

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No:</b>	170041S
<b>Service</b>	Adult Low Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS).
<b>Commissioner Lead</b>	<i>For local completion</i>
<b>Provider Lead</b>	<i>For local completion</i>

#### 1. Scope

**1.1** This specification covers the provision of low secure inpatient services for adults.

#### **1.2 Description**

1.2.1 This service specification describes low secure inpatient services for adults (male and female) to be delivered within a clearly defined geographical area at multi-regional, regional and/or sub-regional level with service configuration determined locally based on population needs and existing service provision. This specification will be subject to review 3 years after publication.

#### **1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners**

1.3.1 NHS England commissions adult secure mental health services and associated non-admitted care including Access Assessment and Forensic Outreach and Liaison Services (FOLS) for those detained under the Mental Health Act.

1.3.2 Clinical Commissioning Groups (CCGs) commission services for patients on the secure pathway who do not or no longer require High, Medium or Low secure care or FOLS.

## 2. Care Pathway and Clinical Dependencies

### 2.1 Care Pathway

2.1.1 Secure services provide treatment for adults aged 18 and over with mental disorders, these include mental illness (MI), personality disorder (PD) and neurodevelopmental disorders (NDD) including learning disabilities (LD) and autism (ASD). Further detail on the care pathway and service expectations is set out in Appendix 1.

2.1.2 Secure services also provide care and treatment for people who are

- culturally deaf (D) and audiotologically deaf (deaf)
- have acquired brain injury

2.1.3 Patients are liable to be detained under the Mental Health Act and their risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings

2.1.4 Patients typically have complex chronic mental disorders, which are linked to offending or seriously harmful behaviour. Some will be involved with the criminal justice system (CJS), courts and prison, and may have Ministry of Justice (MoJ) restrictions imposed.

2.1.5 Three levels of security currently exist across secure adult inpatient services each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the patient and others including patients, staff and the general public.

- High Secure services provide care and treatment to those adults who present a **grave and immediate risk to the public** and who should not be able to escape from hospital
- Medium secure services provide care and treatment to those adults who present a **serious** risk of harm to others and whose escape from hospital should be prevented
- Low secure services provide care and treatment who present a **significant** risk of harm to others and whose escape from hospital should be impeded

2.1.6 This service specification relates to adult low secure services and includes Access Assessment (Appendix 2) and Forensic Outreach and Liaison Services (FOLS Appendix 3).

2.1.7 Recognised pathways into low secure services include:

- Stepping down from high/medium secure care
- Admission directly from the community
- Admission from acute adult inpatient services
- Admissions from secure child and adolescent mental health services

(CAMHS) as part of the patient's transition to adult services.

2.1.8 There are distinct groups of patients within low secure services:

- Those requiring forensic low secure admission and will generally have been transferred directly from prison or court or have been charged with an offence whilst in the community or another hospital inpatient setting
- Those requiring forensic low secure rehabilitation and who will generally have been transferred from medium secure inpatient services, will have been convicted of a serious offence and be subject to a hospital order (often with restrictions) or have been transferred from prison

2.1.9 The pathway through and out of secure care should be identified early in admission though may be subject to change depending on changing needs or circumstances. The care pathway will be planned in consultation with the patient.

## **2.2 Forensic Outreach and Liaison Services (FOLS)**

2.2.1 FOLS are an important and efficient component of the safe pathway from medium and low secure care into the community. The service manages and facilitates the transition of high risk patients with mental disorders through secure services into the community.

2.2.2 Transition from secure services to the community is recognised as a particularly difficult time. FOLS provide ongoing mental health assessment, formulation and treatment to promote recovery and manage risk.

2.2.3 The specification for FOLS is set out in Appendix 3.

## **2.3 Interdependence with other services**

2.3.1 Low secure services are part of a spectrum of services whose function is to meet the needs of those with mental disorders and/or neurodevelopmental disorders that will benefit from specialist care and treatment within a secure environment. This includes those convicted of terrorist offences or are connected with terrorist activity.

