met, partly met and not met in each category

The following table reports on the total number and percentage of type 1, 2 and 3 standards and the level of compliance achieved by the service:

Type of Standard	Number of Standards	Number Met	Number Partly Met	Number Not Met	Number N/A	Percentage Met
Type 1	93	46	44	3	0	49
Type 2	51	32	16	3	0	63
Type 3	10	5	4	1	0	50
Total	154	83	64	7	0	54

Areas of Achievement

- Management is flexible in their approach to patient admission and challenges. The service has flexibility to move patients between wards and maintain a good patient mix on each of the wards. Considering Alpine ward is currently under refurbishment, the service has adapted well by moving patients to other wards. In addition to moving patients around the service, managers also reported being able to ask brother or sister services to take patients. Management also prioritises learning from adverse events and using this learning for quality improvement. For example, after having a number of patients go AWOL last year, the service analysed data around these cases and found a number of factors that would make a patient more likely to go AWOL.

- Patients provided positive feedback regarding the care provided by the service, stating that staff treat them with compassion, dignity and respect. Patients also stated that they felt listened to and understood, and that they were seen regularly by their named nurse, even outside of designated ward rounds. Those on Aurora ward characterised it as 'feeling like a family'.

- Carers were complimentary of staff. Carers provided excellent feedback on the day, stating that they would rate the service at '5 stars' and as 'the place to be'. Carers noted that the social worker has been very helpful, and that the online meeting every eight weeks facilitated by the social worker for carers and family members is great. They feel their concerns are heard by staff. Carers praised the service's layout and family room.

- Elements of the environment are highly commendable. Staff rooms on the ward are well equipped with resources such as coffee machines and private garden access. The wards are spacious and home to large bedrooms. Wards are equipped with books, TVs, activity tables, and computers, and patients have access to ADL kitchens and workshops like wood working. The service also has a large arts and crats room, music room, DJ equipment and a fully equipped dental suite. The colour of the staff uniform denotes the type of staff, making it easy to identify staff.

- Staff on the MSU are getting regular supervision, including line management and clinical supervision. They also shared that they are offered reflective practice sessions on each ward. This is an improvement since the last full review, when some staff were receiving reflective practice and others were not.

Areas for Development

- While patients generally provide positive feedback about their care, they have identified some areas requiring improvement. Patients on the MSU stated

that they do not have many activities in the evenings and on the weekends. They added that some activities, such as green walking sessions, are on offer but do not always happen due to short staffing. They also shared that not all staff members knock on patient doors before entering.

- Carers stated that they used to provide family therapy and psychoeducation to carers and that bringing this back would be beneficial to them. The service has stated that they offer this to carers, however the carer spoken to was not aware of this offering. They added that the service also used to host coffee mornings where carers could meet other parents or relatives. Carers reiterated the need to improve the OT provision.

- Morale among the MSU staff is low and staff stated that this is due to high turnover and vacancies. They also stated that the service is 'not as compassionate to the lack of staff as they could have been' and that it has been a stressful few years on account of staffing levels. Staff shared that the service 'Here For You' is available for staff, however, staff were divided as to whether this was useful. Staff shared that they feel their 'line manager says all the right things' but that their complaints are never followed through on.

- There are parts of the training for MSU staff that should be refreshed and revisited. Staff on the MSU feel that the induction training, including the security training, is not comprehensive. They added that the face to face training is not enough. Staff also struggled to understand what generic information they could provide to carers in the event patient withdraw consent, and they could not identify their safeguarding lead.

- There are aspects of the self-review that were not fully completed and this has affected the team's overall score. It is noted no case note audits were completed.

Recommendations

The following areas were highlighted by the review team as key recommendations for service development:

- Ensure that staff members on induction are instructed to knock on patient bedrooms before entering and use staff meetings to remind new, bank/agency and permanent staff on the importance of maintaining patient privacy and dignity alongside patient safety. Place a standing item on community agenda meetings around patient dignity and respect. Consider also having patient preferences on signs on their doors about how they wish to be observed. Explore options for increasing OT availability during weekends to provide patients with meaningful and engaging activities. Alternatively, in collaboration with patients, create a weekend timetable of self-led activities and involve ward staff in these activities. Continue to gather patient feedback

on what activities they would like to see over weekends.

- Continue to disseminate welcome packs to all carers and keep a record of who has received these. As well as providing written information on family therapy and psychoeducation available to carers, put up posters in the visitors' room of this information and communicate this during visits, meetings and phone calls with carers. Offer carers one-to-one time to walk through their needs, questions and concerns. It could be beneficial to investigate the disconnect between what is on offer and what carers experience.

- Regularly gather staff feedback as to what wellbeing initiatives would be helpful to support staff and consider appointing a wellbeing champion to implement these. This review could include a review of the 'Here For You' service and whether staff feel it is effective and helpful. Having an open door policy and offering monthly manager 'drop in' sessions for staff could be beneficial. Develop plans to improve staff retention and recruitment. Include training and staff retention as standing agenda items for discussion during staff meetings and supervisions. The service should offer additional training to allow staff to upskill and to support them in their development. This could help with staff retention and wellbeing.

- No evidence was provided of a training matrix on carer awareness. If this is in place, consider revisiting carer awareness training with current staff, emphasising how to communicate when a patient has withdrawn consent. If this is not in place, implement carer awareness training as part of the induction process. Consider a refresher on how to speak with carers at the service's next away day.

- For future peer-reviews, split tasks as a team to ensure all evidence is submitted, surveys and case note audits are completed, and all self-review commentary is provided.

For information about how the service performed on the previous review visits, see appendix 4.

About the Low Secure Service

The following information has been provided by the service:

Brockfield House is a 98 bedded mixed medium and low secure facility for men and women located near Wickford in south Essex. The building was opened in October 2009 which replaced and enhanced existing provision as part of the Trusts improvement plans. Forensic Mental Health Services are provided for those between 18 and 65 years old, detained under the Mental Health Act or Court Order.

The service cares for patients in conditions of low and medium security including those who:
• Need inpatient assessment and treatment
• No longer require high secure care but need ongoing treatment in secure services
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• Require step down from high secure services

Referrals usually come via the East of England collaborative which EPUT leads on. The service also accepts referrals from the prison service, courts and the police.

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And two Low Secure
wards:

Causeway (Female) 16 beds
Dune (Male) 15 beds

Service Profile

Address of service
Kemble Way, Wickford, SS11 7FE

Catchment area

East of England

Names of ward included in the review
Causeway and Dune

Number of beds
98

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Staffing information (whole time equivalent)

Staffing	WTE
Consultant psychiatry	6.0
Non-consultant medical input e.g. Staff	8.0
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Occupational therapy	6.0
Social work	5.0
Ward manager	7.0
Nursing	45.0
Healthcare assistants	65.0
Security/Control room staff	6.0
Education staff	1.0
Dietician	0.0
Primary healthcare (please list)	GP x 1 RGN's Physical Health Lead
Others (e.g. Drama Therapist, Art Therapist, Family Therapist and Activities Co-ordinator) (please state)	Activity Coordinators Fitness Instructors

Low Secure Review Summary (Cycle 9)

Brockfield House fully met 51% of standards for forensic mental health services.

The following graph summarises the key findings from the service's participation in cycle 9 of the review process.

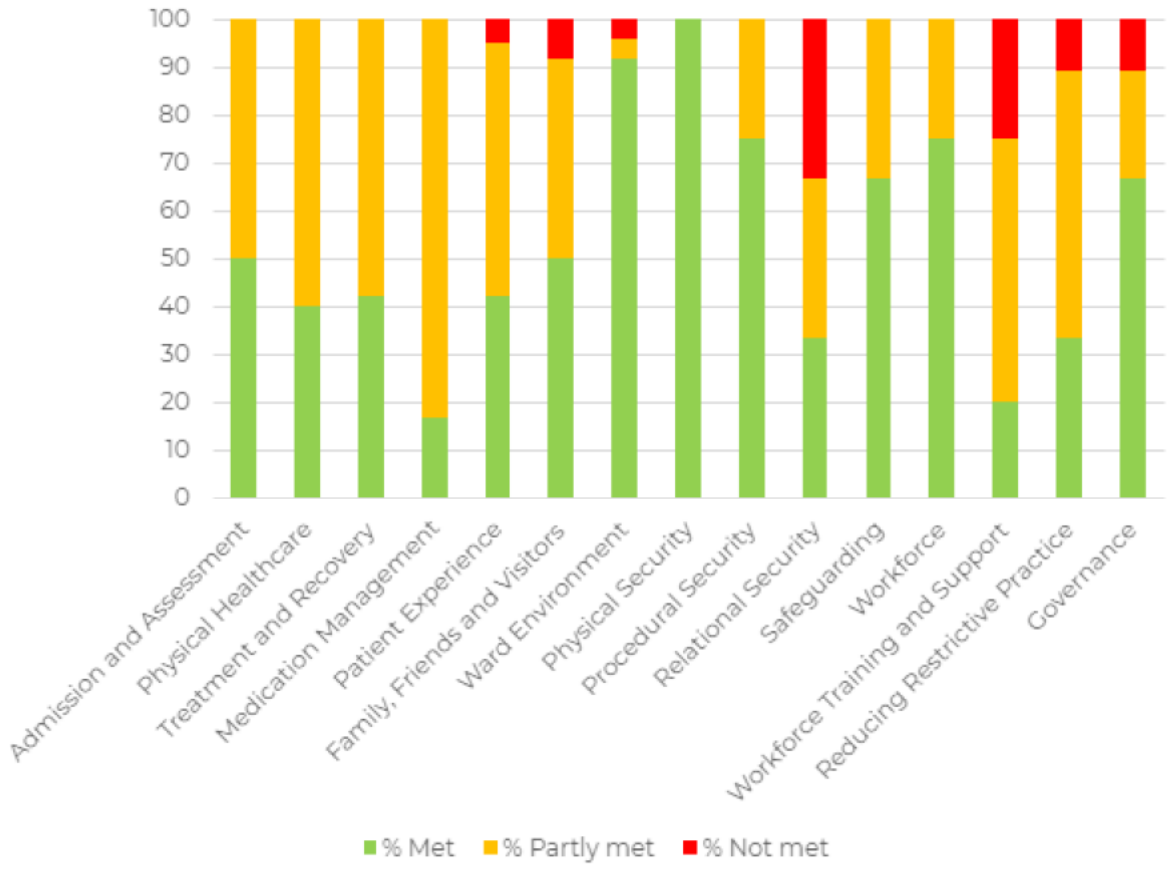


Figure 2: Percentage and number of criteria met, partly met and not met in each category

The following table reports on the total number and percentage of type 1, 2 and 3 standards and the level of compliance achieved by the service:

Type of Standard	Number of Standards	Number Met	Number Partly Met	Number Not Met	Number N/A	Percentage Met
Type 1	93	44	43	6	0	47
Type 2	51	30	18	3	0	59
Type 3	10	5	3	2	0	50
Total	154	79	64	11	0	51

Areas of Achievement

- Management is flexible in their approach to patient admission and challenges. The service has flexibility to move patients between wards and maintain a good patient mix on each of the wards. Considering Alpine ward is currently under refurbishment, the service has adapted well by moving patients to other wards. In addition to moving patients around the service, managers also reported being able to ask brother or sister services to take patients. Management also prioritizes learning from adverse events and using this learning for quality improvement. For example, after having a number of patients go AWOL last year, the service analysed data around these cases and found a number of factors that would make a patient more likely to go AWOL.

- Patients on the LSU felt safe, listened to and respected. They also shared that they can discuss their personal goals to help with their recovery in ward rounds or in weekly one on ones with their key workers. Patients shared that they are able to speak with staff 'anytime' and that they have always had a clear plan and goals throughout their stay at the service.

- Carers were complimentary of staff. Carers provided excellent feedback on the day, stating that they would rate the service at '5 stars' and as 'the place to be'. Carers noted that the social worker has been very helpful, and that the online meeting every eight weeks facilitated by the social worker for carers and family members is great. They feel their concerns are heard by staff. Carers praised the service's layout and family room.

- Elements of the environment are highly commendable. Staff rooms on the ward are well equipped with resources such as coffee machines and private garden access. The wards are spacious and home to large bedrooms. Wards are equipped with books, TVs, activity tables, and computers, and patients have access to ADL kitchens and workshops like wood working. The service also has a large arts and crats room, music room, DJ equipment and a fully equipped dental suite. The colour of the staff uniform denotes the type of staff, making it easy to identify staff.

- Staff on the LSU were very knowledgeable regarding access to local organisations and connectivity with other organisations. They shared that patients have access to voluntary organisations, community centres and other local organisations. The recovery college patients can use has budgeting classes, along with traditional courses like maths and English.

Areas for Development

- There are some parts of the patient experience that could be improved. Patients on the LSU shared that they feel activities on the ward and their leave

are not happening because of low staffing levels. Patients cited that 'over half of the OTs have left', acknowledging that this was impacting the number of activities available to them. This was supported by staff, who shared that they were not always able to take patients on leave when staffing levels were low. Patients asked that more activities and a diversity of activities be offered on the wards. Patients also noted that they are dissatisfied with the food at the service, stating that portion sizes could be bigger.

- LSU staff pointed towards a 'culture issue' regarding feeling comfortable speaking up. Staff shared that they did not always feel comfortable challenging decisions made by the MDT. Staff provided mixed responses as to whether they could take concerns to their line managers. LSU staff also stated that they were often unable to take breaks during their shifts, and that when they do take breaks, some feel it is difficult to have a real break with staff members coming in and out of the break room. Staff shared that some 'find it better to go and sit in your car' rather than use the staff rooms on the wards.

- Overall, staff on the LSU did not know the difference between management and clinical supervision. It is also unclear when staff are getting supervision; assistant psychologists have both clinical and line management supervision monthly but no other staff members could pinpoint when they were getting supervision or what kind of supervision this was. There was also a lack of understanding of relational security by all staff and no awareness of the See Think Act framework.

- The seclusion room on Dune Ward should be refurbished. There are issues with the line of sight to the bathroom. The bathroom is separate from the room, so there is no direct access for the patient to toilet facilities. In order for the patient to use the bathroom, staff would need to unlock the seclusion room and escort them to the bathroom.

- There are aspects of the self-review that were not fully completed and this has affected the team's overall score. It is noted no case note audits were completed.

Recommendations

The following areas were highlighted by the review team as key recommendations for service development:

- Record and audit occasions where planned activities or patient leave is cancelled and put in an action plan to address this. Reschedule missed leave as soon as possible. Explore options for increasing OT availability during weekends to provide patients with meaningful and engaging activities. Alternatively, in collaboration with patients, create a weekend timetable of self-led activities and involve ward staff in these activities. Continue to gather

patient feedback on what activities they would like to see over weekends. Reach out to the catering team again and invite them to the community meeting for patients to provide feedback and input into the menu. Work collaboratively with the catering team to update the menu and ensure patient needs are being met, this could include taster sessions. Following the meeting, conduct regular surveys to gather ongoing input and monitor satisfaction levels and establish a clear channel for providing updates to and from the catering team.

- Evaluate staffing levels each day to ensure there are enough staff available on each shift so each member of staff is able to take a break when needed. Furthermore, conduct a service wide environmental audit to identify an alternative room on-site which can be adapted into a space where staff can go to decompress during their break times. Obtain further feedback from staff on how the environment can be improved so it meets their individual needs

- Ensure staff receive formal monthly management supervision. Create a supervision tree so staff understand who their supervisor is and ensure all sessions are clearly documented. Use staff meetings to ensure staff understand the difference between clinical and management supervision and signpost to the supervision posters seen within the service. It is recommended that staff on the LSU have a refresher on relational security. Posters with the relational security wheel were observed on the ward, however, these posters were not filled in with information. Ensure staff are signposted to the See Think Act literature available in staff offices and staff rooms. Embed relational security, its definition and how it applies to staff's day-to-day role in handovers, staff meetings and supervisions. Relational security should also be included as a standing agenda item in team meetings and during staff supervision sessions.

- Put in a business case for refurbishing Dune Ward's seclusion room. There should be clear lines of sight to the toilet as well as direct access to toilet facilities for a patient who is in seclusion.

- For future peer-reviews, split tasks as a team to ensure all evidence is submitted, surveys and case note audits are completed, and all self-review commentary is provided.

For information about how the service performed on the previous review visits, see appendix 4.

Appendix 1: Self-Review and Peer-Review Commentary – Medium Secure

This section is formed by self-review commentary provided by the service and commentary made by the peer-review team. Individual standards are scored as met (2), partly met (1), not met (0) or not applicable (7).

Admission and Assessment - Medium Secure

This section explores patient admission and assessment processes, including multi-disciplinary decision-making and information provided to patients on arrival to the service.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
1 [2]	Patients receive a multidisciplinary pre-admission assessment of need and risk which accords with an access assessment for secure care and good practice in relation to mental health measures and CPA/CMHF. Guidance: *An admission tool is available to consider risk and levels of security.*	Met	All patients are assessed pre admission and MDT discuss and plan treatment prior to admission.	Met	Managers reported that they have a weekly referral meeting and that for new admissions, a medic and nurse provide an assessment. The also stated that, if the patient has a particular psychological need, they send a psychologist for the assessment. They added that the service aspires to have a care plan in place when the patient arrives to the service.
2 [2]	The multi-disciplinary team make decisions about patient admission or transfer. In making those decisions, they take account of patient mix and the potential to compromise safety	Met	Admission and transfer pathway considers relational security and patient mix, potential risks.	Met	Managers reported that careful consideration is given to placements and that the service can have a say on who is admitted. The service can also ask a 'brother' or 'sister' unit for help. They noted that, given they

	and/or therapeutic activity when deciding where a patient will be placed. Guidance: *Decisions to accept or refuse patients are recorded.*				have a number of wards, patients can be moved between wards.
3 [1]	The service provides information to referrers about how to make a referral.	Met	This information is available to all referrers and overseen by the Collaborative.	Met	This standard is scored using the self-review commentary. The service states that information is available for all referrers and that this information is overseen by the provider collaborative.
4 [1]	The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. Guidance: *This includes data around the use of seclusion and length of stay in the unit for different groups*	Met	We use Datix Power BI and our EPR system to generate reports to guide our operational policy.	Partly Met	Managers reported that the service uses HONAS and Power BI to analyse their data. They added that currently, there is no data collection addressing protected characteristics and inequalities in care planning and treatment.
5 [1]	Patients have a comprehensive mental health assessment which is started within four hours of admission. This involves the multi-disciplinary team and includes consideration of the patient's:	Met	Our mental health assessment starts at point of referral and continues throughout the admission until discharge. Our mental	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit was submitted. The service states that the mental health assessment includes the points listed in the

	• Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development Sustainability Principle: Improving value		health assessment includes mental health and medication, psychosocial and psychological needs and feeds into care plans that build on strengths and identify areas for development. It will occur within four hours of admission but in most cases before this.		standard.
6 [1]	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for); • Arrangements for pets.	Met	These areas will be considered, our Social work team will address any potential concerns.	Partly Met	This standard is scored using the self-review commentary and case note audits. The service states that the points of the standard will be considered and that the social work team addresses any potential concerns, however no case not audit has been provided.
7 [1]	Patients admitted to the ward outside the area in which they live have a review of their placement at least every three months.	Met	Working within the East of England Collaborative all our referrals will remain as close to home as practicably possible.	Met	Managers reported that patients who are admitted from outside of the area they live are discussed in referral meetings, though the service noted that it is unlikely a patient would be placed out of area. Their placement would be discussed

					in a monthly catch up the service has with commissioners.
8 [1]	On admission to the service, patients feel welcomed by staff members who explain why they are in hospital. Guidance: *Staff members show patients around and introduce themselves and other patients, offer them refreshments and address them using their preferred name and correct pronouns. Staff should enquire as relevant how they would like to be supported in regard to their gender.*	Met	We have a welcome process that is part of our operational model, include tour, introductions and service information.	Met	Patient survey responses largely agree that, upon arrival to the service, they felt welcome by staff and staff members explained why they were in the service. Patients spoken to on the day stated that they were shown around and felt welcome.
9 [2]	The patient is given an information pack on admission that contains the following: • Admission criteria; • Clinical pathways describing access and discharge; • How the service involves patients; • A description of the service; • The therapeutic programme; • Information about the staff team;	Met	Welcome packs cover all these aspects.	Partly Met	Patient survey responses are mixed as to whether they received a welcome pack on admission. A welcome pack has been observed that conforms to all the points of the standard.

	• The unit code of conduct; • Key service policies (e.g., permitted items, smoking policy); • Resources to meet spiritual, cultural or gender needs				
10 [1]	Patients are given accessible written information which staff members talk through with them as soon as practically possible. The information includes: • Their rights regarding admission and consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to view their health records; • How to raise concerns,	Met	These areas are included in the welcome packs.	Partly Met	A welcome pack has been observed. The welcome pack is missing how to access a second opinion and how patients can view their health records.

	complaints and give compliments.				
11 [1]	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	Met	All consent and capacity assessments are documented on approved systems and paperwork.	Partly Met	This standard is scored using the case note audit and self-review commentary. No case note audit is provided. The service states that consent and capacity assessments are documented in their approved systems and through paperwork.
12 [2]	The ward/unit works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	Met	The service has access to translator services.	Met	This standard is scored using the self-review commentary. The service states that it has access to a translator service.

Physical Healthcare - Medium Secure

This section reports on physical healthcare assessments, needs and interventions.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
13 [1]	Patients have a comprehensive physical health review. This is started within four hours of admission, or as	Met	Our physical health offer is comprehensive and starts on referral. We	Partly Met	This standard is scored using the self-review commentary and the case note audit. No case note audit

	soon as is practically possible. If all or part of the examination is declined, then the reason is recorded, and repeated attempts are made. Sustainability Principle: Prioritise Prevention		have a physical health lead for the service. Our physical health assessments are completed within four hours of admission. Our staff are aware that some vital signs can be taken without hands on. If patients decline it is revisited at the patients' convenience.		is provided. The service states that the physical health offer is comprehensive and starts on referral and that the service has a physical health lead. The service states that physical health assessments are completed within four hours of admission and that, where patients decline the assessment, it is revisited with the patient at their convenience.
14 [2]	Patients have access to physical health programmes in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health. Guidance: *Patients are informed of the higher physical health risks for patients in secure mental health, such as diabetes, dyslipidaemia, hypertension, epilepsy, asthma etc. and gender-specific needs.*	Met	Our physical health offer is comprehensive, our physical health leads supports care plans for all physical health issues.	Met	Patients spoken to on the day noted access to a doctor who comes onto the wards and provided examples of physical health screening programmes they have access to, including a pap smear test.
15 [1]	Patients have follow-up investigations and treatment when concerns about their physical health are identified	Met	We have clear processes for referring patients to secondary physical care if required.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that

	during their admission. Guidance: *This is undertaken promptly, and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services*				they have clear processes for referring patients to secondary physical care when required.
16 [1]	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	Met	Emergency medical equipment is checked daily.	Met	Emergency medical equipment is maintained and checked daily.
17 [1]	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. Sustainability Principle: Consider Carbon	Met	Patients have access to healthy lifestyle support, this will all be care planned. Our patients have care plans that address healthy eating, physical exercise and smoking cessation where applicable.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that patients have access to healthy lifestyle support and that this is care planned and that care plans address the points listed in the standard.