2.3.2 Key partnerships include:

- NHS England
- High secure and low secure services
- NHS / Independent / Third Sector providers
- Local mental health services (including PICUs and community mental health services)
- Advocacy Services
- Carer Support Services
- Department of Health (DH)

- Ministry of Justice (MoJ)
- Courts
- Police
- Her Majesty's Prison and Probation Service (HMPPS)
- Multi Agency Public Protection Arrangements (MAPPA)
- Health and Justice commissioned offender health services
- Offender Personality Disorder Services
- Social Care Agencies
- Care Quality Commission
- Appropriate Regulators
- Housing associations and other accommodation agencies

In order to ensure, where clinically indicated, that patient who have been convicted of terrorist offences or connected with terrorist activity have appropriate access to adult secure inpatient services, providers must work closely with all relevant partner agencies to share information at key stages of the pathway to ensure public protection is always a consideration.

These partners may vary based on each individual situation but, in addition to those noted above, can include:

- HMPPS
- MHCS
- Courts
- JEXU
- PREVENT
- MAPPA
- HO
- Tribunals
- Parole Boards

2.3.3 The service must have Caldecott and information governance compliant protocols and structures in place to enable the appropriate sharing of clinical information with other agencies

2.3.4 Low secure services must provide training and education programmes and should participate in research/development activity which promotes the continual improvement of the service and outcomes for patients.

2.3.5 In addition they must ensure that the patients in their service have equal access with non-secure service users to participate in research activity. The service will ensure that all staff are able to participate in these activities without affecting care and treatment or business continuity.

2.3.6 There must be a well-managed interface with child and adolescent mental health services (CAMHS), in particular CAMHS forensic mental health inpatient services, to ensure smooth transition to adult services where indicated.

### **3. Population Covered and Population Needs**

#### **3.1 Population Covered By This Specification**

- 3.1.1 This service specification relates to adults who are the commissioning responsibility of NHS England and ordinarily resident in England.

#### **3.2 Population Needs**

- 3.2.1 Assessing the incidence and prevalence of adult mental disorders likely to require secure care is challenging. There are a number of factors relating to a) the population prevalence of mental disorders that require detention in hospital and b) the level of risk to the public from people with these mental disorders, which make non-secure hospital care unsafe. A comprehensive mental health service review has been undertaken in 2016-17 across England to determine the population need for secure care. This complements the Transforming Care Programme for learning disability services and autistic spectrum disorder services.
- 3.2.2 The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 reported that one in three adults aged 16-74 (37%) with conditions such as anxiety or depression, surveyed in England, were accessing mental health treatment, in 2014. This figure has increased from one in four (24%) since the last survey was carried out in 2007. Overall, around one in six adults (17%) surveyed in England met the criteria for a common mental disorder (CMD) in 2014. Women were more likely than men to have reported CMD symptoms. One in five women (19%) had reported CMD symptoms, compared with one in eight men (12%). Women were also more likely than men to report severe symptoms of CMD; 10% of women surveyed reported severe symptoms compared to 6% of men.
- 3.2.3 In terms of the Mental Health Act (1983), the CQC report monitoring use of the Mental Health Act in 2015-16 showed detention rates have continued to rise in recent years and 2014-15 saw the highest ever year-on-year rise (10%) to 58,400 detentions.

#### **3.3 Expected Significant Future Demographic Changes**

- 3.3.1 The Mental Health Service Review has estimated future demographic changes. Whilst there is some evidence from NHS Benchmarking data in 2016-17 that some patients could be supported in the community rather than a secure hospital, the community services are often not in place. The Five Year Forward View secure care programme has a strategy to develop new specialist community forensic services to optimise hospital bed use. This may reduce bed numbers overall. However, the rising demand from prisons, especially for adult secure care means that in 2016 the annual audits reported circa 100 prisoners were waiting for transfer to an adult secure hospital.

### **3.4 Evidence Base**

- 3.4.1 There are no randomised controlled trials comparing secure care with non-secure care. The criminal justice system, through the courts and prison services have within the Mental Health Act (1983) a legal framework to ensure people with a mental disorder who are a risk to the public receive evidenced based care for their mental health condition within an environment that has the level of security equivalent to a prison. Secure services primarily offer the same treatments as in the rest of mental health services but in a secure setting.
- 3.4.2 There are studies that follow-up patient discharged from secure hospitals which show reduced reoffending (e.g. Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis Seena Fazel, Zuzanna Fimińska, Christopher Cocks, Jeremy Coid The British Journal of Psychiatry Jan 2016, 208 (1) 17-25; DOI: 10.1192/bjp.bp.114.149997. This showed some evidence that patients discharged from secure services have lower offending outcomes than many comparative groups. Services could consider improving interventions aimed at reducing premature mortality, particularly suicide, in discharged patients.

## **4. Outcomes and Applicable Quality Standards**

### **4.1 Quality Statement – Aim of Service**

- 4.1.1 Low secure services provide a model of integrated services incorporating all elements of the service pathway and aim to deliver effective, timely, therapeutic recovery-focussed services for patients with a mental disorder assessed as presenting a significant risk of harm to others.
- 4.1.2 The expected outcomes of the service support the national ambition set out in the Five Year Forward View and Building the Right Support to reduce lengths of stay, ensure admission to hospital only takes place when absolutely necessary, reduce variation in service access and availability and improve the experience of patients, their families and carers using mental health services.
- 4.1.3 All low secure services must be recovery-orientated and outcome-focused.
- 4.1.4 The core objectives are to:
- Assess, formulate and treat mental disorders including neurodevelopmental disorders such as learning disability and autism
  - Reduce the risk of harm to self and others
  - Provide individualised care that meets needs of and includes the patient and family and carers in decision-making
  - Provide a time-limited intervention that supports recovery and enables a

safe transition through the care pathway

- Provide all patients with a full multi-disciplinary assessment including assessment of risk and formulation resulting in a care plan developed in collaboration with them and reflective of their wishes and aspirations
- Achieve delivery of efficient and seamless transfers of patients between care settings
- Use the Care Programme Approach to underpin service delivery
- Proactively manage violence and aggression
- Provide a range of meaningful activities and therapeutic programmes
- Deliver care within a therapeutic regime that places primary importance on behavioural approaches, de-escalation and psychopharmacological treatment of mental illness and agitated behaviour in the context of mental disorder

#### 4.2 NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

#### 4.3 Indicators Include:

No.	Indicator	Data source	Domain(s)	CQC Key Question
<b>Clinical Outcomes</b>				
101	% of eligible adult medium and low secure service staff who received clinical supervision at least monthly from a forensic clinician.	SSQD	5	safe, effective
102	% of staff who have received annual safeguarding vulnerable adults training.	SSQD	5	safe, effective
103	Number of episodes of physical restraint.	Provider	1, 5	safe, effective.

	including use of rapid tranquillisation, per occupied bed days			caring
104	% of self-harm incidents per occupied bed days	Provider	1, 3	safe, effective, caring
105	% patients with improved HoNOS score on discharge	Provider	3, 4	safe, effective, caring
106	Risk Reduction - Average length of time to first escorted community leave	Provider	3, 4, 5	safe, effective, caring
107	Risk Reduction - Average length of time to first unescorted community leave	Provider	3, 4, 5	safe, effective, caring
108	Risk Reduction - Average length of Stay measured in occupied bed days for people who are discharged in the quarter.	Provider	3, 4, 5	safe, effective, caring
109	% patients discharged from hospital to a community forensic/outreach team	Provider	2, 3, 4, 5	safe, effective, caring
110	% of delayed discharges due to the shortage of accommodation in the community	Provider	2, 4, 5	safe, effective, caring, responsive
111	% of urgent Access Assessments undertaken and delivered within the timescales as detailed within the service specification.	Provider	2, 4, 5	safe, effective, caring, responsive
112	% of non-urgent Access Assessments undertaken and delivered within the timescales as detailed within the service specification.	Provider	2, 4, 5	safe, effective, caring, responsive
113	Physical Health Improvement - % patients with a comprehensive primary care service including GP registration and health clinics	Provider	3, 4	Effective, caring
114	Physical Health Improvement - % patients registered with dentist	Provider	3, 4	Effective, caring
115	Physical Health Improvement - % patients receiving annual physical health check	Provider	1, 2, 3, 4	Safe, effective, caring
116	Physical Health Improvement - %	Provider	1, 2, 3, 4	Safe, effective.