Treatment and Recovery - Medium Secure

This section focuses on care planning, multi-disciplinary review processes, and interventions, activities and therapies in relation to patient outcomes.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
18 [1]	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy. Guidance: *Where possible, the patient writes the care plan themselves or with the support of staff.*	Met	Care plans cover all aspects of care and are written collaboratively with patients, patients are offered a copy.	Partly Met	This standard is scored based on the case note audit and carer and patient survey responses. No case note audit is provided. Patient survey responses largely agree that they have a written care plan, that it reflects their individual needs, that they were involved in developing the plan, and that they are offered a copy. Carer survey responses are mixed as to whether their loved one has a written care plan, were able to contribute to its development and were offered a copy. Patients spoken to on the day agreed that they have a care plan, have copies and are involved in its production.
19 [2]	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	Met	All treatment and care goals are reviewed by patient and MDT throughout admission.	Partly Met	This standard is scored using the case note audit and patient survey responses. No case note audit is provided. Patient survey responses largely agree that staff regularly discuss their progress against their own personal goals. Patients spoken to on the day said that their goals were discussed with staff.
20	Every patient has a seven-day	Met	All our wards have a	Partly Met	Patient survey responses largely

[2]	personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. Guidance: *This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*		therapeutic seven day timetable facilitated by activity coordinators, OT, psychology and chaplaincy.		disagree that there are interesting activities on the ward. Patients spoken to on the day stated that they have timetables but that lack of staff means they do not get a lot of activities. Some of the activities that patients mentioned at the service included the gym, football, volleyball, pool, movie night and karaoke.
21 [1]	There is a documented formalised review of care or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback.	Met	A formal initial ward round / care planning meeting occurs within the first week. Patients will be supported by keyworker, MDT and advocate and carers if required.	Partly Met	This standard is scored using the self-review commentary, case note audit and patient surveys. No case note audit is provided. Patient survey responses are mixed as to whether staff helped prepare them for their first ward round. The service states that a formal initial ward round or care planning meeting occurs within the first week of patient admission.
22 [1]	Patients are encouraged and supported to play a key participating role in their formal review meeting (such as Care Programme Approach or equivalent) and the patient's views are clearly documented.	Met	Patients contribute to their ward round and discharge planning, they are supported by keyworker to prepare for ward rounds.	Partly Met	Patient survey responses all agree that they have had a formal review meeting, but those who responded could not remember whether they felt able to contribute their own views or if staff supported them to prepare for this meeting. Patients

	Guidance: *Other professionals involved should be routinely invited, and carers in accordance with patient's wishes.*				spoken to on the day stated that they have attended these meetings and are able to invite anyone they want to attend.
23 [2]	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Recovery colleges.	Met	We have a number of patients who access community activity, this is all care planned. Patients on discharge pathway will meet peer support workers attached to Community forensic Team.	Partly Met	Patient survey responses are mixed as to whether they have access to all of the local organisations listed in the standard. Staff reported that patients have access to a recovery college. Service user representatives on each ward attend the recovery college meeting each month. Patients also have the opportunity to work in a charity shop. The staff did not mention if patients have access to community centres and local religious/cultural groups.
24 [1]	The team and patient jointly develop a leave plan, which is shared with the patient, that includes: • The aim and therapeutic purpose of section 17 leave that clearly links to the overarching plan for the care pathway; • A risk assessment and risk management plan that includes an explanation of what	Met	Our leave plans consider all these points and will be dependent on patient pathway and risk.	Partly Met	This standard is scored using the self-review commentary and patient survey responses. The service states that leave plans consider all points of the stated and are dependent on patient care pathway and risk. A leave plan was observed that includes the aim and therapeutic purpose of section 17 leave and risk assessment plan. The leave plan does not contain contact details of

	to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit and crisis numbers.				the ward and crisis numbers. Patient survey responses mostly agree that for those with leave, they have a leave plan. No patient survey responses address whether they feel involved in developing their leave plan.
25 [1]	Staff agree leave plans with carers where appropriate, allowing carers sufficient time to prepare.	Met	All leave plans are shared with carers when appropriate and in good time.	Met	Carer survey responses mostly agree that staff agree leave plans with them when their loved one visits. Carers spoken to on the day did not all have consent from their loved one around knowing about leave plans. One carer noted that they want more information about who to contact and would like to express their concerns about whether unescorted leave is right for their loved one.
26 [1]	When patients are absent without leave, the team (in accordance with local policy): • Activates a risk management plan; • Makes efforts to locate the patient; • Alerts carers, people at risk and the relevant authorities;	Met	We have clear AWOL policy, we have recently introduced grab packs which can be shared with police, that contain all information, picture and potential locations patients may go to. AWOL risk management plans are formulated and	Met	Managers reported that they recently did a thematic review of their AWOL policy given they had a number of patients go AWOL last summer. They identified risks for AWOL and instituted a grab pack they provide to police in the case of a patient who is absent without leave. The service states that their AWOL policy conforms with the

	• Escalates as appropriate		reviewed in ward rounds. Our policy ensures that we actively try to locate the patient, alert carers and relevant authorities and escalate to police and other agencies as required.		points listed in the standard.
27 [1]	The team supports patients to access support with finances, benefits, debt management and housing needs.	Met	We have a welfare service and social work team, all patients on a discharge pathway will work with the community forensic team who will support transition, housing, benefits etc.	Partly Met	This standard is scored using the self-review commentary, and patient and staff surveys. The service stated that they have a welfare service and social work team and that patients on the discharge pathway work with the community forensic team for support. Staff survey responses largely agree that patients are offered the opportunity to access support with needs referenced in the standard. Patient survey responses largely agree that those who need the support are given it to access benefits, but are mixed in terms of access to finances, debt management and housing.
28 [2]	Patients and their carer are invited to a discharge meeting and are involved in decisions about discharge plans.	Met	Patients and carers are fully involved in their discharge planning.	Met	Carer survey responses are mixed as to whether they are invited to discharge meetings and involved in decisions about the loved one's

					discharge. Patient survey responses, for those preparing for discharge, largely agree that they are invited to meetings about their discharge. Staff reported that carers and patients are typically routinely invited to these meetings, though they added that a lot of patients do not consent to carer involvement.
29 [2]	The service works proactively with the home area care coordinator and next point of care (including other in-patient services, forensic outreach teams, community mental health teams or prison) to ensure delays to discharge for those medically ready are appropriately identified and steps taken to expedite. Guidance: *Patient discharge plans feature triggers and arrangements for 'recall' to the service if the patient relapses. When patients are transferred between services there is a handover which ensures that the new team have an up to date care plan and risk assessment.*	Met	We work closely with the local community forensic team who start working with patients nine months prior to expected discharge.	Met	Staff reported that the service works with a care coordinator and a specialist community forensic team. The community team is linked in with patients prior to discharge. Staff added that they help support patients to view the accommodation.

30 [1]	Mental health practitioners carry out a thorough assessment of the person's personal, social, safety and practical needs to reduce the risk of suicide on discharge. Guidance: *Where possible, this should be completed in partnership with carers*	Met	Transition to community is managed by community forensic team who start working with patient whilst still inpatient, risk to self is assessed and reviewed.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that the community forensic team works with the patient prior to discharge and that they assess risk to self.
31 [1]	The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge. Guidance: *The plan includes details of:* • *Care in the community/aftercare arrangements;* • *Crisis and contingency arrangements including details of who to contact;* • *Medication including monitoring arrangements;* • *Details of when, where and who will follow up with the patient.*	Met	The care plan / discharge plan will be continued by the community forensic team who will share with all other partners in the community.	Partly Met	A care plan has been observed. The care plan is missing details of when, where and who will follow up with the patient and crisis and contingency arrangements. It is unclear if the plan is sent to everyone identified within 24 hours of discharge. No case note audit is provided.

	Sustainability Principle: Priroritise Prevention				
32 [2]	A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent). The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation.	Met	The community forensic team will ensure the patient is registered with a GP and they will receive the discharge summary/information.	Partly Met	A discharge summary has been observed. It is unclear when it is sent to the patient's GP and others concerned. No case note audit is provided.
33 [1]	The team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 72 hours of discharge.	Met	Follow up is completed by the ward and the community forensic team. The follow up is within 48 hours from both the discharging ward and the Specialist Community Forensic Team.	Met	Managers reported that 90% of discharges go to the specialist community mental health team (SCMHT) and that the SCMHT do inreach work six to nine months in advance of discharge. They added that the social work team have occasionally done follow ups. The service states that the follow-up is done within 48 hours of discharge.
34 [3]	Teams provide support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. Guidance: *The team provides transition mentors; transition support packs; or*	Met	Discharge or transfer to another service is planned collaboratively with patient and carers	Met	This standard is scored using the self-review commentary. The service states that patients' discharge or transfer to another service is planned in collaboration with patients and carers.

	training for patients on how to manage transitions				
35 [1]	Clinical outcome measurement is collected at two time points (at assessment and discharge). Guidance: *This includes patient-reported outcome measurements where possible. This can include Historical, Clinical, Risk 20 (HCR-20), Short Term Assessment of Risk and Treatability (START), Health of the Nation Outcome Scale Secure (HoNOS Secure), FORensic oUtcome Measure (FORUM), Wales Applied Risk Research Network (WARRN) or Dangerousness, Understanding, Recovery, and Urgency Manual (DUNDRUM).*	Met	We use and update HCR-20 and HONOS throughout the admission. HCR – 20 is a dynamic document throughout admission. HONOS secure is completed on admission and discharge as a minimum.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that they use and update HCR-20 and HONOS through the admission, and that this clinical outcome measurement is collected at assessment and discharge at a minimum.
36 [1]	The ward/ unit/ organisation has a care pathway for patients who are pregnant or in the postpartum period. Guidance: *Patients who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there*	Met	The organisation does have a pathway, on our wards we would unlikely met this scenario and if so safeguarding procedures would be followed.	Met	This standard is scored using the self-review commentary. This states that the service has a pathway and that if a patient was pregnant or postpartum, safeguarding procedures would be followed.

	are exceptional circumstances.				

Medication Management - Medium Secure

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
37 [1]	All staff members who administer medications have been assessed as competent to do so. The assessment is completed at least once every three years using a competency-based tool.	Met	We have a clear medication management policy which includes competency tools. I can confirm that the medication competency assessment is completed once every three years as a minimum.	Met	This standard is scored using the self-review commentary. This states that the service has a clear medication management policy, including competency tools. The service states that the medication competency assessment is completed once every three years at a minimum.
38 [1]	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	Met	Medication issues or changes are discussed in ward round, shared with carers, all patients have access to pharmacy support. We have care plans around medication management and this includes expectations and timescales for efficacy. Patients give	Partly Met	This standard is scored using the self-review commentary, case note audit and patient surveys. The service states that medication issues or changes are discussed in ward rounds and that patients have access to pharmacy support. They add that care plans are set around medication management, which includes expectations, timescales and patient consent. Patients largely

			consent for medication treatment, or the appropriate procedures within the MHA are followed.		agree that staff have discussed risks and benefits of their medication. No case note audit is provided.
39 [1]	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually. If a physical health abnormality is identified, this is acted upon.	Met	We use NICE guidance to ensure all physical health risks that could arise from using medication are monitored correctly. Our patients have all the physical health checks indicated by the medication they are on. Our physical health lead monitors to ensure that the checks are completed at the right frequency, three months then annually or more if the physical health checks indicate it.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that they use the National Institute for Health and Care Excellence (NICE) guidance. The service states that checks are completed at three months and annually.
40 [1]	Patients have their medications reviewed at least every two weeks. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.	Met	All medication is reviewed in the fortnightly ward round or more frequently if required. Our medication reviews include therapeutic response,	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that all medication is reviewed on the fortnightly ward round. The service adds that the reviews include all the

	Guidance: *Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.* Sustainability Principle: Consider Carbon		safety, assessment of side effects and management plan and discusses patients views in terms of using the medication.		points listed in the standard.
41 [1]	Every patient's PRN medication is reviewed at least every 2 weeks.: frequency, dose and indication. Guidance: *Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.*	Met	PRN is reviewed at each ward round, it will be removed if not being used. We don't put PRN on charts for emergency as routine. Within fortnightly medication reviews, PRN dosage and frequency will be discussed and reviewed. This will be in relation to use and effectiveness over the previous fortnight.	Partly Met	This standard is scored using the self-review commentary and the case note audit. No case note audit is provided. The service states that PRN medication is reviewed at each ward round on a fortnightly basis. The service adds that these reviews include discussion of frequency, dose and indication.
42 [2]	Patients and carers and prescribers are able to meet with a pharmacist to discuss medications.	Met	Pharmacy service is available to all patients and carers, they attend ward round and are an integral part of MDT.	Partly Met	This standard is scored based on the self-review commentary and patient, carer and staff surveys. The service states that the pharmacy is available to all patients and carers. Staff

					survey responses show that staff who are prescribers are able to speak with a pharmacist. Patient survey responses are mixed as to whether they are able to meet with a pharmacist. Carers survey responses largely disagree that they are able to meet with a pharmacist.

Patient Experience - Medium Secure

This section focuses on the experience of patients at the service, including communication, respect and co-production.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
43 [1]	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their family or carers, are respected and reviewed regularly.	Met	We have clear conversations and information around confidentiality. Consent to share information is revisited regularly.	Partly Met	This standard is scored using the self-review commentary and patient and carer survey responses. The services states that they have conversations and provide information around confidentiality and that consent is revisited regularly. Carer and patient survey responses are mixed as to whether this is explained to them.
44 [1]	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates).	Met	We have an onsite advocate; all patients also have access to IMHA	Met	This standard is scored using the self-review commentary. The service states that there is an onsite

			service.		advocate and that patients have access to an IMHA service. Patient survey responses largely agree that they have access to an advocate or advocacy service.
45 [1]	Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy. Guidance: *Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.*	Met	Patients have access to phone and internet and this is underpinned by clear policy.	Met	Patient survey responses largely agree that they have access to computers with internet and mobile phones. Staff reported that patients generally have a brick phone on the ward, and that those with unescorted leave can use smartphones while on leave. The therapy suite has a computer that patients can access. Additionally, staff mentioned that internet access is risk assessed on a case by case basis and that the service will suspend the internet when there are data breaches.
46 [1]	Patients and carers feel treated with compassion, dignity and respect by staff members. Guidance: *This includes respect of an individual's race, age, expressed social gender, marital status, sexual orientation, maternity, disability, social and cultural background.*	Met	Our staff treat patients and carers with dignity and respect.	Met	Patient and carer survey responses largely agree that they feel treated with compassion, dignity and respect by staff members. Patients spoken to on the day all agreed.

47 [1]	Patients feel listened to and understood by staff members.	Met	Our staff ensure patients are listened to and their needs are understood and met.	Met	Patient survey responses and patients spoken to on the day agreed that they feel listened to and understood by staff members.
48 [1]	Patients are involved (wherever possible) in decisions about their level of therapeutic observation by staff. Guidance: *Patients are also supported to understand how the level can be reduced*.	Met	Observation are discussed and care planned.	Partly Met	Patient survey responses are mixed as to whether they are involved in decisions about their level of therapeutic observation by staff. Patients spoken to on the day felt supported in understanding how observations can be reduced.
49 [1]	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. Guidance: *This can include feedback surveys, focus groups, community meetings and patient representatives*. Sustainability Principle: Empowering Individuals	Met	We use I Want Great Care and are using it to gain feedback at all points of admission from patients and carers.	Partly Met	This standard is scored using the self-review commentary. The service states that they use 'I Want Great Care' for feedback from patients and carers. Patient survey responses are mixed as to whether they are asked for feedback about their experience of the service. Carer survey responses largely disagree that they are asked for feedback about their experience with the service.
50 [2]	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics.	Met	We analyse feedback, we are improving this and are promoting I Want Great Care.	Partly Met	Managers reported that the service uses 'I Want Great Care' QR codes for patient and carer feedback. The acknowledged that they could do better at collecting feedback and

					the service is planning to create a carers' care plan. It is unclear if the service is using the data they collect to identify any differences of experiences by protected characteristics.
51 [2]	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. Guidance: *This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.*	Met	Minuted community meetings occur monthly with daily community meetings also giving the opportunity for patients to voice their opinions. We also have monthly patient forum	Partly Met	Patient survey responses were mixed as to whether the ward community meeting takes place weekly or monthly. Patients spoken to on the day stated that the meeting takes place monthly.
52 [2]	The service has a service user and carer involvement and co-production strategy covering all aspects of service delivery along with a designated lead for patient and carer involvement. This	Met	The organisation has a strategic plan which ensures focus on co-production	Partly Met	A Trust-wide carer strategy has been observed. The strategy states that co-production continues to evolve and the aim is to embed co-production. However, the plan is not

	individual contributes to the leadership of the service. Guidance: *The strategy is developed through use of the 'Carer support and involvement in secure mental health services toolkit' (NHS England, 2018).*				specific to carer involvement and co-production strategy covering all aspects of service delivery with a designated lead for patient and carer involvement.
53 [3]	The service facilitates access to a peer support service.	Met	Peer support is available by third sector partners who work with the community forensic team.	Met	Staff reported that patients have access to a community peer support worker as well as a discharge planning group where former patients attend.
54 [1]	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	Met	Food provision is reviewed to ensure variety and dietary needs are catered for.	Partly Met	Patient survey responses largely agree that meals are nutritional and balances and are big enough portions, but are mixed as to whether they are varied, offer choice and reflect cultural and religious needs. Patients spoken to on the day stated that food choices were good with an okay portion size.
55 [1]	Patients know who the key people are in their team and how to contact them if they have any questions.	Met	All patients have a allocated nurse and secondary worker. They are given details on admission of the wider members of their MDT.	Met	This standard is scored using the self-review commentary. The service states that all patients have an allocated nurse and secondary worker. Patient survey responses largely agree that they know which member of staff they can talk to if

					they have any questions.
56 [2]	Patients receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.	Met	These are provided by OT and psychology.	Met	This standard is scored using the self-review commentary and patient survey responses. The service states that information on psychoeducation topics listed in the standard are provided by OTs and psychology. Patient survey responses for those that need education on these topics, largely agree that they receive it.
57 [1]	Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). Guidance: *This assessment considers risk to self, risk to others and risk from others.* Sustainability Principle: Prioritise Prevention	Met	A dynamic risk assessment document is completed with patient involvement. Safety and management of risks is included. We have access to FGC to support relatives and friends to be involved in managing risk.	Partly Met	This standard is scored using the self-review commentary, case note audit and patient survey responses. No case note audit is provided. The service states that a risk assessment document is completed in collaboration with patients, and this includes safety and management of risks. Patient survey responses are mixed on whether they have a safety plan in place and whether they are involved in this process.
58 [1]	Following assessment, patients promptly begin evidence-based therapeutic interventions which are	Met	All our interventions are evidenced based and tailored to individual need.	Met	Managers reported that they have an extensive list of therapeutic interventions provided to patients following assessment.

	appropriate to the bio-psychosocial needs.				
59 [1]	Each patient is offered a one-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.	Met	Regular 1:1 with keyworker more than weekly to discuss progress.	Partly Met	Patient survey responses are mixed as to whether one-to-one sessions with a staff member take place once a week. Patients spoken to on the day did not specify whether time with staff was requested or scheduled, and how often this takes place.
60 [1]	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness, physical health and treatment.	Met	All are offered information on illness and treatment. If consent id not given by patients, carers will still be given generic information about the service.	Partly Met	This standard is scored using the self-review commentary, and patient and carer survey responses. The service states that carers and patients are offered information on illness and treatment. Carer survey responses mostly agree that they receive information about their loved one verbally, though not in writing. Carer survey responses were mixed on receiving information about their loved one's physical health verbally, though again not in writing. Patient survey responses largely agree they receive information about their mental illness and treatment verbally; responses are mixed as to whether

					they receive this information in writing.
61 [2]	Patients, according to risk assessment, have access to regular 'green' walking sessions. Guidance: *Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rainwear.* Sustainability Principle: Consider Carbon	Met	All patients with appropriate leave have opportunities to engage in walks away from traffic. If nil recourse to public funds appropriate attire would be provided.	Met	Patient survey responses largely agree that they have access to 'green' walking sessions either 'always' or 'often'. Patients spoken to on the day stated that these are available daily, though for security reasons only two patients are allowed at a time to join.

Family, Friends and Visitors - Medium Secure

This section explores the experiences and needs of family, friends and visitors that engage with the service.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
62 [2]	The team provides each carer with accessible carer's information. Guidance: *Information is provided verbally and in writing (e.g., in a carers'pack). This includes the names and contact details of key staff members on the unit and who to*	Met	We have welcome pack Trust-wide and local information.	Met	Carer survey responses and carers spoken to on the day largely agree that they were provided information when their loved one arrived to the service. A carers welcome pack was observed to fit the points of the standard.

	contact in an emergency. It also includes other local sources of advice and support such as local carers'groups, carers' workshops and relevant charities.				
63 [1]	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. Guidance: *This is an opportunity for carers to discuss what support or services they need, including physical, mental and emotional needs. Arrangements should be made through the carer's local council.*	Met	Carers receive information on how to access a carers assessment.	Partly Met	Carer survey responses largely disagree that the service has explained what a carers assessment is and that they know how to access it. One carer spoken to on the day knew what a carer's assessment is and is now considering it.
64 [2]	Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network. Guidance: *This could be a group/network which meets face-to-face or communicates electronically.*	Met	Our social work team provide carer forums.	Partly Met	Carer survey responses mostly disagree that they have access to a carer support network or group. Carers spoken to on the day shared that they have access to a group the social worker facilitates every eight weeks where they can ask questions. The carer added that the service previously offered coffee mornings and requested that they bring this back as it was a way to

					connect with other parents and family.
65 [2]	Carers feel supported by the ward staff members.	Met	Carers will be supported by staff and offered one to one time if requested.	Met	Carer survey responses mostly feel supported by ward staff members. Carers spoken to on the day agreed that staff are mostly helpful. One carer noted that the social worker is very communicative. Another stated that 'all staff I have met are good' and that they have a 'huge amount of professionalism'.
66 [1]	Carers are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents Sustainability Principle: Empowering Individuals	Met	Carers are involved in ward round and care planning, we are introducing carers care plans so their views, situation, means of contact etc can be recorded.	Partly Met	Carer survey responses mostly disagree that they are able to participate in decisions about their loved one's care planning. Carers spoken to on the day were positive about engagement and one noted that they are invited to ward round and feel involved.
67 [2]	The patient's carer is contacted as soon as possible by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.	Met	Carers, if appropriate will be involved at point of referral.	Met	Carer survey responses mostly agreed that they were contacted as soon as possible by a staff member to notify them of the admission. Carers spoken to on the day knew their loved one was being admitted to the service.
68 [2]	Carers are offered individual time with staff members, within 48 hours of the	Met	Carers will be offered time with staff to discuss	Not Met	Carer survey responses disagree they were given individual time to

	patient's admission to discuss concerns and their own needs. Sustainability Principle: Empowering Individuals		their situation at the earliest point, this is often prior to admission.		speak with staff within 48 hours of the patient's admission. Carers spoken to on the day also disagree that they were offered this. Staff survey responses are mixed as to whether they carers are offered this.
69 [1]	The team knows how to respond to carers when the patient does not consent to their involvement. Guidance: *The ward may receive information from the carer in confidence.*	Met	Staff know they can provide generic information about the service.	Partly Met	Staff survey responses largely agree that they know what information they can share with a carer whose loved one has withdraw consent. Staff reported that 'it is unlikely to be able to give any information' to the carer, but did not specify that they could provide generic information about the service or that they could ask receive information from the carer about the patient.
70 [2]	There is a designated visitors' room within the secure perimeter. The space must meet the following requirements: • Suitable to maintain privacy and confidentiality; • Provide a homely environment; • Observations enable private conversations; • Accessible by patients and visitors.	Met	Designated family room is within the perimeter and enables comfort and privacy.	Met	The service has a dedicated visitors room within the secure perimeter. The visitors room meets the requirements of the standard.