	patients with physical healthcare improvement plan			caring
<b>Patient Outcomes</b>				
201	% of completed patient satisfaction surveys	SSQD	4	effective, caring
202	% patients with a completed PREOM using PREOM Tool reporting an overall improvement in their experience	Provider	4	effective, caring
<b>Structure &amp; Process</b>				
301	There is a multi-disciplinary team in place as detailed in the service specification.	Self-declaration	1, 2, 3, 4, 5	safe, effective, caring, responsive, well-led
302	All patients have individualised care plans.	Self-declaration	1, 2, 3, 4, 5	safe, effective, caring, responsive
303	CPA meetings are held within the first three months of admission and then every six months.	Self-declaration	1, 2, 3, 4	safe, effective, caring, responsive
304	All patients have estimated date of discharge within 4 weeks of admission	Self-declaration	1,2,3,4	safe, effective, caring, responsive
305	The medium and low secure unit adheres to the standards of the Royal College of Psychiatry Quality Network Standards for Forensic Care (CCQI) and other clinical guidelines within the service specification.	Self-declaration	1, 2, 3, 4, 5	safe, effective, caring
306	Where clinical supervision for adult medium and low secure service staff is undertaken, supervision actions are recorded and regular audits of activity are undertaken.	Self-declaration	5	safe, effective

Detailed definitions of indicators setting out how they will be measured are included in schedule 6.

4.3.1 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.3.2 Applicable CQUIN goals are set out in Schedule 4D

## 5. Applicable Service Standards

### 5.1 Applicable Obligatory National Standards

- 5.1.1 Robust procedures relating to the responsibilities of services and staff under the Mental Health Act and other relevant legislation must be put in place and regularly reviewed.
- 5.1.2 The service must deliver services, comply to and work within the requirements of
- Royal College of Psychiatrists Quality Network Standards for Forensic Care CCQI [www.qnfmhs.co.uk](http://www.qnfmhs.co.uk) Providers must be members of the Quality Network and participate in the peer review process
  - Mental Health Act 1983 and Code of Practice 2015  
[www.gov.uk/government/publications/code-of-practice-mental-health-act-1983](http://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983)  
[www.legislation.gov.uk/ukpga/2007/12/contents](http://www.legislation.gov.uk/ukpga/2007/12/contents)
  - Mental Capacity Act 2005 and Code of Practice 2007 and supplement to the Code on the Deprivation of Liberty Safeguards 2007  
[www.gov.uk/government/publications/mental-capacity-act-code-of-practice](http://www.gov.uk/government/publications/mental-capacity-act-code-of-practice)  
[www.legislation.gov.uk/ukpga/2005/9/contents](http://www.legislation.gov.uk/ukpga/2005/9/contents)
  - Criminal Justice Act 2003 [www.legislation.gov.uk/ukpga/2003/44/contents](http://www.legislation.gov.uk/ukpga/2003/44/contents)
  - The Good Practice Guide. The Transfer and Remission of Adult Prisoners under s47 and s48 of the Mental Health Act (DH 2011)
- 5.1.3 Services must ensure compliance against the Care Quality Commission's (CQC) "Essential Standards of Quality and Safety" (2010) [www.cqc.org.uk](http://www.cqc.org.uk) with respect to maintaining safety and in the management of emergencies. This must include
- Provision of appropriately trained staff
  - Availability of appropriate staffing capacity
  - Robust on call arrangements,
  - Easy access to emergency medical equipment
  - Facilitation of rapid access for emergency services into the unit.
- 5.1.4 All staff involved in administering or prescribing rapid tranquilisation, or monitoring patients to whom parenteral rapid tranquilisation has been administered, must receive on-going competency training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) covering airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators. The policy for Rapid Tranquilisation must be easily accessible to all staff.
- 5.1.5 NICE Guidance for the treatment of the following must be adhered to:

- CG136 Service User Experience in Adult MH Services
- CG82 Schizophrenia
- CG38 Bipolar disorder
- CG90 Depression in adults
- CG120 Psychosis with coexisting substance misuse
- CG77 Antisocial personality disorder
- CG78 Borderline personality disorder
- CG51 Drug misuse: psychosocial interventions
- CG25 Violence (short-term management)
- CG133 Self-harm (longer term management)
- CG142 Autism in adults