71 [2]	The service is able to safely facilitate child visits and is equipped with a range of age-appropriate facilities such as toys, games and books. Guidance: *The children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit. Sufficient staff should be made available to enable children to visit during evenings and weekends.*	Met	Children visits are facilitated, pre arrangement is required and goes through the social work team.	Met	The service can facilitate child visits and has age-appropriate facilities available.
72 [1]	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	Met	We have sufficient technology available to ensure patients can contact family and friends virtually.	Partly Met	This standard is scored using the self-review commentary and patient and carer survey responses. The service states that they have technology to ensure virtual family visits. Patient and carer survey responses are mixed as to whether they are able to speak to their carers and loved ones virtually.
73 [2]	The pathway of care takes into account victim issues and is developed in liaison with relevant supervisory agencies e.g. the responsible local authority, offender manager and/or MAPPA.	Met	All care pathways including discharge pathway involve involvement with MAPPA and MARAC.	Met	Managers reported that the service liaises with relevant supervisor agencies and attends meetings with MAPPA.

Ward Environment - Medium Secure

This section reports on the hospital environment and its facilities.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
74 [1]	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms. There is an agreed response when the alarm is raised.	Met	All staff and visitors have panic alarms, and call buttons are located on all wards. The service has a 24 hour response team.	Met	Staff, patients and visitors are all given alarms and there is an agreed upon response when the alarm is raised. Panic buttons are located in patient rooms.
75 [1]	All patient information is kept in accordance with current legislation. Guidance: *This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	Met	All staff and visitors have panic alarms, and call buttons are located on all wards. The service has a 24 hour response team.	Met	Patient information is kept in accordance with current legislation. No confidential information was viewed by peer review members on the day.
76 [1]	The environment complies with current legislation on disabled access. Guidance: *Relevant assistive*	Met	The site and all wards are accessible by wheelchair.	Met	The service has a lift and wards are accessible by wheelchair.

	technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.				
77 [2]	Staff members and patients can control heating, ventilation and light on the ward/unit. Guidance: *For example, patients are able ventilate their rooms through the use of windows, they have access to light switches, and they can request adjustments to control heating.*	Met	Heating, ventilation and lighting is controllable by staff and patients.	Met	Patients are able to ventilate their rooms by opening windows, have access to lighting and can ask staff on the ward to change the temperature of the rooms.
78 [2]	Patients are able to personalise their bedroom spaces and the ward environment where appropriate. Guidance: *For example, by putting up photos and pictures*.	Met	Appropriate personalisation of bedroom is permitted.	Met	Patient surveys responses largely agree that they are able to personalise their bedroom spaces and the ward environment. This was observed on the day.
79 [1]	Furnishings minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.	Met	Our site is anti-lig where fittings are available. We have regular ligature audits and a heat map to identify current risks.	Partly Met	Furnishing minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points on Forest, Lagoon and Fuji wards. On Aurora ward, furniture is not tied down and is not heavy weighted.
80	Patients are supported to access	Met	Patients have access to	Met	While patient survey responses are

[1]	materials and facilities that are associated with specific cultural or spiritual practices, e.g., covered copies of faith books, access to a multi-faith room, or access to groups.		multi-faith room and materials to support their cultural and spiritual practices.		mixed on whether they have access to materials and facilities associated with specific cultural or spiritual practices, a multi-faith room with copies of faith books was observed on the day.
81 [2]	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	Met	All wards have multi-faith rooms and an onsite chaplaincy service.	Met	Patient survey responses listed access to faith-specific support such as a church service, a spirituality group, a multi-faith room and chaplain. Patients spoken to on the day stated that you can request time at the multi-faith room.
82 [2]	The ward/unit has a designated room for physical examination and minor medical procedures.	Met	All wards have fully equipped clinic rooms.	Met	All wards have a designated clinic room.
83 [2]	The service has at least one bathroom/shower room for every three patients.	Met	All rooms are en-suite.	Met	The service has at least one bathroom/shower room for every three patients.
84 [2]	All patients have single bedrooms.	Met	All patients have single bedrooms.	Met	All patients at the service have single bedrooms.
85 [3]	Every patient has an en-suite bathroom.	Met	All rooms have en-suite facility.	Partly Met	Every patient on Forest, Lagoon and Aurora wards have an en-suite bathroom. Patients on Aurora share bathrooms on the ward.

86 [3]	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.	Met	Rooms are neutral colour and patients can add safe decoration.	Met	The service can designate gender neutral bathrooms and toilet facilities for patients who would prefer a non-gendered care environment.
87 [1]	Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom. Guidance: *This may be subject to risk assessment including emergencies*.	Met	All staff knock on doors before entering.	Met	Patient survey responses largely agree that staff members respect their personal space. Patients spoken to on the day agreed, stating that staff always knock before entering their bedroom.
88 [2]	Ward/unit-based staff members have access to a dedicated staff room. Sustainability Principle: Empowering Staff	Met	All wards have a dedicated staff room.	Met	The medium secure wards each have a dedicated staff room.
89 [2]	Patients are consulted about changes to the ward/unit environment.	Met	We have had recent refurbishment work, patients are consulted and updated daily in community meetings.	Met	This standard is scored using the self-review commentary and patient survey responses. The service states that the consult patients on refurbishment work and update patients daily in community meetings. Patient survey responses largely agree that, when changes are made to the environment, they are consulted.
90 [1]	Patients have access to safe outdoor space every day.	Met	All wards have access to outside spaces.	Met	Patient survey responses largely agree that they have access to safe

	Sustainability Principle: Consider Carbon				outdoor space every day. Outdoor garden spaces on each ward were observed on the day.
91 [3]	All patients can access a charge point for electronic devices such as mobile phones.	Met	Charging facilities are available.	Met	Patients can access a charge point for electronic devices.
92 [2]	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. Guidance: *Hot drinks may be available on a risk-assessed basis.*	Met	Hot drinks and snacks are available at all times.	Met	Patients can make their own hot and cold drinks and snacks 24 hours a day.
93 [2]	All patients can access a range of current culturally specific resources for entertainment, which reflect the service's population. Guidance: *This may include recent magazines, daily newspapers, books, board games, a TV and DVD player with DVDs, computers and internet access (where risk assessment allows).*	Met	Patients can have access to all materials no restricted or prohibited. Patients can request these items in community meetings or supported to purchase.	Met	Patient survey responses largely agree that they have access to a range of self-led entertainment. Boardgames, laptops are other resources were observed on the day.
94 [2]	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	Met	All wards have quiet areas.	Met	All wards have a quiet room or de-escalation space that is not a patient bedroom.

95 [1]	In services where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and ventilated; • It has adequate lighting, including a window(s) that provides natural light; • It has direct access to toilet/washing facilities; • It has limited furnishings (which include a bed, pillow, mattress and blanket or covering); • It is safe and secure, and does not contain anything that could be potentially harmful; • It includes a means of two-way communication with the team; • It has a clock that patients can see.	Met	The service has 2 seclusion rooms, and they meet the standards set out by COP.	Met	The seclusion rooms on the medium secure wards were in use on the day of the review. The peer review team was unable to view the rooms on the day. This is scored based on the service's self-review commentary and on the most recent full review report.
96 [1]	Patients and staff members feel safe on the ward.	Met	The service provides safe environment, safe	Partly Met	Patient survey responses largely agree that they feel safe on the

			staffing, safe procedures.		ward. Patients spoken to on the day agreed and added that staff check patient alarms every week. Staff survey responses are mixed as to whether they feel safe on the ward, with some staff stating they do not feel safe as 'sometimes staff are not present and the ward environment is chaotic' and 'we have a lot of staff who are not fit for the job due to attitude towards work'.
97 [1]	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.	Met	Ligature audits are completed on all wards at least annually.	Met	A ligature audit for Dune ward has been observed and fits the points of the standard.

Physical Security - Medium Secure

This section details the physical security in place at the service, focusing on the internal and external perimeter, responsibilities of the security lead, and key management.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
98 [1]	The service manages physical security	Met	We have reviewed QNFMHS Physical	Met	The service manages physical security according to the standards

	according to the standards stated in the QNFMHS Physical Security in Secure Care guidance.		Security in Secure Care guidance and are fully compliant.		stated in the QNFMHS Physical Security in Secure Care guidance. While the service mentions a contingency plan is in place, it does not specify the chain of operational control, communications, patient and staff security, maintaining continuity in treatment and accommodation.

Procedural Security - Medium Secure

This section focusses on the formal policies, procedures and guidance in place at the service.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
99 [2]	There are formalised policies, procedures and guidance which have been co-produced where possible on: • Anti-bullying (for staff and patients, for those who are bullying, and those who are being bullied). • Supporting patients' use of electronic equipment and safe access to the internet, including specific advice	Met	These are all available on the intranet and hard copies on all wards.	Met	This standard is scored using the self-review commentary. The service states that all formalised policies listed in the standard are available on the intranet as well as in hard copies on all wards.

	around the appropriate use of social networking sites, confidentiality and risk. • Effective liaison with local police on incidents of criminal activity/harassment/violence and other criminal justice agencies, where relevant (a memorandum of understanding is in place with local police on reporting crime). • Minimising restrictive practices (a process for reviewing restrictive practices is documented with specified timescales. Individual care plans focus on minimisation and restrictive practices).				
100 [1]	• Managing situations where patients are absent without leave. • Patient observation and engagement. • Conducting searches of patients and their personal	Met	All these policies are available on intranet and in hard copy. When patients are AWOL, the team will discuss and reflect on recent observation and engagement.	Met	This standard is scored using the self-review commentary. The service states that policies are available on the intranet and in hard copy. The service adds that they have policies for each of the points of the standard listed.

	property, staff members, visitors and the environment. • Prevention of suicide and management of self-harm. • Visiting, including procedures for children and unwanted visitors (i.e. those who pose a threat to patients, or to staff members).		Furthermore, engagement and obs levels will be reviewed when patient returns. Room and property searches will take place to ascertain what the patient may have with them, phone etc. The team will escalate and notify police if they have concerns around self-harm or suicide. Visting procedures will be reviewed with support of social workers particularly if under 18s are identified as visitors.		
101 [1]	Services have an easily accessible business continuity plan that provides guidance for a range of emergency planning eventualities. This includes testing by live and/or desktop exercises at least six-monthly.	Met	The service has a BCP which is available on all wards. The contents are discussed in team meetings and quality and safety meetings. Our service complete desk top exercises every six months at a minimum to look at the effectiveness of our Business	Met	This standard is scored using the self-review commentary. This states that the service has a business continuity plan that is available on all wards, and whose contents are discussed in team meetings. The service adds that the plan includes testing by desktop exercises at least six-monthly.

			.Continuity Plan.		
102 [2]	There is a process in place to enable patients and their representatives to view policies and procedures critical to their care. These are stored in ways that staff, patients and carers find accessible and easy to use.	Met	All our policies are made available on request. many are accessible through the internet.	Met	This standard is scored using the self-review commentary and patient and staff survey responses. The service states that all policies are made available on request and many are accessible through the internet. Staff survey responses largely agree that policies and procedures are easily accessible. Patient survey responses are mixed as to whether they know how to access policies and procedures critical to their care.

Relational Security - Medium Secure

This section explores policies and practice relating to relational security, including induction, skill development and communication.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
103 [1]	There is a relational security component to the induction programme for all staff that includes the See Think Act framework. This is refreshed annually.	Met	Relational security is fully covered in induction and regularly reviewed.	Met	Staff reported that relational security is part of the security training on induction and that it is done annually. Staff mentioned that it was only part of the corporate induction. The relational security wheels on the

					ward posters are unlabeled. It is recommended that these are labeled so staff are reminded of relational security while on their shifts.
104 [3]	The service has a co-produced strategy to respond to requests from victims, patients or carers to participate in restorative justice.	Met	We have worked hard over the last years to include debriefs on any Datix incident of racial abuse, these will soon be available for physical and sexual assault / abuse incidents. they process allows victims to discuss the issues with perpetrators in a controlled environment. Within our work on debriefs and 'repair meetings' we ensure coproduction.	Partly Met	This standard is scored using the self-review commentary. This states that the service includes debriefs on any Datix incident of racial abuse, and that they are rolling this out for physical and sexual abuse incidents. A process is in place to allow victims to discuss issues with perpetrators in a controlled environment. The service adds that they ensure coproduction through debriefs and 'repair' meetings, but it is unclear if carers are included in this work.
105 [1]	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. There is a record kept. Guidance: *It is good practice to utilise the relational security explorer wheel.*	Met	Our handovers follow a clear template which cavers all areas of care and risk, over the last year all our handovers include a visual walkround between the incoming and outgoing	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that their handovers follow a template. Staff survey responses largely agree that handovers allow adequate time to discuss patients' needs.

			NIC where all patients are seen and greeted (if appropriate).		

Safeguarding - Medium Secure

This section explores safeguarding processes, focusing on formal procedures and raising concerns.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
106 [1]	There is a local designated safeguarding lead who can give advice and ensure that all safeguarding issues are raised and resolved, and links into the safeguarding processes within the organisation/provider collaborative. Guidance: *On admission, a record is made for each patient of any children known to be in their social network, their relationship to those children and any known risks whether or not reflected in convictions.*	Met	Safeguarding processes are clear, wards have designated leads and social work support. The trust has clear policies and a dedicated safeguarding team, all safeguarding referrals are reviewed in quality and safety meetings.	Partly Met	Staff reported that there are posters up on the wards and on the intranet about the safeguarding processes. The daily sitrep meeting is a space where they can discuss safeguarding concerns, however some staff stated that they do not get this. It was unclear if ward based staff spoken to on the day knew their designated safeguarding lead.
107 [1]	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to	Met	Staff have forums and opportunities to raise concerns, we have whistleblowing policies	Met	Staff survey responses are mixed as to whether they feel able to challenge decisions within the team. For those that are not always

	follow when raising concerns or whistleblowing. Sustainability Principle: Empowering Staff		and access to F2SU guardian.		comfortable challenging decisions, they noted that it 'can be difficult to challenge due to the hierarchy within the MDT' and that 'some issues are still not attended to when challenged'. Staff spoken to on the day were positive about feeling comfortable challenging decisions. They referenced the Freedom to Speak Up training as well as the service's whistleblowing policy. They added that they can always raise concerns in the monthly MDT meeting and during their line management supervision.
108 [1]	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.	Met	All folders have sexual safety folders, we have recently benchmarked against the national tool and had a trust sexual safety conference.	Met	Staff survey responses largely agree that they feel confident preventing and responding to sexual exploitation, coercion, intimidation and abuse. Staff reported that there is a folder in the MDT room on sexual safety, and that there is a new policy and guidelines for reporting sexual safety concerns that staff are familiar with.

Workforce - Medium Secure

This section reports on the staffing and skill mix of the service, as well as support and training provided to staff members.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
109 [1]	There is a psychologist who is part of the multi-disciplinary team. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.	Met	Psychology is available to the whole service, clinical and assistants.	Met	This standard is scored using the self-review commentary. This states that psychology is available to the whole service.
110 [1]	There is an occupational therapist who is part of the multi-disciplinary team. They work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions.	Met	An occupational therapist is available to the whole service, qualified and activity coordinators.	Met	This standard is scored using the self-review commentary. This states that an occupational therapist is available for the whole service along with activity coordinators.
111 [3]	There is dedicated sessional input from arts or creative therapists.	Met	Our activity timetable includes creative sessions. Our therapists have skills in providing arts and creative therapies.	Partly Met	This standard is scored using the self-review commentary. This states that the service's activity timetable includes creative sessions. The service adds that their therapists have skills in providing arts and creative therapies, but it is unclear if

					they are arts and creative therapists.
112 [1]	The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services. Sustainability Principle: Empowering Staff	Met	Daily morning sitrep, reports staffing skill Grab Bag and TASID training, any activity that may need support, escalation flowchart is available for concerns out of hours. Our qualified staff all have training in relational security and this includes how to effectively priortise tasks and manage safety when staffing is reduced.	Partly Met	Managers reported that the ward assesses daily staffing levels in morning sitreps where the team could report concerns. They also have a roster lead who is in charge of monitoring staffing. In case staffing levels fall short, the service has access to agency and bank staff. The service states adds that staff have training in relational security, including how to prioritise tasks and manage safety when staffing is reduced. It is unclear if this is part of an agreed upon contingency plan.
113 [1]	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency.	Met	There is a robust OOH service that covers the service, normal hours have full medical cover. Our duty Dr is located on site at all times so can attend within 30 minutes.	Met	This standard is scored using the self-review commentary. This states that an Out of Hours (OOH) service is available. For normal hours, the service has full medical cover. The service adds that the duty doctor can reach the site within 30 minutes.
114 [2]	The ward/unit is staffed by permanent staff members, and unfamiliar bank or	Met	We have considerably reducing our use of bank and agency recently, by	Partly Met	Managers reported an improvement in the use of permanent staff and noted that they do not use agency

	agency staff members are used only in exceptional circumstances, e.g., in response to additional clinical need or shortterm absence of permanent staff		making the processes for regular staff to pick up extra shifts easier.		staff as much as they used to. They added that the service has some bank staff that have worked with the service for years. It is unclear if unfamiliar bank or agency staff are used only in exceptional circumstances.
115 [2]	Patient or carer representatives are involved in the interview process for recruiting potential staff members. Guidance: *The representatives should have experience of the relevant service.* Sustainability Principle: Empowering Individuals	Met	We regularly have patient representatives on interview panels.	Met	This standard is scored using the self-review commentary. The service states that they regularly have patient representatives on interview panels.
116 [1]	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. Guidance: *Staff have the right to one uninterrupted 20-minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	Met	Staff are allocated one hour break and have a staff area to use.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that staff are allocated a one hour break on their shifts and are able to access a staff area. Staff survey responses largely agree that they are able to take breaks.

Workforce Training and Support - Medium Secure

This section reports on the staffing and skill mix of the service, as well as support and training provided to staff members.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
117 [1]	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. Guidance: *Supervision should be profession specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	Met	Supervision occurs monthly, this is tracked and abnomolies reported through quality and safety meetings.	Met	Staff survey responses largely agree that they are receiving clinical supervision at least on a monthly basis. Staff reported that the assistant psychologists receive this weekly while the nursing, social work and occupational therapists receive this on a monthly basis.
118 [2]	All staff members receive individual line management supervision at least monthly.	Met	Line management supervision occurs monthly, tracked and monitored.	Met	Staff survey responses largely agree that they receive line management supervision on a monthly basis, which staff spoken to on the day also reported.
119 [3]	Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice. Sustainability Principle: Empowering Staff	Met	Reflective practice is planned on all wards and facilitated by psychology, we are always trying to improve attendance levels.	Met	Staff survey responses largely agree that they have access to reflective practice at least every six weeks. Staff reported that psychology offers a monthly reflective practice on each ward. It was noted that the pharmacy team is not always invited. It is recommended that

					invitations to reflective practice are sent out to all staff on each ward.
120 [1]	The service actively supports staff health and wellbeing. Guidance: *For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports, and taking action where needed.* Sustainability Principle: Empowering Staff	Met	Staff have access to well-being support services. The service has patient engagement representatives, and access to an employee relations lead.	Partly Met	Staff survey responses largely agree that the service actively supports their health and wellbeing. Staff reported that they have access to a resource called 'Here For You' but that staff do not always find it helpful and some have raised concerns about its helpfulness. A wellbeing section is part of their supervision where staff can raise complaints. Staff noted that the service still has a lot of vacancies and that the service has had to build itself back up. Staff also added that they are only allowed three absences a year and that this can be difficult for staff members.
121 [1]	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as	Met	All staff have a trust induction and an extensive local induction where they have opportunities to shadow and show mastery of competencies required by their role.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that staff have a Trust induction and local induction on core competencies. Staff survey responses largely agree that they received the points of the standard in their induction.

	met.				
122.1 [1]	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.2 [1]	Physical health assessment and management. Guidance: *This could include training in understanding physical health problems, undertaking physical observations, basic life support, and Early Warning Signs.*	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.3 [1]	Safeguarding vulnerable adults and children. Guidance: *This includes recognising and responding to the signs of abuse, exploitation, or neglect.* Sustainability Principle: Prioritise Prevention	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.4 [1]	Risk assessment and management. Guidance: *This includes assessing and managing suicide risk and self-harm, and the prevention and management*	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.

	of challenging behaviour. Sustainability Principle: Prioritise Prevention				
122.5 [1]	Recognising and communicating with patients with cognitive impairment and learning disabilities.	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.6 [1]	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.).	Met	This training is provided.	Not Met	No training on inequalities in mental health access has been observed.
122.7 [2]	Carer awareness, family inclusive practice and social systems, including carers'rights in relation to confidentiality.	Met	This training is provided.	Not Met	No training matrix on carer awareness has been observed.
122.8 [2]	Recovery and outcomes approaches.	Met	This training is provided.	Not Met	No training matrix on recovery and outcomes approaches has been observed.
122.9 [2]	Assessing and managing suicide risk and self-harm.	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was

					completed.
122.10 [2]	Prevention and management of aggression and violence	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.11 [2]	A patient's perspective.	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
123 [1]	All clinical staff undergo specific training in therapeutic observation when they are inducted into a Trust or changing wards. This includes: • Principles around positive engagement with patients; • When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this.	Met	This training is provided.	Not Met	No training matrix on therapeutic observations has been observed.
124 [1]	All staff members who deliver therapies and activities are appropriately trained and supervised. Sustainability Principle: Staff Empowerment	Met	This training is provided.	Not Met	No training or supervision matrix has been observed.

125 [1]	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. Sustainability Principle: Prioritise Prevention	Met	We have regular simulations of physical health emergencies, we also have drop in sessions on site where staff can refresh themselves with emergency medical procedures and equipment.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that they regularly have simulations of physical health emergencies and drop in sessions for staff to refresh themselves. Staff survey responses largely agree that they know how to identify and manage an acute physical health emergency.
126 [2]	Patient and/or carer representatives are involved in delivering and developing staff training.	Met	Patients support security training. We recently have employed Family Ambassadors and expert by experience who will be involved in delivering training.	Met	This standard is scored using the self-review commentary. This states that patients support security training at the service and that they have recently employed family ambassadors and experts by experience to be involved in delivering training.

Reducing Restrictive Practices - Medium Secure

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
127 [1]	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. Guidance: *This includes avoiding the*	Met	We are constantly reviewing restrictions with a view to safely reduce. Restrictions are	Met	Staff reported that patients are cared for in the least restrictive environment possible. Restrictive practices are discussed in monthly

	use of blanket rules and assessing risk on an individual basis.		reviewed three times a week by clinical leads.		MDT meetings and a patient representative attends. The service also hosted an away day with a focus on restrictive practice.
128 [1]	The team uses seclusion only as a last resort and for the minimum possible period only.	Met	We have done lots of work on scrutinising seclusion sessions and ensuring care plans are robust and involve the patient in how to end an episode of seclusion. Seclusion is only used as a last resort and for the minimum possible period. We have done training recently on ensuring the care plans for a patient in seclusion include patients voice and clear information about how staff and patients can work towards ending the episode.	Met	This standard is scored using the self-review commentary. This states that the service has worked on scrutinising sessions and ensuring care plans involved the patient in how to end periods of seclusion. The service adds that seclusion is used only as a last resort and for the minimum possible period.
129 [1]	In units where long term segregation is used, the area used conforms to standards as prescribed by the Mental Health Act Code of Practice (or	Met	The LTS pathway is carried out in suitable environments, LTS and seclusion paperwork is scrutinised weekly and	Met	The service reports that the area used for LTS conforms to standards and that LTS and seclusion paperwork is looked at on a weekly basis.

	equivalent). Guidance: *This includes patients having access to meaningful and therapeutic activity and outdoor space.*		used for learning.		
130 [1]	When restraint is used, staff members restrain in adherence with accredited restraint techniques.	Met	All staff are TASID trained.	Met	This standard is scored using the self-review commentary. This states that staff are trained in Therapeutic and Safe Interventions and De-escalation (TASID) training.
131 [1]	Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018 (or equivalent).	Met	All incidents of restrictive Practice will be recorded on Datix, debriefs will follow if required.	Met	This standard is scored using the self-review commentary. This states that any incident of restrictive practice is recorded on Datix and is followed by a debrief.
132 [1]	Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs, including respiratory rate, monitored by staff members and any deterioration is responded to. Guidance: *If a patient declines to have their vital signs monitored, this should be recorded in patient records and re-offered again as appropriate.*	Met	We have clear policy around monitoring patients' physical health following restrictive practices.	Partly Met	The self-review commentary states that the service has a policy around monitoring patients' physical health following restrictive practices such as rapid tranquilisation. No case note audit is provided.

133 [2]	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.	Met	We ensure that all staff have passed engagement and observation competencies, we ensure qualified staff also complete Level 3 observations as we acknowledge it is an important intervention.	Partly Met	This standard is scored using the self-review commentary and patient and staff survey responses. The service states that all staff must have training in observation. Patient and staff survey responses are mixed as to whether patients on observations receive at least one hour per day being observed by a member of staff who is familiar to them.
134 [1]	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions	Met	Patients have PBS plans that support the patient and staff to promote more positive behaviours to get needs met. This reduces restrictive practice.	Partly Met	The self-review commentary states that patients have Positive Behaviour Support (PBS) plans to support patients and staff to reduce restrictive interventions. No case note audit is provided.
135 [1]	The service collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. Guidance: *Audit data are used to*	Met	We have an active programme of reviewing and reducing restrictive practices using QI methodology and Life QI, We monitor use and report to a monthly reducing restrictive practice forum.	Partly Met	Managers reported that the service collects data on gender and ethnicity, however, they did not describe whether they use an audit to actively reduce the use of restrictive interventions year on year.

	compare the service to national benchmarks where possible.				

Governance - Medium Secure

This section focuses on the governance processes of the service, as well as quality improvement and research activity.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
136 [2]	The ward team use quality improvement methods to implement service improvements.	Met	The service has a QI lead who supports the teams with QI methodology and Life QI for oversight.	Partly Met	This standard is scored using the self-review commentary and staff survey responses. This states that the service has a quality improvement lead who support the teams. Staff survey responses are mixed as to whether they are able to engage in quality improvement initiatives.
137 [2]	The team actively encourages patients and carers to be involved in quality improvement initiatives.	Met	All QI projects are co-produced.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that all quality improvement initiatives are co-produced. Staff have included examples such as discussing QI projects in community meetings and patient forums, and drafting policies in co-production

					with carers and patients.
138 [3]	The service supports research and the implementation of evidence-based interventions. There is a local research strategy linked to the needs of patients and workforce.	Met	The service has an audit team who base audits on recent local and national research. All interventions are evidence based. NICE guidance updates are monitored and policy updated accordingly.	Partly Met	This standard is scored using the self-review commentary. This states that the service has an audit team who use local and national research, and that interventions given to patients are evidence-based.
139 [1]	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this	Met	The service uses Datix, are staff know that Datix is used to improve practice and learn lessons. the service contributes to the Trust's learning collaborative.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that they use Datix to report incidents and that staff understand this system is used to improve practice and learn lessons. Staff survey responses 100% agree that thy are able to quickly ad efficiently report incidents.
140 [1]	When serious mistakes are made in care, this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement (or equivalent).	Met	The trust has a DOC policy and this is followed when mistakes are made.	Met	Managers reported that, when serious mistakes are made, the service follows the Duty of Candour policy.
141 [1]	Staff members, patients and carers who are affected by a serious incident including restraints and/or rapid	Met	We offer debriefs and post incident support following incidents,	Met	Carer and staff survey responses largely agree that they are offered support after a serious incident

	tranquilisation are offered post-incident support. Guidance: *This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection* Sustainability Principle: Empowering Individuals		psychology referrals or facilitation is often recommended.		involving restraints and/or rapid tranquilisation. Patients who have been involved in serious incidents agree that they are offered this support as well. Staff reported that staff present for a serious incident are offered support.
142 [1]	Lessons learned from patient safety incidents, safeguarding themes/trends and complaints are shared with the team and the wider organisation/provider collaborative. There is evidence that changes have been made as a result of sharing the lessons.	Met	We follow the Patient Safety Incident Response Framework and staff have had training, all lessons are shared through the trust's learning collaborative.	Met	Managers reported that the service has a safety folder that is available to staff. They added that they share lessons learned through the provider collaborative.
143 [2]	Services are developed in partnership with appropriately experienced patients and carers who have an active role in decision making.	Met	Operational policy has been recently reviewed, patient and carer groups were consulted throughout this process and we have many examples of where their views have resulted in changes to how we operate.	Met	This standard is scored using the self-review commentary. This states that the service recently reviewed its operational policy and that patient and carer groups were consulted during this process.

144 [3]	The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan (or equivalent). It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team.	Partly Met	Sustainability is acknowledged and considered although we don't currently have a clear plan of action for each service, however the organisation strategic plan acknowledges the intention to offer services in a greener and sustainable way.	Not Met	Managers reported that they were not aware of a written green plan in place. No green plan has been observed.

Appendix 2: Self-Review and Peer-Review Commentary – Low Secure

This section is formed by self-review commentary provided by the service and commentary made by the peer-review team. Individual standards are scored as met (2), partly met (1), not met (0) or not applicable (7).

Admission and Assessment - Low Secure

This section explores patient admission and assessment processes, including multi-disciplinary decision-making and information provided to patients on arrival to the service.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
1 [2]	Patients receive a multidisciplinary pre-admission assessment of need and risk which accords with an access assessment for secure care and good practice in relation to mental health measures and CPA/CMHF. Guidance: *An admission tool is available to consider risk and levels of security.*	Met	All patients are assessed pre admission and MDT discuss and plan treatment prior to admission.	Met	Managers reported that they have a weekly referral meeting and that for new admissions, a medic and nurse provide an assessment. The also stated that, if the patient has a particular psychological need, they send a psychologist for the assessment. They added that the service aspires to have a care plan in place when the patient arrives to the service.
2 [2]	The multi-disciplinary team make decisions about patient admission or transfer. In making those decisions, they take account of patient mix and the potential to compromise safety and/or therapeutic activity when	Met	Admission and transfer pathway considers relational security and patient mix, potential risks.	Met	Managers reported that careful consideration is given to placements and that the service can have a say on who is admitted. The service can also ask a 'brother' or 'sister' unit for help. They noted that, given they have a number of wards, patients

	deciding where a patient will be placed. Guidance: *Decisions to accept or refuse patients are recorded.*				can be moved between wards.
3 [1]	The service provides information to referrers about how to make a referral.	Met	This information is available to all referrers and overseen by the provider collaborative.	Met	This standard is scored using the self-review commentary. The service states that information is available for all referrers and that this information is overseen by the provider collaborative.
4 [1]	The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. Guidance: *This includes data around the use of seclusion and length of stay in the unit for different groups*	Met	We use Datix Power BI and our electronic patient record (EPR) system to generate reports to guide our operational policy.	Partly Met	Managers reported that the service uses HONAS and Power BI to analyse their data. They added that currently, there is no data collection addressing protected characteristics and inequalities in care planning and treatment.
5 [1]	Patients have a comprehensive mental health assessment which is started within four hours of admission. This involves the multi-disciplinary team and includes consideration of the patient's: • Mental health and medication;	Met	Our mental health assessment starts at point of referral and continues throughout the admission until discharge. The mental health assessment will be completed within 4	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit was submitted. The service states that the mental health assessment starts at point of referral and continues throughout the admission until discharge. The service states that

	• Psychosocial and psychological needs; • Strengths and areas for development Sustainability Principle: Improving value		hours of admission. Mental health, diagnosis and medication history and options are assessed. Psychosocial and psychological needs are assessed and care planned. The assessment will identify strengths and areas for development so they can be incorporated into the care plans.		the mental health assessment includes the points listed in the standard.
6 [1]	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for); • Arrangements for pets.	Met	These areas will be considered, our social work team will address any potential concerns.	Partly Met	This standard is scored using the self review commentary and case note audits. No case note audit are provided. The service states that the points of the standard will be considered and that the social work team addresses any potential concerns.
7 [1]	Patients admitted to the ward outside the area in which they live have a review of their placement at least every three months.	Met	Working within the East of England Collaborative all our referrals will remain as close to home as practicably possible.	Met	Managers reported that patients who are from outside of the area they live are discussed in referral meetings, though the service noted that it is unlikely a patient would be placed out of area. Their placement

					would be discussed in a monthly catch up the service has with commissioners.
8 [1]	On admission to the service, patients feel welcomed by staff members who explain why they are in hospital. Guidance: *Staff members show patients around and introduce themselves and other patients, offer them refreshments and address them using their preferred name and correct pronouns. Staff should enquire as relevant how they would like to be supported in regard to their gender.*	Met	We have a welcome process that is part of our operational model, include tour, introductions and service information.	Met	Patient survey responses largely agree that, upon arrival to the service, they felt welcomed by staff and staff members explained why they were in the service. Patient's spoken to on the day stated that they were shown around by staff, though some new patients did not feel welcome. However they all felt staff explained why they were at the service, and one patient said that they were very unwell when they came in and now feel like their relationships with staff and other patients are much better.
9 [2]	The patient is given an information pack on admission that contains the following: • Admission criteria; • Clinical pathways describing access and discharge; • How the service involves patients; • A description of the service; • The therapeutic programme;	Met	Welcome packs cover all these aspects.	Partly Met	Patient survey responses are mixed as to whether they received a welcome pack on admission. A welcome pack has been observed that conforms to all the points of the standard.

	• Information about the staff team; • The unit code of conduct; • Key service policies (e.g., permitted items, smoking policy); • Resources to meet spiritual, cultural or gender needs				
10 [1]	Patients are given accessible written information which staff members talk through with them as soon as practically possible. The information includes: • Their rights regarding admission and consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to view their health	Met	These areas are included in the welcome packs.	Partly Met	A welcome pack has been observed. The welcome pack is missing how to access a second opinion and how patients can view their health records.

	records; • How to raise concerns, complaints and give compliments.				
11 [1]	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	Met	All consent and capacity assessments are documented on approved systems and paperwork.	Partly Met	This standard is scored using the case note audit and self-review commentary. No case note audit is provided. The service states that consent and capacity assessments are documented in their approved systems and through paperwork.
12 [2]	The ward/unit works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	Met	The service has access to translator services.	Met	This standard is scored using the self-review commentary. The service states that it has access to a translator service.

Physical Healthcare - Low Secure

This section reports on physical healthcare assessments, needs and interventions.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
13 [1]	Patients have a comprehensive	Met	Our physical health offer	Partly Met	This standard is scored using the

	physical health review. This is started within four hours of admission, or as soon as is practically possible. If all or part of the examination is declined, then the reason is recorded, and repeated attempts are made. Sustainability Principle: Prioritise Prevention		is comprehensive and starts on referral. We have a physical health lead for the service. Our physical health assessments are completed within 4 hours of admission. Our staff are aware that some vital signs can be taken without hands on. If patients decline it is revisited at the patient's convenience.		self-review commentary and the case note audit. No case note audit is provided. The service states that the physical health offer is comprehensive and starts on referral and that the service has a physical health lead. The service states that physical health assessments are completed within four hours of admission and that, where patients decline the assessment, it is revisited with the patient at their convenience.
14 [2]	Patients have access to physical health programmes in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health. Guidance: *Patients are informed of the higher physical health risks for patients in secure mental health, such as diabetes, dyslipidaemia, hypertension, epilepsy, asthma etc. and gender-specific needs.*	Met	Our physical health offer is comprehensive, our physical health leads supports care plans for all physical health issues.	Met	Patients spoken to on the day noted access to a doctor and that regular observations are done daily in the clinic room. Health concerns can be discussed on ward round. Patients added that injuries are looked at immediately and one patient offered that they have had access to diabetic eye tests.
15 [1]	Patients have follow-up investigations	Met	We have clear processes for referring patients to	Partly Met	This standard is scored using the self-review commentary and case

	and treatment when concerns about their physical health are identified during their admission. Guidance: *This is undertaken promptly, and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services*		secondary physical care if required.		note audit. No case note audit is provided. The service states that they have clear processes for referring patients to secondary physical care when required.
16 [1]	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	Met	Emergency medical equipment is checked daily.	Met	Emergency medical equipment is maintained and checked daily.
17 [1]	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. Sustainability Principle: Consider Carbon	Met	Patients have access to healthy lifestyle support, this will all be care planned. Our patients have care plans that address healthy eating, physical exercise and smoking cessation where applicable.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that patients have access to healthy lifestyle support and that this is care planned. The service states that patients have access to healthy lifestyle support and that this is care planned and that care plans address the points listed in the standard.

Treatment and Recovery - Low Secure

This section focuses on care planning, multi-disciplinary review processes, and interventions, activities and therapies in relation to patient outcomes.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
18 [1]	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy. Guidance: *Where possible, the patient writes the care plan themselves or with the support of staff.*	Met	Care plans cover all aspects of care and are written collaboratively with patients, patients are offered a copy.	Partly Met	This standard is scored based on the case note audit and carer and patient survey responses. No case note audit is provided. Patient survey responses largely agree that they have a written care plan, that it reflects their individual needs, that they were involved in developing the plan, and that they are offered a copy. Carer survey responses are mixed as to whether their loved one has a written care plan, were able to contribute to its development and were offered a copy. Patients spoken to on the day agreed that they have a written care plan but provided mixed responses as to whether they have a copy of it. Patients added that they meet with key workers fortnightly and discuss their care plans.
19 [2]	Staff members review patients'	Met	All treatment and care	Partly Met	This standard is scored using the

	progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.		goals are reviewed by patient and MDT throughout admission.		case note audit and patient survey responses. No case note audit is provided. Patient survey responses largely agree that staff regularly discuss their progress against their own personal goals. Patients spoken to on the day said that their personal goals can be discussed in ward rounds or one to one meetings with key workers on a weekly basis. A patient added that they 'can speak to [staff] any time'. Another patient stated that they have always had a clear plan and goals throughout their stay.
20 [2]	Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. Guidance: *This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*	Met	All our wards have a therapeutic seven day timetable facilitated by activity coordinators, occupational therapist, psychology and chaplaincy.	Partly Met	Patient survey responses largely disagree that there are interesting activities on the ward. Patients spoken to on the day provided mixed feedback on whether there were seven-day timetables. On Lagoon ward, they did not have an occupational therapist for over a year. Patients stated that there was more to do on Aurora ward but still a lack of activity. Patients added that there were no evening or weekend activities.
21	There is a documented formalised	Met	A formal initial ward	Partly Met	This standard is scored using the

[1]	review of care or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback.		round/care planning meeting occurs within the first week. Patients will be supported by keyworker, MDT and advocate and carers if required.		self-review commentary, case note audit and patient surveys. No case note audit is provided. Patient survey responses are mixed as to whether staff helped prepare them for their first ward round. The service states that a formal initial ward round or care planning meeting occurs within the first week of patient admission.
22 [1]	Patients are encouraged and supported to play a key participating role in their formal review meeting (such as Care Programme Approach or equivalent) and the patient's views are clearly documented. Guidance: *Other professionals involved should be routinely invited, and carers in accordance with patient's wishes.*	Met	Patients contribute to their ward round and discharge planning, they are supported by keyworker to prepare for ward rounds.	Met	Patient survey responses all agree that they have had a formal review meeting, but those who responded could not remember whether they felt able to contribute their own views or if staff supported them to prepare for this meeting. Patients spoken to on the day stated that they have a chance to participate and can speak with a doctor before the CPA to prepare.
23 [2]	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: • Voluntary organisations;	Met	We have a number of patients who access community activity, this is all care planned. Patients on discharge pathway will meet peer support workers attached to community	Partly Met	Patient survey responses are mixed as to whether they have access to all of the local organisations listed in the standard. Staff reported patients do have access to voluntary organisations and community centres, as well as church services. Patients also have access to a

	• Community centres; • Local religious/cultural groups; • Recovery colleges.		forensic team.		recovery college where they can take courses on subjects like budgeting, maths and English.
24 [1]	The team and patient jointly develop a leave plan, which is shared with the patient, that includes: • The aim and therapeutic purpose of section 17 leave that clearly links to the overarching plan for the care pathway; • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit and crisis numbers.	Met	Our leave plans consider all these points and will be dependent on patient pathway and risk.	Partly Met	This standard is scored using the self-review commentary and patient survey responses. The service states that leave plans consider all points of the stated and are dependent on patient care pathway and risk. A leave plan was observed that includes the aim and therapeutic purpose of section 17 leave and risk assessment plan. The leave plan does not contain contact details of the ward and crisis numbers. Patient survey responses mostly agree that for those with leave, they have a leave plan. No patient survey responses address whether they feel involved in developing their leave plan.
25 [1]	Staff agree leave plans with carers where appropriate, allowing carers sufficient time to prepare.	Met	All leave plans are shared with carers when appropriate and in good time.	Met	Carer survey responses mostly agree that staff agree leave plans with them when their loved one visits. Carers spoken to on the day did not all have consent from their loved one around knowing about leave

					plans. One carer noted that they want more information about who to contact and would like to express their concerns about whether unescorted leave is right for their loved one.
26 [1]	When patients are absent without leave, the team (in accordance with local policy): • Activates a risk management plan; • Makes efforts to locate the patient; • Alerts carers, people at risk and the relevant authorities; • Escalates as appropriate	Met	We have clear AWOL policy, we have recently introduced grab packs which can be shared with police, that contain all information, picture and potential locations patients may go to. AWOL risk management plans are formulated and reviewed in ward rounds. Our policy ensures that we actively try to locate the patient, alert carers and relevant authorities and escalate to police and other agencies as required.	Met	Managers reported that they recently did a thematic review of their AWOL policy given they had a number of patients go AWOL last summer. They identified risks for AWOL and instituted a grab pack they provide to police in the case of a patient who is absent without leave. The service states that their AWOL policy conforms with the points listed in the standard.
27 [1]	The team supports patients to access support with finances, benefits, debt management and housing needs.	Met	We have a welfare service and social work team, all patients on a discharge pathway will work with the community forensic	Partly Met	This standard is scored using the self-review commentary, and patient and staff surveys. The service stated that they have a welfare service and social work team and that patients

			team who will support transition, housing, benefits etc.		on the discharge pathway work with the community forensic team for support. Staff survey responses largely agree that patients are offered the opportunity to access support with needs referenced in the standard. Patient survey responses largely agree that those who need the support are given it to access benefits, but are mixed in terms of access to finances, debt management and housing.
28 [2]	Patients and their carer are invited to a discharge meeting and are involved in decisions about discharge plans.	Met	Patients and carers are fully involved in their discharge planning.	Met	Carer survey responses are mixed as to whether they are invited to discharge meetings and involved in decisions about the loved one's discharge. Patient survey responses, for those preparing for discharge, largely agree that they are invited to meetings about their discharge. Staff reported that carers and patients are invited to discharge meetings and generic information is given to carers where patients withdraw consent.
29 [2]	The service works proactively with the home area care coordinator and next point of care (including other in-patient	Met	We work closely with the local community forensic team who start working with patients nine	Met	Staff reported that the service works with community mental health teams to plan discharge. The community teams are invited to

	services, forensic outreach teams, community mental health teams or prison) to ensure delays to discharge for those medically ready are appropriately identified and steps taken to expedite. Guidance: *Patient discharge plans feature triggers and arrangements for 'recall' to the service if the patient relapses. When patients are transferred between services there is a handover which ensures that the new team have an up to date care plan and risk assessment.*		months prior to expected discharge.		ward rounds and to CPAs. The pharmacy team liaises with GPs as well.
30 [1]	Mental health practitioners carry out a thorough assessment of the person's personal, social, safety and practical needs to reduce the risk of suicide on discharge. Guidance: *Where possible, this should be completed in partnership with carers*	Met	Transition to community is managed by community forensic team who start working with patient whilst still inpatient, risk to self is assessed and reviewed.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that the community forensic team works with the patient prior to discharge and that they assess risk to self.
31 [1]	The team sends a copy of the patient's care plan or interim discharge	Met	The care plan/discharge plan will be continued by the community forensic	Partly Met	A care plan has been observed. The care plan is missing details of when, where and who will follow up with

	summary to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge. Guidance: *The plan includes details of:* • *Care in the community/aftercare arrangements;* • *Crisis and contingency arrangements including details of who to contact;* • *Medication including monitoring arrangements;* • *Details of when, where and who will follow up with the patient.* Sustainability Principle: Priroritise Prevention		team who will share with all other partners in the community.		the patient and crisis and contingency arrangements. It is unclear if the plan is sent to everyone identified within 24 hours of discharge. No case note audit is provided.
32 [2]	A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent). The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation.	Met	The community forensic team will ensure the patient is registered with a GP and they will receive the discharge summary / information.	Partly Met	A discharge summary has been observed. It is unclear when it is sent to the patient's GP and others concerned. No case note audit is provided.
33	The team makes sure that patients who	Met	Follow up is completed	Met	Managers reported that 90% of

[1]	are discharged from hospital have arrangements in place to be followed up within 72 hours of discharge.		by the ward and the community forensic team. The follow up is within 48 hours from both the discharging ward and the Specialist Community Forensic Team.		discharges go to the specialist community mental health team (SCMHT) and that the SCMHT do inreach work six to nine months in advance of discharge. They added that the social work team have occasionally done follow ups. The service states that the follow-up is done within 48 hours of discharge.
34 [3]	Teams provide support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. Guidance: *The team provides transition mentors; transition support packs; or training for patients on how to manage transitions*	Met	Discharge or transfer to another service is planned collaboratively with patient and carers.	Met	This standard is scored using the self-review commentary. The service states that patient discharge or transfer to another service is planned in collaboration with patients and carers.
35 [1]	Clinical outcome measurement is collected at two time points (at assessment and discharge). Guidance: *This includes patient-reported outcome measurements where possible. This can include Historical, Clinical, Risk 20 (HCR-20), Short Term Assessment of Risk and*	Met	We use and update HCR-20 and HONOS throughout the admission. HCR – 20 is dynamic document throughout admission. HONOS secure is completed on admission and discharge as a	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that they use and update HCR-20 and HONOS through the admission, and that this clinical outcome measurement is collected at assessment and discharge at a

	Treatability (START), Health of the Nation Outcome Scale Secure (HoNOS Secure), FORensic oUtcome Measure (FORUM), Wales Applied Risk Research Network (WARRN) or Dangerousness, Understanding, Recovery, and Urgency Manual (DUNDRUM).		minimum.		minimum.
36 [1]	The ward/ unit/ organisation has a care pathway for patients who are pregnant or in the postpartum period. Guidance: *Patients who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.*	Met	The organisation does have a pathway, on our wards we would unlikely met this scenario and if so, safeguarding procedures would be followed.	Met	This standard is scored using the self-review commentary. This states that the service has a pathway and that if a patient was pregnant or postpartum, safeguarding procedures would be followed.

Medication Management - Low Secure

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
37 [1]	All staff members who administer medications have been assessed as competent to do so. The assessment is	Met	We have a clear medication management policy which includes competency tools. I can	Met	This standard is scored using the self-review commentary. This states that the service has a clear medication management policy,

	completed at least once every three years using a competency-based tool.		confirm that the medication competency assessment is completed once every 3 years as a minimum.		including competency tools. The service states that the medication competency assessment is completed once every three years at a minimum.
38 [1]	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	Met	Medication issues or changes are discussed in ward round, shared with carers, all patients have access to pharmacy support. We have care plans around medication management and this includes expectations and timescales for efficacy. Patients give consent for medication treatment, or the appropriate procedures within the MHA are followed.	Partly Met	This standard is scored using the self-review commentary, case note audit and patient surveys. The service states that medication issues or changes are discussed in ward rounds and that patients have access to pharmacy support. They add that care plans are set around medication management, which includes expectations, timescales and patient consent. Patients largely agree that staff have discussed risks and benefits of their medication. No case note audit is provided.
39 [1]	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually. If a physical health abnormality is identified, this is acted	Met	We use NICE guidance to ensure all physical health risks that could arise from using medication are monitored correctly. Our patients have all the physical health checks indicated by the	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that they use the National Institute for Health and Care Excellence (NICE) guidelines. The service states that checks are completed at three

	upon.		medication they are on. Our physical health lead monitors to ensure that the checks are completed at the right frequency, three months then annually or more if the physical health checks indicate it.		months and annually.
40 [1]	Patients have their medications reviewed at least every two weeks. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. Guidance: *Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.* Sustainability Principle: Consider Carbon	Met	All medication is reviewed in the fortnightly ward round or more frequently if required. Our medication reviews include therapeutic response, safety, assessment of side effects and management plan and discusses patients views in terms of using the medication.	Partly Met	This standard is scored using the self-review commentary and case note audit. No case note audit is provided. The service states that all medication is reviewed on the fortnightly ward round. The service adds that the reviews include all the points listed in the standard.
41 [1]	Every patient's PRN medication is reviewed at least every 2 weeks.: frequency, dose and indication.	Met	PRN is reviewed at each ward round, it will be removed if not being used. We don't put PRN	Partly Met	This standard is scored using the self-review commentary and the case note audit. No case note audit is provided. The service states that

	Guidance: *Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.*		on charts for emergency as routine. Within fortnightly medication reviews, PRN dosage and frequency will be discussed and reviewed. This will be in relation to use and effectiveness over the previous fortnight.		PRN medication is reviewed at each ward round on a fortnightly basis. The service adds that these reviews include discussion of frequency, dose and indication.
42 [2]	Patients and carers and prescribers are able to meet with a pharmacist to discuss medications.	Met	Pharmacy service is available to all patients and carers, they attend ward round and are an integral part of MDT.	Partly Met	This standard is scored based on the self-review commentary and patient, carer and staff surveys. The service states that the pharmacy is available to all patients and carers. Staff survey responses show that staff who are prescribers are able to speak with a pharmacist. Patient survey responses are mixed as to whether they are able to meet with a pharmacist. Carers survey responses largely disagree that they are able to meet with a pharmacist.

Patient Experience - Low Secure

This section focuses on the experience of patients at the service, including communication, respect and co-production.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
43 [1]	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their family or carers, are respected and reviewed regularly.	Met	We have clear conversations and information around confidentiality. Consent to share information is revisited regularly.	Partly Met	This standard is scored using the self-review commentary and patient and carer survey responses. The services states that they have conversations and provide information around confidentiality and that consent is revisited regularly. Carer and patient survey responses are mixed as to whether this is explained to them.
44 [1]	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates).	Met	We have an onsite advocate, all patients also have access to IMHA service.	Met	This standard is scored using the self-review commentary. The service states that there is an onsite advocate and that patients have access to an IMHA service. Patient survey responses largely agree that they have access to an advocate or advocacy service.
45 [1]	Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy. Guidance: *Staff members ensure the use of such equipment respects the*	Met	Patients have access to phone and internet and this is underpinned by clear policy.	Met	Patient survey responses largely agree that they have access to computers with internet and mobile phones. Staff reported that patients have brick phones on the ward, and that those with unescorted leave can use smartphones while on leave. Additionally, staff mentioned that patients have access to computers

	privacy and dignity of everyone and know how to manage situations when this is breached.				on the ward.
46 [1]	Patients and carers feel treated with compassion, dignity and respect by staff members. Guidance: *This includes respect of an individual's race, age, expressed social gender, marital status, sexual orientation, maternity, disability, social and cultural background.*	Met	Our staff treat patients and carers with dignity and respect.	Met	Patient and carer survey responses largely agree that they feel treated with compassion, dignity and respect by staff members. Patients spoken to on the day all agreed.
47 [1]	Patients feel listened to and understood by staff members.	Met	Our staff ensure patients are listened to and their needs are understood and met.	Met	Patient survey responses and patients spoken to on the day agreed that they feel listened to and understood by staff members.
48 [1]	Patients are involved (wherever possible) in decisions about their level of therapeutic observation by staff. Guidance: *Patients are also supported to understand how the level can be reduced.*	Met	Observations are discussed and care planned.	Partly Met	Patient survey responses are mixed as to whether they are involved in decisions about their level of therapeutic observation by staff. Patients spoken to on the day were not sure if patients were involved in these decisions.
49 [1]	The service asks patients and carers for their feedback about their experiences of using the service and this is used to	Met	We use I Want Great Care (IWGC) and are using it to gain feedback at all	Partly Met	This standard is scored using the self-review commentary. The service states that they use 'I Want Great

	improve the service. Guidance: *This can include feedback surveys, focus groups, community meetings and patient representatives.* Sustainability Principle: Empowering Individuals		points of admission from patients and carers.		Care' for feedback from patients and carers. Patient survey responses are mixed as to whether they are asked for feedback about their experience of the service. Carer survey responses largely disagree that they are asked for feedback about their experience with the service.
50 [2]	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics.	Met	We analyse feedback, we are improving this and are promoting IWGC.	Partly Met	Managers reported that the service uses 'I Want Great Care' QR codes for patient and carer feedback. The acknowledged that they could do better at collecting feedback and the service is planning to create a carers' care plan. It is unclear if the service is using the data they collect to identify any differences of experiences by protected characteristics.
51 [2]	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. Guidance: *This is an opportunity for patients to share experiences, to highlight issues of safety and quality*	Met	Minuted community meetings occur monthly with daily community meetings also giving the opportunity for patients to voice their opinions. We also have monthly patient forum.	Partly Met	Patient survey responses were mixed as to whether the ward community meeting takes place weekly or monthly. Patients spoken to on the day stated that the meeting takes place monthly.

	on the ward/unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.				
52 [2]	The service has a service user and carer involvement and co-production strategy covering all aspects of service delivery along with a designated lead for patient and carer involvement. This individual contributes to the leadership of the service. Guidance: *The strategy is developed through use of the 'Carer support and involvement in secure mental health services toolkit' (NHS England, 2018).*	Met	The organisation has a strategic plan which ensures focus on co-production.	Partly Met	A Trust-wide carer strategy has been observed. The strategy states that co-production continues to evolve and the aim is to embed co-production. However, the plan is not specific to carer involvement and co-production strategy covering all aspects of service delivery with a designated lead for patient and carer involvement.
53 [3]	The service facilitates access to a peer support service.	Met	Peer support is available by third sector partners who work with the community forensic team.	Not Met	Staff spoken to on the day had no awareness of peer support services available at the service.
54 [1]	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific	Met	Food provision is reviewed to ensure variety and dietary needs	Partly Met	Patient survey responses largely agree that meals are nutritional and balances and are big enough

	dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.		are catered for.		portions, but are mixed as to whether they are varied, offer choice and reflect cultural and religious needs. Patients spoken to on the day stated that food on Aurora ward is self catered and that patients are given a weekly budget. They added that prior to self catering, the food at the service was not nice or big enough, though they were provided with healthy options.
55 [1]	Patients know who the key people are in their team and how to contact them if they have any questions.	Met	All patients have an allocated nurse and secondary worker. They are given details on admission of the wider members of their MDT.	Met	This standard is scored using the self-review commentary. The service states that all patients have an allocated nurse and secondary worker. Patient survey responses largely agree that they know which member of staff they can talk to if they have any questions.
56 [2]	Patients receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.	Met	These are provided by occupational therapy and psychology.	Met	This standard is scored using the self-review commentary and patient survey responses. The service states that information on psychoeducation topics listed in the standard are provided by occupational therapists and psychology. Patient survey responses for those that need education on these topics, largely

					agree that they receive it.
57 [1]	Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). Guidance: *This assessment considers risk to self, risk to others and risk from others.* Sustainability Principle: Prioritise Prevention	Met	A dynamic risk assessment document is completed with patient involvement. Safety and management of risks is included. We have access to FGC to support relatives and friends to be involved in managing risk,	Partly Met	This standard is scored using the self-review commentary, case note audit and patient survey responses. No case note audit is provided. The service states that a risk assessment document is completed in collaboration with patients, and this includes safety and management of risks. Patient survey responses are mixed on whether they have a safety plan in place and whether they are involved in this process.
58 [1]	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.	Met	All our interventions are evidenced based and tailored to individual need.	Met	Managers reported that they have an extensive list of therapeutic interventions provided to patients following assessment.
59 [1]	Each patient is offered a one-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.	Met	Regular one to one with keyworker more than weekly to discuss progress.	Partly Met	Patient survey responses are mixed as to whether one-to-one sessions with a staff member take place once a week. Patients spoken to on the day did not specify whether time with staff was requested or scheduled, and how often this takes

					place.
60 [1]	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness, physical health and treatment.	Met	All are offered information on illness and treatment. If consent id not given by patients, carers will still be given generic information about the service.	Partly Met	This standard is scored using the self-review commentary, and patient and carer survey responses. The service states that carers and patients are offered information on illness and treatment. Carer survey responses mostly agree that they receive information about their loved one verbally, though not in writing. Carer survey responses were mixed on receiving information about their loved one's physical health verbally, though again not in writing. Patient survey responses largely agree they receive information about their mental illness and treatment verbally; responses are mixed as to whether they receive this information in writing.
61 [2]	Patients, according to risk assessment, have access to regular 'green' walking sessions. Guidance: *Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or*	Met	All patients with appropriate leave have opportunities to engage in walks away from traffic. If nil recourse to public funds appropriate attire would be provided.	Met	Patient survey responses largely agree that they have access to 'green' walking sessions either 'always' or 'often'. Patients spoken to on the day stated that this is subject to leave. Patients added that they have access to an outdoor gym.

	rainwear. Sustainability Principle: Consider Carbon				

Family, Friends and Visitors - Low Secure

This section explores the experiences and needs of family, friends and visitors that engage with the service.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
62 [2]	The team provides each carer with accessible carer's information. Guidance: *Information is provided verbally and in writing (e.g., in a carers'pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers'groups, carers' workshops and relevant charities.*	Met	We have welcome pack Trustwide and local information.	Met	Carer survey responses and carers spoken to on the day largely agree that they were provided information when their loved one arrived to the service. A carers welcome pack was observed to fit the points of the standard.
63 [1]	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.	Met	Carers receive information on how to access a carers	Partly Met	Carer survey responses largely disagree that the service has explained what a carers assessment

	Guidance: *This is an opportunity for carers to discuss what support or services they need, including physical, mental and emotional needs. Arrangements should be made through the carer's local council.*		assessment.		is and that they know how to access it. One carer spoken to on the day knew what a carer's assessment is and is now considering it.
64 [2]	Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network. Guidance: *This could be a group/network which meets face-to-face or communicates electronically.*	Met	Our social work team provide carer forums.	Partly Met	Carer survey responses mostly disagree that they have access to a carer support network or group. Carers spoken to on the day shared that they have access to a group the social worker facilitates every eight weeks where they can ask questions. The carer added that the service previously offered coffee mornings and requested that they bring this back as it was a way to connect with other parents and family.
65 [2]	Carers feel supported by the ward staff members.	Met	Carers will be supported by staff and offered one to one time if requested.	Met	Carer survey responses mostly feel supported by ward staff members. Carers spoken to on the day agreed that staff are mostly helpful. One carer noted that the social worker is very communicative. Another stated that 'all staff I have met are good' and that they have a 'huge amount

					of professionalism'.
66 [1]	Carers are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents Sustainability Principle: Empowering Individuals	Met	Carers are involved in ward round and care planning, we are introducing carers care plans so their views, situation, means of contact etc can be recorded.	Partly Met	Carer survey responses mostly disagree that they are able to participate in decisions about their loved one's care planning. Carers spoken to on the day were positive about engagement and one noted that they are invited to ward round and feel involved.
67 [2]	The patient's carer is contacted as soon as possible by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.	Met	Carers, if appropriate will be involved at point of referral.	Met	Carer survey responses mostly agreed that they were contacted as soon as possible by a staff member to notify them of the admission. Carers spoken to on the day knew their loved one was being admitted to the service.
68 [2]	Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns and their own needs. Sustainability Principle: Empowering Individuals	Met	Carers will be offered time with staff to discuss their situation at the earliest point, this is often prior to admission.	Not Met	Carer survey responses disagree they were given individual time to speak with staff within 48 hours of the patient's admission. Carers spoken to on the day also disagree that they were offered this. Staff survey responses are mixed as to whether they carers are offered this.
69 [1]	The team knows how to respond to carers when the patient does not consent to their involvement. Guidance: *The ward may receive*	Met	Staff know they can provide generic information about the service.	Partly Met	Staff survey responses largely agree that they know what information they can share with a carer whose loved one has withdraw consent.

	information from the carer in confidence.				Staff reported that, when patients withdraw consent, staff will establish what information the patient wants to share with the carer. Nursing staff did not provide any comment on how they would respond to carers in this situation.
70 [2]	There is a designated visitors' room within the secure perimeter. The space must meet the following requirements: • Suitable to maintain privacy and confidentiality; • Provide a homely environment; • Observations enable private conversations; • Accessible by patients and visitors.	Met	Designated family room is within the perimeter and enables comfort and privacy.	Met	The service has a dedicated visitors room within the secure perimeter. The visitors room meets the requirements of the standard.
71 [2]	The service is able to safely facilitate child visits and is equipped with a range of age-appropriate facilities such as toys, games and books. Guidance: *The children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit. Sufficient staff should be made*	Met	Children visits are facilitated, pre arrangement is required and goes through the social work team.	Met	The service can facilitate child visits and has age-appropriate facilities available.

	available to enable children to visit during evenings and weekends.				
72 [1]	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	Met	We have sufficient technology available to ensure patients can contact family and friends virtually.	Partly Met	This standard is scored using the self-review commentary and patient and carer survey responses. The service states that they have technology to ensure virtual family visits. Patient and carer survey responses are mixed as to whether they are able to speak to their carers and loved ones virtually.
73 [2]	The pathway of care takes into account victim issues and is developed in liaison with relevant supervisory agencies e.g. the responsible local authority, offender manager and/or MAPPA.	Met	All care pathways including discharge pathway involve involvement with MAPPA and MARAC.	Met	Managers reported that the service liaises with relevant supervisor agencies and attends meetings with MAPPA.

Ward Environment - Low Secure

This section reports on the hospital environment and its facilities.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
74 [1]	Staff members, patients and visitors are able to raise alarms using panic	Met	All staff and visitors have panic alarms, and call buttons are located on all	Met	Staff, patients and visitors are all given alarms and there is an agreed upon response when the alarm is

	buttons, strip alarms, or personal alarms. There is an agreed response when the alarm is raised.		wards. The service has a 24 hour response team.		raised. Panic buttons are located in patient rooms.
75 [1]	All patient information is kept in accordance with current legislation. Guidance: *This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	Met	All staff and visitors have panic alarms, and call buttons are located on all wards. The service has a 24 hour response team.	Met	Patient information is kept in accordance with current legislation. No confidential information was viewed by peer review members on the day.
76 [1]	The environment complies with current legislation on disabled access. Guidance: *Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	Met	The site and all wards are accessible by wheelchair.	Met	The service has a lift and wards are accessible by wheelchair.
77 [2]	Staff members and patients can control heating, ventilation and light on the ward/unit.	Met	Heating, ventilation and lighting is controllable by staff and patients.	Met	Patients are able to ventilate their rooms by opening windows, have access to lighting and can ask staff on the ward to change the

	Guidance: *For example, patients are able ventilate their rooms through the use of windows, they have access to light switches, and they can request adjustments to control heating.*				temperature of the rooms.
78 [2]	Patients are able to personalise their bedroom spaces and the ward environment where appropriate. Guidance: *For example, by putting up photos and pictures.*	Met	Appropriate personalisation of bedroom is permitted.	Met	Patient surveys responses largely agree that they are able to personalise their bedroom spaces and the ward environment. This was observed on the day.
79 [1]	Furnishings minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.	Met	Our site is anti-lig where fittings are available. We have regular ligature audits and a heat map to identify current risks.	Met	Furnishings on the ward minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.
80 [1]	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g., covered copies of faith books, access to a multi-faith room, or access to groups.	Met	Patients have access to multi-faith room and materials to support their cultural and spiritual practices.	Met	While patient survey responses are mixed on whether they have access to materials and facilities associated with specific cultural or spiritual practices, a multi-faith room with copies of faith books was observed on the day.
81 [2]	Patients have access to relevant faith-specific support, preferably through someone with an understanding of	Met	All wards have multi-faith rooms and an on-site chaplaincy service.	Met	Patient survey responses listed access to faith-specific support such as a church service, a spirituality

	mental health issues.				group, a multi-faith room and chaplain. Patients spoken to on the day stated that they have access to a chaplain, church services and the multi-faith room.
82 [2]	The ward/unit has a designated room for physical examination and minor medical procedures.	Met	All wards have fully equipped clinic rooms.	Met	All wards have a designated clinic room.
83 [2]	The service has at least one bathroom/shower room for every three patients.	Met	All rooms are en-suite.	Met	All rooms on the LSU are en-suite.
84 [2]	All patients have single bedrooms.	Met	All patients have single bedrooms.	Met	All patients on the LSU have single bedrooms.
85 [3]	Every patient has an en-suite bathroom.	Met	All rooms have en-suite facility.	Met	Every patient on the LSU has an en-suite bathroom.
86 [3]	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.	Met	Rooms are neutral colour and patients can add safe decoration.	Met	The service can designate gender neutral bathrooms and toilet facilities for patients who would prefer a non-gendered care environment.
87 [1]	Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom. Guidance: *This may be subject to risk*	Met	All staff knock on doors before entering.	Met	Patient survey responses largely agree that staff members respect their personal space. Patients spoken to on the day gave mixed

	assessment including emergencies.				responses. One patient stated that not all staff knock before entering and that he has told them he is not happy for them to just walk in.
88 [2]	Ward/unit-based staff members have access to a dedicated staff room. Sustainability Principle: Empowering Staff	Met	All wards have a dedicated staff room.	Met	All wards have a dedicated staff room.
89 [2]	Patients are consulted about changes to the ward/unit environment.	Met	We have had recent refurbishment work, patients are consulted and updated daily in community meetings.	Met	This standard is scored using the self-review commentary and patient survey responses. The service states that the consult patients on refurbishment work and update patients daily in community meetings. Patient survey responses largely agree that, when changes are made to the environment, they are consulted.
90 [1]	Patients have access to safe outdoor space every day. Sustainability Principle: Consider Carbon	Met	All wards have access to outside spaces.	Met	Patient survey responses largely agree that they have access to safe outdoor space every day. Outdoor garden spaces on each ward were observed on the day.
91 [3]	All patients can access a charge point for electronic devices such as mobile phones.	Met	Charging facilities are available.	Met	Patients can access a charge point for electronic devices.

92 [2]	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. Guidance: *Hot drinks may be available on a risk-assessed basis.*	Met	Hot drinks and snacks are available at all times.	Met	Patients can make their own hot and cold drinks and snacks 24 hours a day.
93 [2]	All patients can access a range of current culturally specific resources for entertainment, which reflect the service's population. Guidance: *This may include recent magazines, daily newspapers, books, board games, a TV and DVD player with DVDs, computers and internet access (where risk assessment allows).*	Met	Patients can have access to all materials no restricted or prohibited. Patients can request these items in community meetings or supported to purchase.	Met	Patient survey responses largely agree that they have access to a range of self-led entertainment.
94 [2]	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	Met	All wards have quiet areas.	Met	All wards have a quiet room or de-escalation space that is not a patient bedroom.
95 [1]	In services where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and	Met	The service has two seclusion rooms, and they meet the standards set out by COP.	Not Met	The seclusion room on Dune ward does not have open lines of sight to the bathroom. It does not have direct access to a toilet as the bathroom is separate and staff must unlock the room in order for the

	ventilated; • It has adequate lighting, including a window(s) that provides natural light; • It has direct access to toilet/washing facilities; • It has limited furnishings (which include a bed, pillow, mattress and blanket or covering); • It is safe and secure, and does not contain anything that could be potentially harmful; • It includes a means of two-way communication with the team; • It has a clock that patients can see.				patient to exit and use the toilet. The review team observed that the light fitting against the wall is a potential ligature risk and that the seclusion room does not have a clock for patients to see.
96 [1]	Patients and staff members feel safe on the ward.	Met	The service provides safe environment, safe staffing, safe procedures.	Partly Met	Patient survey responses largely agree that they feel safe on the ward. Patients spoken to on the day agreed. Staff survey responses are mixed as to whether they feel safe on the ward, with some staff stating they don't feel safe as 'sometimes staff are not present and the ward environment is chaotic' and 'we

					have a lot of staff who are not fit for the job due to attitude towards work'.
97 [1]	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.	Met	Ligature audits are completed on all wards at least annually.	Met	A ligature audit for Dune ward has been observed and fits the points of the standard.

Physical Security - Low Secure

This section details the physical security in place at the service, focusing on the internal and external perimeter, responsibilities of the security lead, and key management.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
98 [1]	The service manages physical security according to the standards stated in the QNFMHS Physical Security in Secure Care guidance.	Met	We have reviewed QNFMHS Physical Security in Secure Care guidance and are fully compliant.	Met	The service manages physical security according to the standards stated in the QNFMHS Physical Security in Secure Care guidance. While the service mentions a contingency plan is in place, it does not specify the chain of operational control, communications, patient and staff security, maintaining continuity in treatment and

					accommodation.

Procedural Security - Low Secure

This section focusses on the formal policies, procedures and guidance in place at the service.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
99 [2]	There are formalised policies, procedures and guidance which have been co-produced where possible on: • Anti-bullying (for staff and patients, for those who are bullying, and those who are being bullied). • Supporting patients' use of electronic equipment and safe access to the internet, including specific advice around the appropriate use of social networking sites, confidentiality and risk. • Effective liaison with local police on incidents of criminal activity/harassment/violence and other criminal justice	Met	These are all available on the intranet and hard copies on all wards.	Met	This standard is scored using the self-review commentary. The service states that all formalised policies listed in the standard are available on the intranet as well as in hard copies on all wards.

	agencies, where relevant (a memorandum of understanding is in place with local police on reporting crime). • Minimising restrictive practices (a process for reviewing restrictive practices is documented with specified timescales. Individual care plans focus on minimisation and restrictive practices).				
100 [1]	• Managing situations where patients are absent without leave. • Patient observation and engagement. • Conducting searches of patients and their personal property, staff members, visitors and the environment. • Prevention of suicide and management of self-harm. • Visiting, including procedures for children and unwanted visitors (i.e. those who pose a	Met	All these policies are available on intranet and in hard copy. When patients are AWOL, the team will discuss and reflect on recent observation and engagement. Furthermore, engagement and obs levels will be reviewed when patient returns. Room and property searches will take place to ascertain what the patient may have with	Met	This standard is scored using the self-review commentary. The service states that policies are available on the intranet and in hard copy. The service adds that they have policies for each of the points of the standard listed.

	threat to patients, or to staff members).		them, phone etc. The team will escalate and notify police if they have concerns around self-harm or suicide. Visting procedures will be reviewed with support of social workers particularly if under 18s are identified as visitors.		
101 [1]	Services have an easily accessible business continuity plan that provides guidance for a range of emergency planning eventualities. This includes testing by live and/or desktop exercises at least six-monthly.	Met	The service has a BCP which is available on all wards. The contents are discussed in team meetings and quality and safety meetings. Our service complete desk top exercises every six months at a minimum to look at the effectiveness of our Business Continuity Plan.	Met	This standard is scored using the self-review commentary. This states that the service has a business continuity plan that is available on all wards, and whose contents are discussed in team meetings. The service adds that the plan includes testing by desktop exercises at least six-monthly.
102 [2]	There is a process in place to enable patients and their representatives to view policies and procedures critical to their care. These are stored in ways that staff, patients and carers find accessible and easy to use.	Met	All our policies are made available on request. many are accessible through the internet.	Partly Met	This standard is scored using the self-review commentary and patient and staff survey responses. The service states that all policies are made available on request and many are accessible through the internet. Staff survey responses

					largely agree that policies and procedures are easily accessible. Patient survey responses are mixed as to whether they know how to access policies and procedures critical to their care.

Relational Security - Low Secure

This section explores policies and practice relating to relational security, including induction, skill development and communication.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
103 [1]	There is a relational security component to the induction programme for all staff that includes the See Think Act framework. This is refreshed annually.	Met	Relational security is fully covered in induction and regularly reviewed.	Not Met	Staff spoken to on the day reported that they receive a 'key talk' on induction. Staff did not share how often a relational security training is refreshed and did not have awareness of the See Think Act framework.
104 [3]	The service has a co-produced strategy to respond to requests from victims, patients or carers to participate in restorative justice.	Met	We have worked hard over the last years to include debriefs on any Datix incident of racial abuse, these will soon be available for physical and sexual assault / abuse	Partly Met	This standard is scored using the self-review commentary. This states that the service includes debriefs on any Datix incident of racial abuse, and that they are rolling this out for physical and sexual abuse incidents. A process is in place to allow victims

			incidents. the process allows victims to discuss the issues with perpetrators in a controlled environment. Within our work on debriefs and 'repair meetings' we ensure coproduction.		to discuss issues with perpetrators in a controlled environment. The service adds that they ensure coproduction through debriefs and 'repair' meetings, but it is unclear if carers are included in this work.
105 [1]	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. There is a record kept. Guidance: *It is good practice to utilise the relational security explorer wheel.*	Met	Our handovers follow a clear template which cavers all areas of care and risk, over the last year all our handovers include a visual walkround between the incoming and outgoing NIC where all patients are seen and greeted (if appropriate).	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that their handovers follow a template. Staff survey responses largely agree that handovers allow adequate time to discuss patients' needs.

Safeguarding - Low Secure

This section explores safeguarding processes, focusing on formal procedures and raising concerns.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
106	There is a local designated	Met	Safeguarding processes	Met	Staff spoken to on the day identified

[1]	safeguarding lead who can give advice and ensure that all safeguarding issues are raised and resolved, and links into the safeguarding processes within the organisation/provider collaborative. Guidance: *On admission, a record is made for each patient of any children known to be in their social network, their relationship to those children and any known risks whether or not reflected in convictions.*		are clear, wards have designated leads and social work support. The trust has clear policies and a dedicated safeguarding team, all safeguarding referrals are reviewed in quality and safety meetings.		the safeguarding lead and added that they attend social work meetings.
107 [1]	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. Sustainability Principle: Empowering Staff	Met	Staff have forums and opportunities to raise concerns, we have whistleblowing policies and access to F2SU guardian.	Partly Met	Staff survey responses are mixed as to whether they feel able to challenge decisions within the team. For those that are not always comfortable challenging decisions, they noted that it 'can be difficult to challenge due to the hierarchy within the MDT' and that 'some issues are still not attended to when challenged'. Staff spoken to on the day did not always feel comfortable challenging MDT decisions. One staff stated that they could take a concern to certain staff members and some staff discussed speaking with their managers about

					concerns. Most staff agreed that they feel comfortable reporting if something was a serious concern.
108 [1]	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.	Met	All folders have sexual safety folders, we have recently benchmarked against the national tool and had a trust sexual safety conference.	Met	Staff survey responses largely agree that they feel confident preventing and responding to sexual exploitation, coercion, intimidation and abuse. Staff reported they would raise these concerns with the safeguarding lead or go to their manager.

Workforce - Low Secure

This section reports on the staffing and skill mix of the service, as well as support and training provided to staff members.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
109 [1]	There is a psychologist who is part of the multi-disciplinary team. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.	Met	Psychology is available to the whole service, clinical and assistants.	Met	This standard is scored using the self-review commentary. This states that psychology is available to the whole service.
110 [1]	There is an occupational therapist who	Met	Occupational therapy is available to the whole	Met	This standard is scored using the self-review commentary. This states

	is part of the multi-disciplinary team. They work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions.		service, qualified and activity coordinators		that an occupational therapist is available for the whole service along with activity coordinators.
111 [3]	There is dedicated sessional input from arts or creative therapists.	Met	Our activity timetable includes creative sessions. Our therapists have skills in providing arts and creative therapies.	Partly Met	This standard is scored using the self-review commentary. This states that the service's activity timetable includes creative sessions. The service adds that their therapists have skills in providing arts and creative therapies, but it is unclear if they are arts and creative therapists.
112 [1]	The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-	Met	Daily morning sitrep, reports staffing skill Grab Bag and TASID training, any activity that may need support, escalation flowchart is available for concerns out of hours. Our qualified staff all have training in relational security and this includes how to effectively priortise tasks and manage safety when	Met	Managers reported that the ward assesses daily staffing levels in morning sitreps where the team could report concerns. They also have a roster lead who is in charge of monitoring staffing. In case staffing levels fall short, the service has access to agency and bank staff. It is unclear if there is an agreed upon contingency plan, such as the minor and temporary reduction of non-essential services. The service adds that staff have training in

	essential services. Sustainability Principle: Empowering Staff		staffing is reduced.		relational security, including how to prioritise tasks and manage safety when staffing is reduced. It is unclear if this is part of an agreed upon contingency plan.
113 [1]	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency.	Met	There is a robust OOH service that covers the service, Normal hours has full medical cover. Our duty Dr is located on site at all times so can attend within 30 minutes.	Met	This standard is scored using the self-review commentary. This states that an Out of Hours (OOH) service is available. For normal hours, the service has full medical cover. The service adds that the duty doctor can reach the site within 30 minutes.
114 [2]	The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g., in response to additional clinical need or shortterm absence of permanent staff	Met	We have considerably reducing our use of bank and agency recently, by making the processes for regular staff to pick up extra shifts easier.	Partly Met	Managers reported an improvement in the use of permanent staff and noted that they do not use agency staff as much as they used to. They added that the service has some bank staff that have worked with the service for years. It is unclear if unfamiliar bank or agency staff are used only in exceptional circumstances.
115 [2]	Patient or carer representatives are involved in the interview process for recruiting potential staff members. Guidance: *The representatives should have experience of the relevant service.*	Met	We regularly have patient representatives on interview panels.	Met	This standard is scored using the self-review commentary. The service states that they regularly have patient representatives on interview panels.

	Sustainability Principle: Empowering Individuals				
116 [1]	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. Guidance: *Staff have the right to one uninterrupted 20-minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	Met	Staff are allocated one hour break and have a staff area to use.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that staff are allocated a one hour break on their shifts and are able to access a staff area. Staff survey responses largely agree that they are able to take breaks.

Workforce Training and Support - Low Secure

This section reports on the staffing and skill mix of the service, as well as support and training provided to staff members.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
117 [1]	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. Guidance: *Supervision should be profession specific as per professional guidelines and provided by someone*	Met	Supervision occurs monthly, this is tracked and abnomolies reported through quality and safety meetings.	Partly Met	Staff survey responses largely agree that they are receiving clinical supervision at least on a monthly basis. Staff reported that the assistant psychologist has this monthly. No other staff members spoken to on the day shared how often they had clinical supervision.

	with appropriate clinical experience and qualifications.				
118 [2]	All staff members receive individual line management supervision at least monthly.	Met	Line management supervision occurs monthly, tracked and monitored.	Partly Met	Staff survey responses largely agree that they receive line management supervision on a monthly basis. Staff spoken to on the day stated that the assistant psychologists get line management supervision at least monthly. No ward staff stated when they receive individual line management supervision.
119 [3]	Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice. Sustainability Principle: Empowering Staff	Met	Reflective practice is planned on all wards and facilitated by psychology, we are always trying to improve attendance levels.	Met	Staff survey responses largely agree that they have access to reflective practice at least every six weeks. Staff spoken to on the day stated that the psychology team hosts a reflective practice session every six weeks.
120 [1]	The service actively supports staff health and wellbeing. Guidance: *For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing*	Met	Staff have access to well-being support services. The service has patient engagement representatives, and access to an employee relations lead.	Partly Met	Staff survey responses largely agree that the service actively supports their health and wellbeing. Staff spoken to on the day stated that newsletters with resources for staff are shared but some staff felt that the resources are not actively spoken about. Staff shared that it is

	feedback from exit reports, and taking action where needed. Sustainability Principle: Empowering Staff				hard to take their breaks in a staff room where staff are constantly coming and going. Staff also shared that they sometimes prefer to sit in their cars for their breaks.
121 [1]	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met.	Met	All staff have a trust induction and an extensive local induction where they have opportunities to shadow and show mastery of competencies required by their role.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that staff have a Trust induction and local induction on core competencies. Staff survey responses largely agree that they received the points of the standard in their induction.
122.1 [1]	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.2 [1]	Physical health assessment and management. Guidance: *This could include training in understanding physical health problems, undertaking physical observations, basic life support, and*	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.

	Early Warning Signs.				
122.3 [1]	Safeguarding vulnerable adults and children. Guidance: *This includes recognising and responding to the signs of abuse, exploitation, or neglect.* Sustainability Principle: Prioritise Prevention	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.4 [1]	Risk assessment and management. Guidance: *This includes assessing and managing suicide risk and self-harm, and the prevention and management of challenging behaviour.* Sustainability Principle: Prioritise Prevention	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.5 [1]	Recognising and communicating with patients with cognitive impairment and learning disabilities.	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.6 [1]	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and	Met	This training is provided.	Not Met	No training on inequalities in mental health access has been observed.

	application of skills and competencies required in role to deliver equitable care.).				
122.7 [2]	Carer awareness, family inclusive practice and social systems, including carers'rights in relation to confidentiality.	Met	This training is provided.	Not Met	No training matrix on carer awareness has been observed.
122.8 [2]	Recovery and outcomes approaches.	Met	This training is provided.	Not Met	No training matrix on recovery and outcomes approaches has been observed.
122.9 [2]	Assessing and managing suicide risk and self-harm.	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.10 [2]	Prevention and management of aggression and violence	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
122.11 [2]	A patient's perspective.	Met	This training is provided.	Partly Met	A training matrix has been observed however it does not specify the dates of when the training was completed.
123 [1]	All clinical staff undergo specific training in therapeutic observation when they are inducted into a Trust or changing wards. This includes:	Met	This training is provided.	Not Met	No training matrix on therapeutic observations has been observed.

	• Principles around positive engagement with patients; • When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this.				
124 [1]	All staff members who deliver therapies and activities are appropriately trained and supervised. Sustainability Principle: Staff Empowerment	Met	This training is provided.	Not Met	No training or supervision matrix has been observed.
125 [1]	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. Sustainability Principle: Prioritise Prevention	Met	We have regular simulations of physical health emergencies, we also have drop in sessions on site where staff can refresh themselves with emergency medical procedures and equipment.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that they regularly have simulations of physical health emergencies and drop in sessions for staff to refresh themselves. Staff survey responses largely agree that they know how to identify and manage an acute physical health emergency.
126 [2]	Patient and/or carer representatives are involved in delivering and developing staff training.	Met	Patients support security training. We recently have employed Family Ambassadors and expert	Met	This standard is scored using the self-review commentary. This states that patients support security training at the service and that they

			by experience who will be involved in delivering training.		have recently employed family ambassadors and experts by experience to be involved in delivering training.

Reducing Restrictive Practices - Low Secure

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
127 [1]	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. Guidance: *This includes avoiding the use of blanket rules and assessing risk on an individual basis.*	Met	We are constantly reviewing restrictions with a view to safely reduce. Restrictions are reviewed three times a week by clinical leads.	Partly Met	Staff reported that the team is focused on promoting independence for the patient and that they feel comfortable bringing up restrictive practices if they have an issue. However, staff also shared that there is high staff turnover and that there are not always enough senior staff on shifts, which can lead to the use of more blanket restrictions. Staff also noted that patients may not always be able to have their leave if there is not enough staff.
128 [1]	The team uses seclusion only as a last resort and for the minimum possible period only.	Met	We have done lots of work on scrutinising seclusion sessions and ensuring care plans are	Met	This standard is scored using the self-review commentary. This states that the service has worked on scrutinising sessions and ensuring

			robust and involve the patient in how to end an episode of seclusion. Seclusion is only used as a last resort and for the minimum possible period. We have done training recently on ensuring the care plans for a patient in seclusion include patients voice and clear information about how staff and patients can work towards ending the episode.		care plans involved the patient in how to end periods of seclusion. The service adds that seclusion is used only as a last resort and for the minimum possible period.
129 [1]	In units where long term segregation is used, the area used conforms to standards as prescribed by the Mental Health Act Code of Practice (or equivalent). Guidance: *This includes patients having access to meaningful and therapeutic activity and outdoor space*.	Met	The LTS pathway is carried out in suitable environments, LTS and seclusion paperwork is scrutinised weekly and used for learning.	Not Met	The service reports that the area used for LTS conforms to standards and that LTS and seclusion paperwork is looked at on a weekly basis. However, the seclusion room used for LTS on the LSU that was observed did not have clear lines of sight or direct access to a toilet.
130 [1]	When restraint is used, staff members restrain in adherence with accredited restraint techniques.	Met	All staff are TASID trained.	Met	This standard is scored using the self-review commentary. This states that staff are trained in Therapeutic

					and Safe Interventions and De-escalation (TASID) training.
131 [1]	Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018 (or equivalent).	Met	All incidents of restrictive Practice will be recorded on Datix, Debriefs will follow if required.	Met	This standard is scored using the self-review commentary. This states that any incident of restrictive practice is recorded on Datix and is followed by a debrief.
132 [1]	Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs, including respiratory rate, monitored by staff members and any deterioration is responded to. Guidance: *If a patient declines to have their vital signs monitored, this should be recorded in patient records and re-offered again as appropriate.*	Met	We have clear policy around monitoring patients physical health following restrictive practices.	Partly Met	The self-review commentary states that the service has a policy around monitoring patient's physical health following restrictive practices such as rapid tranquilisation. No case note audit is provided.
133 [2]	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.	Met	We ensure that all staff have passed engagement and observation competencies, we ensure qualified staff also complete Level 3	Partly Met	This standard is scored using the self-review commentary and patient and staff survey responses. The service states that all staff must have training in observation. Patient and staff survey responses are mixed as to whether patients on observations

			observations as we acknowledge it is an important intervention.		receive at least one hour per day being observed by a member of staff who is familiar to them.
134 [1]	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions	Met	Patients have PBS plans that support the patient and staff to promote more positive behaviours to get needs met. This reduce restrictive practice.	Partly Met	The self-review commentary states that patients have Positive Behaviour Support (PBS) plans to support patients and staff to reduce restrictive interventions. No case note audit is provided.
135 [1]	The service collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. Guidance: *Audit data are used to compare the service to national benchmarks where possible.*	Met	We have an active programme of reviewing and reducing restrictive practices using QI methodology and Life QI. We monitor use and report to a monthly reducing restrictive practice forum.	Partly Met	Managers reported that the service collects data on gender and ethnicity, however, they did not describe whether they use an audit to actively reduce the use of restrictive interventions year on year.

Governance - Low Secure

This section focuses on the governance processes of the service, as well as quality improvement and research activity.

No.	Standard	Self-Review Score	Self-review comments	Peer-Review Score	Peer-Review Comments
136 [2]	The ward team use quality improvement methods to implement service improvements.	Met	The service has a QI lead who supports the teams with QI methodology and Life QI for oversight.	Partly Met	This standard is scored using the self-review commentary and staff survey responses. This states that the service has a quality improvement lead who support the teams. Staff survey responses are mixed as to whether they are able to engage in quality improvement initiatives.
137 [2]	The team actively encourages patients and carers to be involved in quality improvement initiatives.	Met	All QI projects are co-produced.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that all quality improvement initiatives are co-produced. Staff have included examples such as discussing QI projects in community meetings and patient forums, and drafting policies in co-production with carers and patients.
138 [3]	The service supports research and the implementation of evidence-based interventions. There is a local research strategy linked to the needs of patients and workforce.	Met	The service has an audit team who base audits on recent local and national research. All interventions are evidence based. NICE guidance updates are monitored and policy updated accordingly.	Partly Met	This standard is scored using the self-review commentary. This states that the service has an audit team who use local and national research, and that interventions given to patients are evidence-based.

139 [1]	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this	Met	The service uses Datix, our staff know that Datix is used to improve practice and learn lessons. the service contributes to the Trust's learning collaborative.	Met	This standard is scored using the self-review commentary and staff survey responses. The service states that they use Datix to report incidents and that staff understand this system is used to improve practice and learn lessons. Staff survey responses 100% agree that they are able to quickly and efficiently report incidents.
140 [1]	When serious mistakes are made in care, this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement (or equivalent).	Met	The Trust has a DOC policy and this is followed when mistakes are made.	Met	Managers reported that, when serious mistakes are made, the service follows the Duty of Candour policy.
141 [1]	Staff members, patients and carers who are affected by a serious incident including restraints and/or rapid tranquilisation are offered post-incident support. Guidance: *This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection* Sustainability Principle: Empowering Individuals	Met	We offer debriefs and post incident support following incidents, psychology referrals or facilitation is often recommended.	Met	Carer and staff survey responses largely agree that they are offered support after a serious incident involving restraints and/or rapid tranquilisation. Patients who have been involved in serious incidents agree that they are offered this support as well. While most staff spoken to on the day had not experienced many serious incidents, those that had stated that both they and the patient involved were

					offered post-incident support.
142 [1]	Lessons learned from patient safety incidents, safeguarding themes/trends and complaints are shared with the team and the wider organisation/provider collaborative. There is evidence that changes have been made as a result of sharing the lessons.	Met	We following Patient Safety Incident Response Framework and staff have had training, all lessons are shared through the trust's learning collaborative.	Met	Managers reported that the service has a safety folder that is available to staff. They added that they share lessons learned through the provider collaborative.
143 [2]	Services are developed in partnership with appropriately experienced patients and carers who have an active role in decision making.	Met	Operational policy has been recently reviewed, patient and carer groups were consulted throughout this process and we have many examples of where their views have resulted in changes to how we operate.	Met	This standard is scored using the self-review commentary. This states that the service recently reviewed its operational policy and that patient and carer groups were consulted during this process.
144 [3]	The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan (or equivalent). It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services	Partly Met	Sustainability is acknowledged and considered although we don't currently have a clear plan of action for each service, however the organisation strategic plan acknowledges the	Not Met	Managers reported that they were not aware of a written green plan in place. No green plan has been observed.

	(prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team.		intention to offer services in a greener and sustainable way.		

Appendix 3: Physical Security

Physical Security - medium secure

No.	Type	Standard	Self-Review Score	Self-Review Comments
Section 7				
PS 1H	1	For each criteria please describe the process in place/planned action to meet standard, evidence location and last reviewed date	Met	
PS1-1.1	1	A designated security lead has responsibility for security within the service. The designated individual has relevant experience and training.		One of our 3 Matrons is designated security lead, they have relevant experience and training.
PS1-1.2	1	The designated security lead ensures policies and procedures are proportionate to the risks identified. A process for reviewing restrictive practices is in place, with specified timescales.		All policies are proportionate to risk identified. We have a process for reviewing restrictive practices in a noon sitrep 3 days a week.
PS1-1.3	1	The designated security lead has systems in place to ensure effective liaison with local police on incidents of criminal activity/harassment/violence and other criminal justice agencies, where relevant. A memorandum of understanding is in place with local police on reporting crime.		There are systems and policies that define the way we liaise with police and keep them updated on incidents.
PS1-2.1	1	The secure perimeter is in line with the planning specification for the level of security offered, is protected against climbing, and is easily observable.		Our secure perimeter meets the specified requirements for medium secure, it is anti climb and observable, checked daily.
PS1-2.2	1	There is a daily recorded inspection of the perimeter and programme of maintenance specifically for the perimeter, with evidence of immediate action taken when problems are identified.		Daily checks and escalation processes in place.

PS1-2.3	1	Windows that form part of the external secure perimeter are set within the building masonry, do not open more than 125mm and are designed to prevent the passage of contraband.		Our windows meet these specifications.
PS1-2.4	1	Access to the secure service for visitors, staff and patients is via an airlock.		There is an airlock in the reception area that leads to all the ward environments.
PS1-2.5	1	The reception/control room is: • Within or forms part of the secure external perimeter; • Staffed 24 hours per day 7 days a week or can be made fully operational in the case of an emergency.		The reception control is within the perimeter and staffed 24 hours a day.
PS1-2.6	1	There are controlled systems in place to manage access and egress through all doors and gates that form part of the secure perimeter.		There are systems in place to manage access and egress through the perimeter.
PS1-2.7	1	In outside areas within the secure perimeter, permanent furniture, fixtures and equipment are fixed and are prevented from use as a climb aid.		All furniture and trees etc are fixed and don't pose an absconsion risk.
PS1-3.1	1	There is a key management system in place which accounts for all secure keys/passes, including spare/replacement keys which are held under the control of a senior manager.		We use a Trakka system.
PS1-3.2	1	Secure pass keys are: • On a sealed ring; • Secured to staff at all times within the secure perimeter; • Prevented from being removed from the secure perimeter.		All staff have their own keys on a sealed ring, they cannot be removed past reception.
PS1-3.3	1	There is a process to ensure that: • Keys are not issued until a security induction has been completed;		Keys are only issued after security induction has been completed, approved staff within the Trakka system is updated regularly.

		• Keys are only issued upon the presentation of valid ID; • A list of approved key holders is updated monthly identifying new starters who have completed their induction training and any leavers from the service.		
PS1-3.4	1	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking. Bedrooms have patient operated privacy locks that staff can override from the outside.		All door are anti-barricade and patients can have privacy with locks that can over ridden by staff.
PS1-3.5	1	Doors in rooms used by patients have observation panels with integrated blinds/obscuring mechanisms. These can be operated by patients with an external override feature for staff.		Observations panels can be closed or opened by staff and patients on both sides of the door.
PS1-4.1	1	Where CCTV is in use, there should be passive recording of the perimeter, reception frontage and access from the secure area to reception.		CCTV covers all these areas.
PS1-4.2	1	There are clear lines of sight to enable staff members to view patients. Measures are taken to address blind spots and ensure sightlines are not impeded.		Lines of sight are clear, where required we have mirrors and CCTV to mitigate, all wards have clear documentation on potential 'hotspots' of risk.
PS1-5.1	1	A contingency plan addresses: • The chain of operational control; • Communications; • Patient and staff safety and security; • Maintaining continuity in treatment; • Accommodation; • Testing by live and desktop exercises, including a collective response to rehearsing alarm calls at least six-monthly.		All wards have contingency plans that are reviewed and tested regularly.
PS1-5.2	1	Call button/personal alarms are available to all staff,		Call buttons and personal alarms are available to all staff

		patients and visitors within the secure perimeter.		patients and visitors.
PS1-6.0	1	Developmental practices		The service is always developing and looking for opportunities to improve / use digital technology etc.
Service-wide RAG review				
PS2-1.0	1	Who is responsible?	Met	Service Manager.
PS2-2.0	1	Perimeter and access	Met	Security Lead.
PS2-3.0	1	Inner perimeter and controls	Met	Security Lead / Security Nurses.
PS2-4.0	1	Technology and surveillance	Met	Processes to obtain footage; EPUT digital team.
PS2-5.0	1	Contingency and emergency planning	Met	Service manager / matrons / Senior Management through quality and safety meeting.
PS2-6.0	1	Developmental practices	Met	Developmental practices around security are always considered.
PS2-7.0	1	Audit and review	Met	Full audit calendar in place, discussed in quality and safety meeting.
PS2-8.0	1	Procedural security index document	Met	All procedural security aspects have policy specific to our secure services and available to staff.

Physical Security - low secure

No.	Type	Standard	Self-Review Score	Self-Review Comments
Section 7				
PS 1H	1	For each criteria please describe the process in place/planned action to meet standard, evidence location and last reviewed date	Met	
PS1-1.1	1	A designated security lead has responsibility for security within the service. The designated individual		One of our 3 Matrons is designated security lead, they have relevant experience and training.

		has relevant experience and training.		
PS1-1.2	1	The designated security lead ensures policies and procedures are proportionate to the risks identified. A process for reviewing restrictive practices is in place, with specified timescales.		All policies are proportionate to risk identified. We have a process for reviewing restrictive practices in a noon sitrep 3 days a week.
PS1-1.3	1	The designated security lead has systems in place to ensure effective liaison with local police on incidents of criminal activity/harassment/violence and other criminal justice agencies, where relevant. A memorandum of understanding is in place with local police on reporting crime.		There are systems and policies that define the way we liaise with police and keep them updated on incidents.
PS1-2.1	1	The secure perimeter is in line with the planning specification for the level of security offered, is protected against climbing, and is easily observable.		Our secure perimeter meets the specified requirements for medium secure, it is anti climb and observable, checked daily.
PS1-2.2	1	There is a daily recorded inspection of the perimeter and programme of maintenance specifically for the perimeter, with evidence of immediate action taken when problems are identified.		Daily checks and escalation processes in place.
PS1-2.3	1	Windows that form part of the external secure perimeter are set within the building masonry, do not open more than 125mm and are designed to prevent the passage of contraband.		Our windows meet these specifications.
PS1-2.4	1	Access to the secure service for visitors, staff and patients is via an airlock.		There is an airlock in the reception area that leads to all the ward environments.
PS1-2.5	1	The reception/control room is: • Within or forms part of the secure external perimeter; • Staffed 24 hours per day 7 days a week or can be made fully operational in the case of an emergency.		The reception control is within the perimeter and staffed 24 hours a day.
PS1-2.6	1	There are controlled systems in place to manage		There are systems in place to manage access and egress

		access and egress through all doors and gates that form part of the secure perimeter.		through the perimeter.
PS1-2.7	1	In outside areas within the secure perimeter, permanent furniture, fixtures and equipment are fixed and are prevented from use as a climb aid.		All furniture and trees etc are fixed and don't pose an absconsion risk.
PS1-3.1	1	There is a key management system in place which accounts for all secure keys/passes, including spare/replacement keys which are held under the control of a senior manager.		We use a Trakka system.
PS1-3.2	1	Secure pass keys are: • On a sealed ring; • Secured to staff at all times within the secure perimeter; • Prevented from being removed from the secure perimeter.		All staff have their own keys on a sealed ring, they cannot be removed past reception.
PS1-3.3	1	There is a process to ensure that: • Keys are not issued until a security induction has been completed; • Keys are only issued upon the presentation of valid ID; • A list of approved key holders is updated monthly identifying new starters who have completed their induction training and any leavers from the service.		Keys are only issued after security induction has been completed, approved staff within the Trakka system is updated regularly.
PS1-3.4	1	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking. Bedrooms have patient operated privacy locks that staff can override from the outside.		All door are anti-barricade and patients can have privacy with locks that can over ridden by staff.
PS1-3.5	1	Doors in rooms used by patients have observation panels with integrated blinds/obscuring mechanisms. These can be operated by patients		Observations panels can be closed or opened by staff and patients on both sides of the door.

		with an external override feature for staff.		
PS1-4.1	1	Where CCTV is in use, there should be passive recording of the perimeter, reception frontage and access from the secure area to reception.		CCTV covers all these areas.
PS1-4.2	1	There are clear lines of sight to enable staff members to view patients. Measures are taken to address blind spots and ensure sightlines are not impeded.		Lines of sight are clear, where required we have mirrors and CCTV to mitigate, all wards have clear documentation on potential 'hotspots' of risk.
PS1-5.1	1	A contingency plan addresses: • The chain of operational control; • Communications; • Patient and staff safety and security; • Maintaining continuity in treatment; • Accommodation; • Testing by live and desktop exercises, including a collective response to rehearsing alarm calls at least six-monthly.		All wards have contingency plans that are reviewed and tested regularly.
PS1-5.2	1	Call button/personal alarms are available to all staff, patients and visitors within the secure perimeter.		Call buttons and personal alarms are available to all staff patients and visitors.
PS1-6.0	1	Developmental practices		The service is always developing and looking for opportunities to improve / use digital technology etc.
Service-wide RAG review				
PS2-1.0	1	Who is responsible?	Met	Service Manager.
PS2-2.0	1	Perimeter and access	Met	Security Lead.
PS2-3.0	1	Inner perimeter and controls	Met	Security Lead / Security Nurses.
PS2-4.0	1	Technology and surveillance	Met	Processes to obtain footage; EPUT digital team.
PS2-5.0	1	Contingency and emergency planning	Met	Service manager / matrons / Senior Management through quality and safety meeting.
PS2-6.0	1	Developmental practices	Met	Developmental practices around security are always

				considered.
PS2-7.0	1	Audit and review	Met	Full audit calendar in place, discussed in quality and safety meeting.
PS2-8.0	1	Procedural security index document	Met	All procedural security aspects have policy specific to our secure services and available to staff.

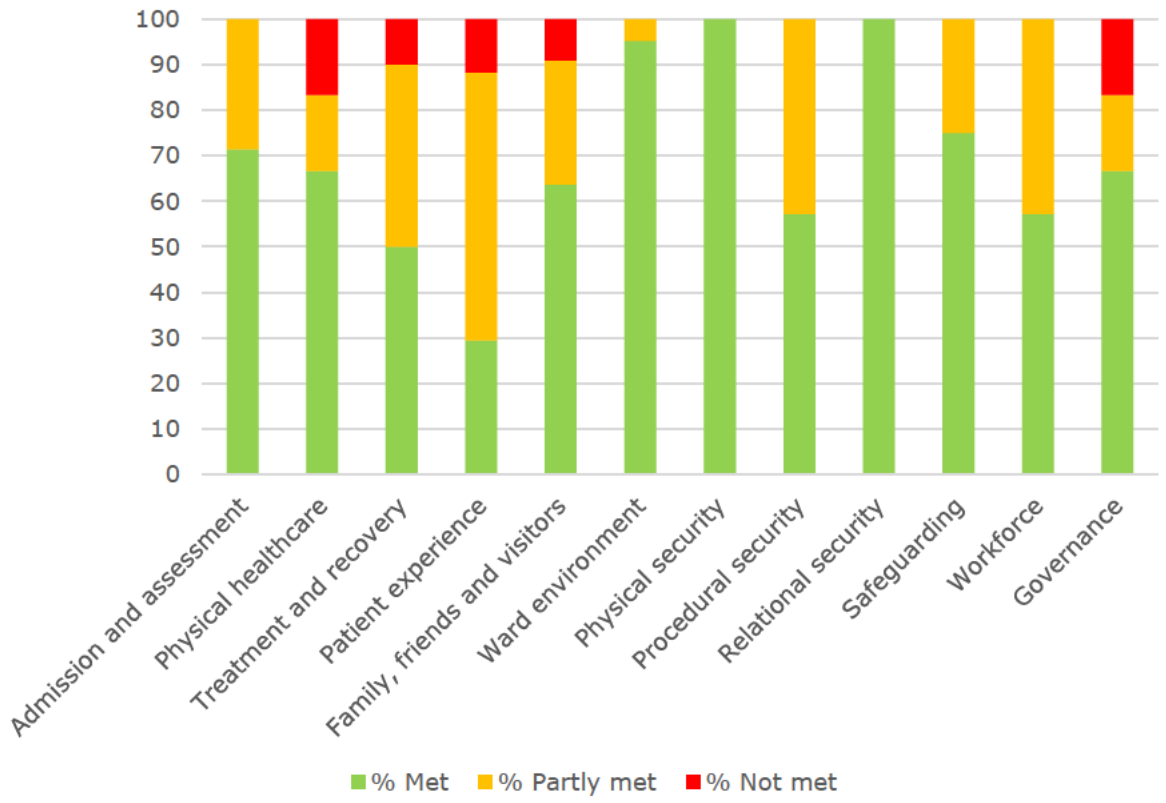
Appendix 4: Previous Review Summary

Member services receive a full review visit, followed by a developmental visit the following year. This section summarises the key findings from the previous two review visits (full review and developmental review).

Medium Secure Services

The service previously received a full review visit on 06 and 07 April 2022 and met 68% of Standards for Forensic Mental Health Services: Low and Medium Secure Care (Fourth Edition). The service also received a developmental review on 05 April 2023.

Figure 3: Percentage and number of criteria met, partly met and not met in each category from the previous full review



The following key themes were highlighted as in need of improvement during the previous full and developmental reviews. Further commentary is provided to outline whether the services has made progress on these areas:

- *Involvement in care and treatment planning could be improved. Patients from across the MSU wards reported that they do not feel involved in the*

development of their care plans. MSU patients described being given large documents which are not easy to understand. It was agreed that care plans should be more straightforward and easier to understand. Patients on Alpine ward summarised their experiences of a lack of collaborative care planning as: "you get given a piece of paper and told to sign it": Patients on the MSU described having care plans and being involved in the process. They also shared that their personal goals are discussed with the staff at the service.

- *Support to patients around maintaining a healthy lifestyle is hindered by the current meal provision. Patients raised that the food offered consists of unhealthy, poor quality meals that do not provide choice or variety. Complaints have been raised regarding this but patients reported that no action has been taken as a result:* Patients on the MSU stated that the food 'could be better' and asked for bigger portions.

- *Some aspects of staff wellbeing and support can be addressed. Staff spoken to indicated that they do not always get the opportunity to take breaks during their shift, as not enough staff are available to cover them. They proposed that break times need to be more structured so staff are aware of when they need to take a break. Staff also suggested a need to access a room off the ward environment where they can decompress, as the only options they have at present are the canteen or their own car:* While the issue of taking breaks was not discussed with MSU staff, they did report that there are staff wellbeing issues and that these are related to staffing levels and a high turnover rate.

- *Staffing levels present a significant challenge for the service, impacting on patient care and staff ability to work effectively. Patients highlighted occasions when there are not enough staff to facilitate leave in the community or off ward activities due to low staffing levels. They also reported feeling that it is more difficult to get staff to listen to them. During periods of particularly low staffing levels, staff spoke of the increased challenge in ensuring effective communication across the team:* MSU staff did reference that staff turnover had remained high over the last few years and that vacancies were high. Patients stated that they wanted more activities in the evenings and on weekends.

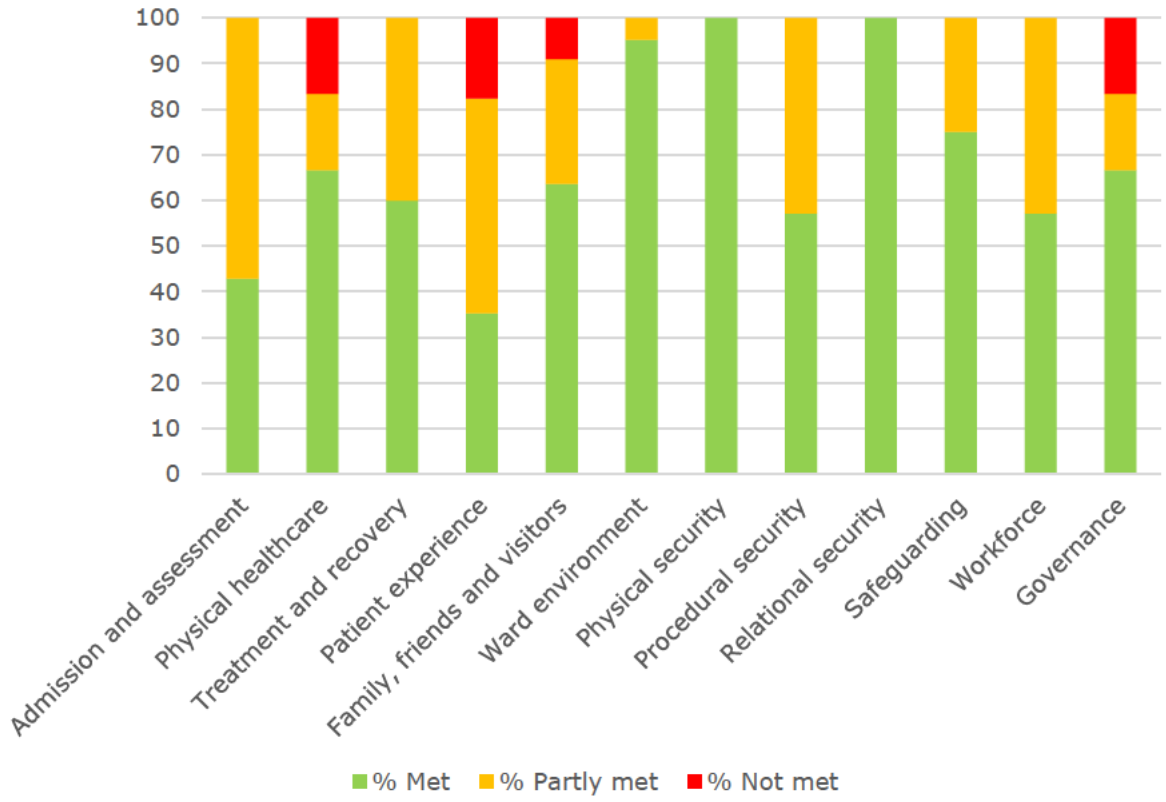
- *Reflective practice is not currently embedded across the MSU. Reflective practice is provided inconsistently across the wards, with some wards having reflective practice monthly while others have it less frequently.:* MSU staff shared that reflective practice is offered every month on each ward. While this is an improvement, it is recommended that information is

shared with every discipline, as pharmacy staff reported that they did not always receive this information.

Low Secure Services

The service previously received a full review visit on 06 and 07 April 2022 and met 64% of Standards for Forensic Mental Health Services: Low and Medium Secure Care (Fourth Edition). The service also received a developmental review on 05 April 2024.

Figure 4: Percentage and number of criteria met, partly met and not met in each category from the previous full review



The following key themes were highlighted as in need of improvement during the previous full and developmental reviews. Further commentary is provided to outline whether the services has made progress on these areas:

- *Involvement in care and treatment planning could be improved. Patients from across the LSU wards reported that they do not feel involved in the development of their care plans. Similarly, patients were unsure about their pathway of care. Lastly, patients were not able to articulate what they needed to do to get to the next point of care:* Patients on the LSU shared that they all have care plans, and the majority felt they were

involved in the development of these care plans. One patient stated that they did not feel involved, saying 'it is read to me'. However, all patients agreed that they can discuss their goals with staff and that there are clear plans in place for them.

- *Support to patients around maintaining a healthy lifestyle is hindered by current meal provision. Patients raised that the food offered consists of unhealthy, poor quality meals that do not provide choice or variety. Complaints have been raised regarding patients reported that no action has been taken as a result:* Patients shared that, before self-catering, the food was not very nice or big enough. Patients still feel as if the food at the service could have larger portions and be healthier.

- *Some aspects of staff wellbeing and support can be addressed. Staff spoken to indicated that they do not always get the opportunity to take breaks during their shift, as not enough staff are available to cover them. They proposed that break times need to be more structured so staff are aware of when they need to take a break. Staff also suggested a need to access a room off the ward environment where they can decompress, as the only options they have at present are the canteen or their own car:* This remains an issue for the service. LSU staff stated that they were often unable to take breaks during their shifts, and that when they do take breaks, some feel it is difficult to have a real break with staff members coming in and out of the break room. Staff shared that some 'find it better to go and sit in your car' rather than use the staff rooms on the wards.

- *Staffing levels present a significant challenge for the service, impacting on patient care and staff ability to perform their job well. Patients highlighted times when there are not enough staff to facilitate leave in the community or off ward activities due to low staffing levels. They also reported feeling that it is more difficult to get staff to listen to them. During periods of particularly low staffing levels, staff spoke of the increased challenge in ensuring effective communication across the team:* LSU staff stated that, due to staffing levels, they cannot always provide leave to patients. Patients stated that they do not always have access to activities and leave.

- *Reflective practice is not currently embedded across the LSU. Reflective practice is provided inconsistently across the wards, with some wards having reflective practice monthly while others have it less frequently:* LSU staff stated that the psychology team provides reflective practice sessions every six weeks. Ward based staff did not comment and it is unclear if they are consistently attending reflective practice.

Appendix 5: Survey Responses

QNFMHS 5th Ed. Case Note Audit Responses		
Question no.	**Question**	**Response**
Qward	Please state which ward the patient is on:	
Q1	Does the patient have a comprehensive mental health assessment?	No responses.
Q2	If no, please explain further in the box below	No responses.
Q3	Was it started within four hours?	No responses.
Q4.a	Does the mental health assessment consider the following:	No responses.
Q4.b	Does the mental health assessment consider the following:	No responses.
Q4.c	Does the mental health assessment consider the following:	No responses.
Q5	Is there evidence that an assessment of the patient's capacity to consent to care and treatment has been performed in accordance with current legislation?	No responses.
Q6.a	On the patient's admission was the following considered:	No responses.
Q6.b	On the patient's admission was the following considered:	No responses.
Q6.c	On the patient's admission was the following considered:	No responses.
Q7	Does the patient have a comprehensive physical health review?	No responses.
Q8	If no, please explain further in the box below:	No responses.
Q9	Was it started within four hours?	No responses.
Q10	Did the patient have follow-up investigations and treatment if concerns about their physical health were identified during their admission?	No responses.
Q11.a	Was the patient offered any of the following personalised healthy lifestyle interventions in their care plan:	No responses.
Q11.b	Was the patient offered any of the following personalised healthy lifestyle interventions in their care plan:	No responses.

Q11.c	Was the patient offered any of the following personalised healthy lifestyle interventions in their care plan:	No responses.
Q11.d	Was the patient offered any of the following personalised healthy lifestyle interventions in their care plan:	No responses.
Q12	Does the patient have a written care plan that reflects their individual needs?	No responses.
Q13	If no, please explain further in the box below:	No responses.
Q14	Did staff members collaborate with the patient and their carer (with patient consent) when developing the care plan?	No responses.
Q15	Was the patient offered a copy of their care plan?	No responses.
Q16.a	Is there evidence the patient's progress against patient-defined goals are reviewed in collaboration with the patient at:	No responses.
Q16.b	Is there evidence the patient's progress against patient-defined goals are reviewed in collaboration with the patient at:	No responses.
Q16.c	Is there evidence the patient's progress against patient-defined goals are reviewed in collaboration with the patient at:	No responses.
Q17	Did the patient have a documented formalised review of care or ward round admission meeting within one week of their admission?	No responses.
Q18	If no, please explain further in the box below	No responses.
Q19	Was the patient supported to attend this?	No responses.
Q20	Has the patient been discharged?	No responses.
Q21	In order to reduce the risk of suicide on discharge, has a thorough assessment of the patient's personal, social, safety, and practical needs been carried out by a mental health practitioner?	No responses.
Q22	Was their care plan or interim discharge summary sent to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge?	No responses.
Q23.a	Does the plan includes details of:	No responses.
Q23.b	Does the plan includes details of:	No responses.

Q23.c	Does the plan includes details of:	No responses.
Q23.d	Does the plan includes details of:	No responses.
Q24	Was a discharge summary sent within one week to the patient's GP and others concerned (with the patient's consent)?	No responses.
Q25.a	Did the discharge summary include:	No responses.
Q25.b	Did the discharge summary include:	No responses.
Q25.c	Did the discharge summary include:	No responses.
Q25.d	Did the discharge summary include:	No responses.
Q25.e	Did the discharge summary include:	No responses.
Q26	Was clinical outcome measurement data collected at two time points (admission and discharge)?	No responses.
Q27	Is a risk assessment conducted as part of the initial assessment?	No responses.
Q28.a	Does the risk assessment include consideration of the following:	No responses.
Q28.b	Does the risk assessment include consideration of the following:	No responses.
Q28.c	Does the risk assessment include consideration of the following:	No responses.
Q29	Does the patient have a risk management plan in place?	No responses.
Q30	Is there evidence that this was co-produced with involvement from the patient?	No responses.
Q31	Is there evidence that this has been shared where necessary with relevant agencies (with consideration of confidentiality)?	No responses.
Q32	Has the patient been prescribed medication?	No responses.
Q33.a	When medication has been prescribed, is there evidence of the following:	No responses.
Q33.b	When medication has been prescribed, is there evidence of the following:	No responses.
Q33.c	When medication has been prescribed, is there evidence of the following:	No responses.
Q33.d	When medication has been prescribed, is there evidence of the following:	No responses.
Q34	Is there evidence that this is reviewed fortnightly?	No responses.

Q35.a	Is there evidence that medication reviews include:	No responses.
Q35.b	Is there evidence that medication reviews include:	No responses.
Q35.c	Is there evidence that medication reviews include:	No responses.
Q35.d	Is there evidence that medication reviews include:	No responses.
Q36	Is the patient's PRN medication reviewed fortnightly, with consideration of the frequency, dose and reasons?	No responses.
Q37	Was the patient prescribed mood-stabilisers or antipsychotics?	No responses.
Q38.a	Has the patient had appropriate physical health assessments at the following time points:	No responses.
Q38.b	Has the patient had appropriate physical health assessments at the following time points:	No responses.
Q38.c	Has the patient had appropriate physical health assessments at the following time points:	No responses.
Q39	If the patient was involved in episodes of control and restraint, or compulsory treatment including tranquilisation, were they observed to be breathing and have their vital signs monitored by staff members, with any deterioration responded to?	No responses.
Q40	If the patient has been harmful to themselves or others, were they supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions?	No responses.

Forensic Carers 5th Edition Responses		
Question no.	**Question**	**Response**
Q1	Is your loved one within a low or medium secure service?	4 Responses: 3 Medium secure 1 Low secure
Q2	What is the name of the ward where your loved one is being cared for? If you would prefer not to state the name of the ward, please move on to the next question.	• Causeway • Alpine • Gary Butt • Forest ward

Q3	My loved one has a written care plan.	4 Responses: 2 Not sure 1 Agree 1 Disagree
Q3a	If agree, I was able to contribute to its development.	1 Responses: 1 Agree
Q3b	I have been offered a copy of my loved one's care plan.	1 Responses: 1 Disagree
Q4	I am invited to discharge meetings and am involved in decisions about discharge plans.	4 Responses: 2 Disagree 1 Neither agree nor disagree 1 Not sure
Q5	I am able to meet with a pharmacist to discuss my loved one's medications.	4 Responses: 3 Disagree 1 Neither agree nor disagree
Q6	I am able to participate in decisions about my loved one's care. This includes being invited to meetings about care planning.	4 Responses: 3 Disagree 1 Neither agree nor disagree
Q7	Confidentiality and its limits have been explained to me.	4 Responses: 2 Not sure 1 Verbally 1 This information has not been explained to me
Q8	I was given information for carers when my loved one arrived at hospital. This includes the names and contact details of key staff members and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.	4 Responses: 2 Agree 1 Neither agree nor disagree 1 Disagree
Q9	The service has explained what a carers assessment is.	4 Responses: 3 Disagree 1 Neither agree nor disagree
Q10	I know how to access a carers assessment if I want one, or who to ask about this.	4 Responses: 2 Neither agree nor disagree 2 Disagree

Q11	When my loved one first arrived at the hospital, staff contacted me and gave me contact details of the ward.	4 Responses: 2 Yes 1 I cannot remember 1 No
Q12	On my loved one's admission, I was offered a conversation with staff to discuss my own concerns, my own needs and family history.	4 Responses: 3 No 1 Yes
Q12a	When did this conversation take place?	1 Responses: 1 After a month
Q13	I am offered information about my loved one's mental health and treatment.	4 Responses: 3 Verbally 1 I do not receive this information
Q14	I am offered information about my loved one's physical health and treatment.	4 Responses: 2 Verbally 2 I do not receive this information
Q15	I know how to, and can easily access, policies and procedures relating to my loved one's care.	4 Responses: 2 Neither agree nor disagree 2 Disagree
Q16	I have been asked for my feedback about my experience of the service.	4 Responses: 2 Disagree 1 Agree 1 Neither agree nor disagree
Q17	Please state how you are asked for your feedback about the service (e.g. feedback surveys, focus groups, carer representative, one to one or group meetings etc) • This survey has been emailed to me. Please note my brother has been in and out of hospital for years now, so I am used to the system, however no information is forthcoming I have always had to call and be proactive and voice my concerns or get updates. The family is always not heard even when it is a crisis.	
Q18	Staff agree leave plans with me when my loved one visits me.	4 Responses: 2 Neither agree nor disagree 1 Not applicable (e.g. my loved one has withdrawn consent) 1 Agree
Q19	I feel staff treat me with compassion, dignity and respect.	4 Responses: 2 Always 1 Usually 1 Prefer not to say

Q20	I know how to access a carer support group if I want to (this might be in the service or in an external network).	4 Responses: 2 Disagree 1 Neither agree nor disagree 1 Agree
Q21	I feel supported by the ward staff members.	4 Responses: 2 Prefer not to say 1 Usually 1 Sometimes
Q22	I am able to speak to my loved one via video call if I am not able to visit in person.	4 Responses: 2 Disagree 1 Neither agree nor disagree 1 Agree
Q23	I am offered support after a serious incident involving me or my loved one.	4 Responses: 2 Agree 1 Disagree 1 Not applicable (e.g. My loved one or I have not been involved in a serious incident)
Q24	Do you have any further comments regarding your experience of the service? • Verbal questioning and information from family in a one to one meeting. • I have found there are exceptional staff over the last 24 years but they are few and far between. There is no consistency and the change of doctors is beyond frustrating. Each doctor thinks they know better than the last and fail to read historic notes. I find I have to tell [name's]history over and over again and failing within the system that has led him back to hospital on several occasions. I have reported my concerns over the years to the services and the frontline staff can only do so much as they are not listened to by doctor. I know this for a fact personally from my experience but also professionally working on mental health wards. Doctors should be made to work weekends and Bank Holidays as patients have to wait until Mondays and ward rounds. It's beyond frustrating to the patients and families. After 24 years of my experience as a carer with a loved one in the services, I can honestly say nothing much has changed. I always just hope to get the good staff and feel sorry for patients. Cameras should also be installed for the patient's safety and because of bad staff. Again, this is from personal experience of failings within the service. • Recently been to visit was planned by one of the social workers, this was all planned by email, got to the clinic information was not passed to the clinic, was really stressful to plan this, as we travel to the UK for this, I hardly get any update on how my member of family progression is doing, and how psychologist assessment are going, communication is not as good as I would like .	
Q25	Do you have any suggestions for how the service may make improvements? • As above and information should be accessible to all relevant staff.	

	• Listen to the carers, as we may not have written qualification but we are qualified in our loved ones' diagnosis. Call carers back within a reasonable time and stop with the blockades. Stop changing doctors as the family and patient have no consistency. • More communication given to families, in how patients progress is going, time is passing and I don't know nothing about my member of family.

QNFMHS Patient Survey 5th Edition Responses		
Question no.	**Question**	**Response**
Q1	Please state which ward you are on:	• Dune (5) • Fuji (5) • Aurora (2) • Lagoon
Q2	Are you in low or medium secure?	13 Responses: 8 Medium Secure 5 Low Secure
Q3	When I arrived at this hospital, I felt welcomed by staff.	13 Responses: 9 Agree 3 I do not remember 1 Disagree
Q4	When I arrived, staff explained why I am in this hospital.	13 Responses: 10 Agree 2 I do not remember 1 Disagree
Q5	I have access to the following electronic items:	Computers with internet - 11 Mobile phones - 8 Other electronic equipment - 3 Computers without internet - 2
Q6	Please state:	
Q7	I feel treated with compassion, dignity and respect by staff.	13 Responses: 10 Agree 2 Neither agree nor disagree 1 Prefer not to say
Q8	I feel listened to and understood by staff.	13 Responses:

		11 Agree 1 Prefer not to say 1 Disagree
Q9	I can access an advocate or advocacy service (e.g. an independent mental health advocate).	13 Responses: 12 Agree 1 Disagree
Q10	I am involved in decisions about my level of observation.	13 Responses: 6 Agree 3 Disagree 3 Not sure 1 Neither agree nor disagree
Q11	The meals provided at the service... [please tick all that apply]	Are big enough portions - 5 Offer choice - 3 Are nutritional and balanced - 3 Are varied - 3 Address my dietary requirements - 2 Reflect my - 2 and others' - 2 cultural and religious needs - 2
Q12	I have a leave plan.	13 Responses: 8 Agree 4 N/A - I do not have a leave 1 Neither agree nor disagree
Q13	I feel involved in developing my leave plan.	No responses.
Q14	I have access to 'green' walking sessions (this is when patients can go for walks in natural areas).	13 Responses: 8 Always 3 Often 1 Sometimes 1 Not sure
Q15	I am able to speak to my family and friends via video call if they are not able to visit in person.	13 Responses: 5 Agree 3 N/A - My family and friends are always able to visit, or I am not in contact with family and friends 2 I don't know 2 Disagree 1 Neither agree nor disagree

Q16	When I am on constant observation, at least one hour per day is with a member of staff who I am familiar with.	13 Responses: 6 Agree 3 N/A - I have not been on constant observation 2 I do not know 2 Disagree
Q17	I am offered support after a serious incident (including instances of restraint or rapid tranquilisation).	13 Responses: 7 N/A - I have not been involved in a serious incident 3 Neither agree nor disagree 3 Agree
Q18	When I arrived, I received a welcome pack containing information about the service.	13 Responses: 5 I do not remember 4 Agree 3 Disagree 1 Neither agree nor disagree
Q19	Confidentiality and its limits have been explained to me in a way that I understand.	13 Responses: 9 Agree 3 Not sure 1 Disagree
Q20	I know which member(s) of staff I can talk to if I have any questions and how to contact them.	13 Responses: 10 Agree 3 Neither agree nor disagree
Q21	I have regular one-to-one sessions with my key worker/named nurse to discuss my care plan, progress and concerns.	13 Responses: 6 Once a week 3 Other 2 I do not have one-to-one sessions 1 Twice a week 1 Less than once a week
Q22	Please specify:	
Q23	I have been offered information about my mental illness and any treatment for this.	13 Responses: 7 Both verbally and in writing 3 Verbally 2 I do not know 1 In writing
Q24	I have been offered information about any physical health condition I have been diagnosed with, and any treatment for this.	13 Responses: 5 N/A - I have not been diagnosed with any physical health condition

		3 Verbally 2 Both verbally and in writing 2 In writing 1 I am not offered this information
Q25	I know how to access policies and procedures relating to my care.	13 Responses: 8 Agree 4 I do not know 1 Disagree
Q26	I am offered support to maintain a healthy lifestyle (for example advice on healthy eating, physical activity and access to support stopping smoking).	11 Responses: 9 Agree 1 I do not know 1 Disagree
Q27	I have a written care plan.	12 Responses: 9 Agree 2 I do not know 1 Disagree
Q28	I feel my care plan reflects my individual needs.	12 Responses: 9 Agree 2 Disagree 1 I do not know
Q29	I feel involved in developing my care plan.	12 Responses: 8 Agree 2 I do not know 1 Disagree 1 Neither agree nor disagree
Q30	I have been offered a copy of my care plan.	12 Responses: 7 Agree 2 I do not remember 2 Disagree 1 Neither agree nor disagree
Q31	Staff regularly discuss my progress against my own personal goals with me.	7 Responses: 4 Agree 2 Neither agree nor disagree 1 I do not know
Q32	There are a range of interesting activities on the ward seven days a week.	5 Responses: 3 Disagree

		1 I do not know 1 Neither agree nor disagree
Q33	Staff helped me prepare for my first ward round (or review of care).	13 Responses: 8 Agree 4 I do not remember 1 Disagree
Q34	I have had a formal review meeting (this might be called a CPA)	13 Responses: 13 Yes
Q35	During the meeting, I felt able to contribute my own views and opinions	2 Responses: 2 I do not remember
Q36	Staff supported me to prepare for this meeting (e.g. by explaining what to expect and what the meeting would be about).	1 Responses: 1 I do not remember
Q37	I am invited to meetings about my discharge.	12 Responses: 6 N/A - I am not preparing for discharge yet 5 Agree 1 Disagree
Q38	Staff have discussed the risks and benefits of my medication with me.	12 Responses: 10 Agree 1 I do not know 1 Disagree
Q39	I am able to meet with a pharmacist to discuss medications.	12 Responses: 7 Agree 3 Neither agree nor disagree 2 Disagree
Q40	I have a safety/management plan in place.	11 Responses: 6 Agree 4 I do not know 1 Neither agree nor disagree
Q41	I have been involved in developing this.	1 Responses: 1 Neither agree nor disagree
Q42	I have received information and encouragement to access local organisations including [please select all that apply]:	Recovery colleges - 6 None of the above - 5 Voluntary organisations - 3 Community centres - 2
Q43	Please specify:	

Q44	Staff help me access support with [please select all that apply]:	Benefits - 7 Finances - 5 N/A - I do not need support with any of the above - 4 Housing needs - 2 Debt management - 1
Q45	I have been offered education to support social inclusion on topics such as activities of daily living, communicating with others, relationships, coping with stigma, stress management and/or anger management.	12 Responses: 6 Agree 4 N/A - I do not need education on these topics 1 Neither agree nor disagree 1 Disagree
Q46	I am asked for my feedback about my experience of the service.	12 Responses: 8 Agree 2 I do not know 1 Neither agree nor disagree 1 Disagree
Q47	Please estate how you are able to provide feedback.	
Q48	Community meetings on the ward take place (these may also be called ward meetings):	12 Responses: 4 I do not know 3 Weekly 3 Monthly 1 Fortnightly 1 There are no community meetings on the ward
Q49	I am able to personalise my bedroom.	12 Responses: 9 Agree 2 Neither agree nor disagree 1 I do not know
Q50	When changes are made to the ward environment, I am asked for my feedback before this happens.	12 Responses: 7 Agree 2 Disagree 2 Neither agree nor disagree 1 N/A - No changes have been made to the ward environment while I have been here.
Q51	I have access to materials and facilities associated with my culture or spiritual practice (e.g. access to a multi-faith room or faith books).	12 Responses: 7 N/A - I do not require this 3 Agree 2 Disagree

Q52	Please provide details of the faith-based support offered to you: • Yes church visit. • Spirituality Group. • Multi-faith room and chaplain. • Spirituality and Church Service.	
Q53	I feel that staff members respect my personal space (for example, they knock before entering my bedroom).	11 Responses: 9 Agree 2 Disagree
Q54	I have access to a safe outdoor space every day.	4 Responses: 3 Always 1 Usually
Q55	I have access to a range of self-led entertainment available on the ward (e.g. magazines, books, board games, TVs etc.)	4 Responses: 3 Always 1 Usually
Q56	I feel safe on the ward.	4 Responses: 2 Always 1 Sometimes 1 Usually
Q57	If sometimes, rarely or never, what can make you feel unsafe?	No responses.
Q58	What else would you like to tell us about the care and treatment you receive? • I am thankful for the help given me. • It's fine. • Everything is good.	
Q59	What other suggestions do you have for how the service may make improvements? • The service is run okay. • More privacy and more leave. • More activities.	

QNFMHS Staff Questionnaire 5th Edition Responses		
Question no.	**Question**	**Response**
Q1	How would you define your job role?	18 Responses: 11 Frontline Staff

		7 Senior manager or clinician (including ward managers)
Q2	Please name the ward(s) you work on.	• Pharmacy • Causeway • Alpine (5) • Forest Ward • Fuji Ward and hospital wide groups at Brockfield House • Lagoon • All wards (3) • Dune & Causeway • Community • SCFT • Dune Ward • Aurora Ward
Q3	Do you work in low secure, medium secure or both?	18 Responses: 9 Both 7 Medium 2 Low
Q4	As a prescriber, I am able to meet with a pharmacist to discuss medications.	18 Responses: 15 N/A - I do not prescribe medication 3 Agree
Q5	Handovers allow adequate time to discuss patients' needs, risks and management plans.	18 Responses: 13 Agree 5 Neither agree nor disagree
Q5a	If disagree, please explain why:	
Q6	Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns and their own needs.	18 Responses: 10 I don't know 5 Always 2 Sometimes 1 Never
Q7	I know what information I can share with a carer whose loved one has withdrawn consent	18 Responses: 15 Agree 2 Neither agree nor disagree 1 Disagree
Q8	I feel safe working on the ward.	18 Responses:

		12 Always 4 Sometimes 1 Prefer not to say 1 I don't know
Q8a	If sometimes or never, please explain: • When patients are on escorted ground leave, it can be intimidating walking through the ground floor where they hang out. • Sometimes staff are not present and the ward environment is chaotic. • We have a lot of staff who are not fit for the job due to attitude towards work and being rude to patients some staff I don't feel confident in their capacity to keep up security or de-escalate a situation, • Patients unpredictable.	
Q9	Policies, procedures and guidelines are accessible and easy to understand.	18 Responses: 15 Agree 3 Neither agree nor disagree
Q10	I feel able to challenge decisions within the team.	18 Responses: 12 Always 5 Sometimes 1 Never
Q10a	If sometimes or never, please explain: • Due to my role, this is not something I am permitted to do. • Not within the competencies of my job role. • My role does not always allow me to challenge the decisions within the team. • At times decisions can be difficult to challenge due to the hierarchy within the MDT. Although most of the time MDT allows others to put forward their argument/point of view. • If the decision is not clarified, I will asked for positive question in other to work effectively. • Some issues are still not attended to when challenged.	
Q11	I would feel confident preventing and responding to sexual exploitation, coercion, intimidation and abuse on the ward.	18 Responses: 14 Agree 4 Neither agree nor disagree
Q12	I am able to take breaks during my shift.	18 Responses: 16 Always 2 Sometimes
Q12a	If sometimes or never, what prevents you from taking your breaks? • No allocated time or too high workload. • We work on 1 qualified so breaks are not assured unless a staff on another ward can cover.	
Q13	How often is line management supervision?	18 Responses:

		14 Monthly 2 Other 1 Weekly 1 Quarterly
Q13a	If other, please state: • Whenever we feel we need it but normally once a month. • Whenever the need to talk.	
Q14	How often is clinical supervision?	18 Responses: 10 Monthly 4 Weekly 2 Quarterly 2 Other
Q14a	If other, please state: • Whenever we feel like we need it but usually once a month. • Usually monthly but if anything needs highlighting can be sooner.	
Q15	How often is reflective practice scheduled?	18 Responses: 13 Monthly 3 Other 1 N/A - I do not have access to reflective practice 1 Weekly
Q15a	If other, please state: • It is held externally however I do not believe it is utilised properly. • Bi-monthly within SCFT. • Was weekly, but not always accessible due to staffing.	
Q16	I feel the service actively looks after staff health and wellbeing.	18 Responses: 14 Yes 2 Not sure 2 No
Q16a	Please give a reason for your answer: • Staff feedback shows this. • Staff are friendly and easy to communicate with. • Included in line management / 1-1 support / CPD / caring environment. • Regular check ins and reflective spaces. • There is nothing done to look after staff wellbeing. • Several initiatives in the Trust targeting wellbeing of staff. • Discussed in supervision.	

	• I do have concerns to how the service supports staff that are involved within safeguarding enquiries. I also have some concern to the training of new starting nursing staff. • Managers are looking after staff. • This is always discussed in staff's monthly supervision. • Because we hire incompetent staff and nothing is done about it I have raised this several times the shifts are not well skilled mixed meaning staff are going in stressed as they are doing all the work. • Have arranged flexible working to suit family issues. • Through huddles and talking on each shift always asked about wellbeing. • They give direction and care toward staff's wellbeing. • During supervision and offering support on away days. • I had some few days off when I lost a relative to mourn him and to report when I am in good condition to work. • All good.	
Q17	During my induction I...(please tick all that apply):	Jointly worked with a more experienced colleague. - 14 Shadowed colleagues on the team. - 14 Was observed. - 12 Received regular supervisions until initial competency targets had been met. - 11 None of the above. - 2
Q18	I am able to identify and manage acute physical health emergencies.	18 Responses: 12 Agree 6 Neither agree nor disagree
Q19	I am able to engage in quality improvement initiatives or projects.	18 Responses: 7 I'm not sure 7 Regularly 4 Sometimes
Q19a	If regularly or sometimes, please provide an example: • Service evaluations. • I completed a service evaluation with the forensic psychological services team on a pilot treatment group. • A number of ongoing QI projects in the service. • Improving access to activities for patients. • I was able to engage in an initiative to reduce incidents on a particular ward through being involved in structured ward based activities. • I participate in improvement initiatives within SCFT we discuss these monthly in the business meeting. • By attending ward organised seminars and face to face training that create positive impact in improving my quality at work.	

	• How to manage/change the service provision due to recruitment issues. • The safety of patients and staff is core on the ward.	
Q19b	In what ways are patients and carers encouraged to take part in these quality improvement initiatives, if at all? • Discussed during patient meetings. • Outcome measures. • Not sure. • I don't think they are. • All are discussed in community meeting and patient forum. • Surveys, MDT meetings for wards and patient forum. • I have written the operational policy for SCFT in co-production with service users and carers. We involve service users in recruitment and they sit on our interview panels. we have held events at SCFT for service users and carers to celebrate the jubilee and other significant events. • We have a patient forum for them to speak how we can do better. • carers are welcome on the ward for visiting; they are shown around the ward and see bed area of who they are visiting. Activities that occasionally go on. • Good communication with patients through one and one section. During communal meeting section. Through engagement with patients. • During monthly MDT meetings where the voice of the patient is heard. • Patients are informed and it is discussed on morning meetings or ward rounds, consent is sought thereafter before it is started.	
Q20	I am able to quickly and effectively report incidents.	18 Responses: 18 Always
Q20a	If sometimes or never, please explain:	
Q21	I have been offered post incident support following a serious or distressing incident.	18 Responses: 10 Always 4 N/A - not been affected by an incident during my time at the service 3 Sometimes 1 Never
Q22	Patients who are on constant observations are observed at least one hour a day by a member of staff who is familiar to them.	18 Responses: 8 Always 6 I'm not sure 4 Sometimes
Q23	Patients are offered the opportunity to access support with finances, benefits, debt management and housing needs.	18 Responses: 14 Agree 3 I don't know

		1 Neither agree nor disagree
Q24	Do you have any suggestions for how the service may make improvements? • More regular nursing staff / experience withing team. • Better training for ward staff. • More focus on staff wellbeing and how staff can be better supported to reduce burn out. • I feel the service is very transparent and this helps us identify improvement areas. • Further training for new starting staff. More activities for patients to reduce boredom and promote good physical health. More reflective practice sessions across all wards. • Better discharge pathways from inpatient to community. • By listening to staff and hearing how stressed they are and how they feel like they are doing all the work how staff feel so unappreciated how staff are sick of working at Brockfield because its safety has gone downhill staff feel like there is a lot of incompetent staff but nothing is said how we are taking on dangerous patients with staff that agro patients. There is a lot of ways the service can make improvements but the service doesn't listen to staff. • Allocated time for support workers to utilize computers for training, checking emails and shifts etc, so support workers spend more time on floor with patients. • To have more staff, it's very hard when you have patients who have escorted area leave to facilitate it especially when so many patients all want to go out. • Staffing still an issue on the ward, late cancellations and last minutes notices are hectic to deal with at times. Also wards should have at least 2 qualified staff per each shift	
Q25	Is there anything that wasn't covered that you would like to include? • This was focussed solely on ward staff and didn't account for members of the MDT. • Really excited about the recent refurbishments that will improve patient and staff experience. • The forensic community services which is part of the secure services and it would be good to see how staff prepared service users for discharge and the support they receive prior to and after discharge back into the community. • Yeah how we feel about the pay. • Staffing - sometimes very hard when working with some bank /agency staff who don't know patients don't want to do security - everything seems to be left on permanent staff. • Staffing numbers should be increased especially during the night shifts. Escorted leaves should be communicated on time and extra staff booked early to cover for that.	

Appendix 6: Glossary

AMPs	Approved Mental Health Professionals
BAME	Black and Minority Ethnic
BSI	British Standards Institute
CAMHS	Child and Adolescent Mental Health Services
CCQI	College Centre for Quality Improvement
CCTV	Closed-Circuit Television
CPA	Care Programme Approach
CPD	Continued Professional Development
CPN	Community Psychiatric Nurse
CQUIN	Commissioning for Quality and Innovation
CRGs	Clinical Reference Groups
CQC	Care Quality Commission
DH	Department of Health
FOLS	Forensic Outreach and Liaison Services
LSU	Low Secure Units
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team
MSU	Medium Secure Unit
NCM	New Care Model
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OT	Occupational Therapy
PDP	Personal Development Plans
PIPEs	Psychologically Informed Planned Environments
PSD	Physical Security Document
PSID	Procedural Security Index Document
QIPP	Quality Innovation Productivity Prevention
QNFMHS	Quality Network for Forensic Mental Health Services
SaLT	Speech and Language Therapist
STA	See Think Act
RCPSYCH	Royal College of Psychiatrists

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

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FORENSIC

The Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

www.rcpsych.ac.uk/qnfmhs
forensics@rcpsych.ac.uk

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

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