## **5.2 Other Applicable National Standards to be met by Commissioned Providers**

- 5.2.1 Robust procedures relating to the responsibilities of provider organisations, services and clinicians under the Mental Health Act 1983 must be put in place and regularly reviewed.
- 5.2.2 Any medical treatment provided to patients must comply with Part 4 of the MHA and, where relevant, the Mental Capacity Act 2005 and the common law.
- 5.2.3 Services must comply with the requirement to liaise with the bodies responsible for providing after-care services to patients under section 117 of the MHA.
- 5.2.4 Low secure services must operate within an ethos that places the patient at the centre of their care and facilitates active engagement in their recovery from mental health difficulties and risk behaviours.
- 5.2.5 Providers must promote equality of access, experience and outcomes across ethnic groups, faiths, gender, disabilities, sexual orientation and socio-economic status.
- 5.2.6 Due to the nature of secure services, it may be necessary for certain blanket restrictions as described in the MHA Code of Practice to apply in order to maintain the overall security of the service and to manage high levels of risk to other patients, staff and members of the public.
- All blanket restrictions must be a necessary and proportionate response to risk, and must be authorised and monitored through the provider organisation's operational and governance procedures.
  - All blanket restrictions must be recorded in writing and be subject to review and evidence consideration of the impact of that restriction on each patient.
- 5.2.7 CPA meetings must be held within the first three months of admission and then every six months.

5.2.8 All patients must have an estimated date of discharge identified within 4 weeks of admission to the service. The estimated date should be reviewed as often as is required but specifically at CPA and CTR reviews.

5.2.9 Care and Treatment Reviews must be held in accordance with national policy which can be accessed via the link <https://www.england.nhs.uk/publication/care-and-treatment-reviews-policy-and-guidance/>

5.2.10 Joint working protocol/care pathway with primary healthcare providers and with specialist and emergency health teams must be developed and followed.

5.2.11 Services must provide social work services in line with national standards.

### **5.3 Other Applicable Local Standards**

Not applicable

## **6. Designated Providers (if applicable)**

Not applicable

## **7. Abbreviation and Acronyms Explained**

The following abbreviations and acronyms have been used in this document:

ABI - Acquired Brain Injury  
CAMHS – Child and Adolescent Mental Health Services  
CCGs – Clinical Commissioning Groups  
CJS – Criminal Justice System  
CMD – Common Mental Disorders  
CQC – Care Quality Commission  
CPA – Care Programme Approach  
CTO – Community Treatment Order  
CTR – Care and Treatment Review  
DH – Department of Health  
FOLS – Forensic Outreach and Liaison Service  
GIC – Gender Identity Clinic  
HMPPS – Her Majesty’s Prison and Probation Service  
IMHA – Independent Mental Health Advocacy  
IRC – Immigration Removal Centres  
LD – Learning Disability  
MI – Mental Illness  
MDT – Multidisciplinary Team  
MAPPA – Multi Agency Public Protection Arrangements  
MHA – Mental Health Act  
NDD – Neurodevelopmental Disorder  
NOMS – National Offender Management Service  
PD – Personality Disorder

PBS – Positive Behavioural Support  
PICU – Psychiatric Intensive Care Unit  
RC – Responsible Clinician

## **Appendix 1**

### **Adult Low Secure Service Specification**

#### **1. Introduction**

- 1.1 Low secure services provide care for those who pose a significant risk to others and require physical security that impedes escape from hospital. Some will have been in contact with the CJS and will have either been charged with or convicted of a criminal offence.
- 1.2 All patients admitted to low secure inpatient services will be detained under the MHA 1983 and the decision to admit will have been based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed whilst in hospital.
- 1.3 The core objectives for secure services are to assess and treat mental disorder, reduce the risk of harm that the patient exhibits to others and to support recovery and rehabilitation.
- 1.4 The expected service outcomes support the national ambition set out in The Five Year Forward View and Building The Right Support to reduce lengths of stay, variation in service availability and access and improve the experience of patient, their families and carers using mental health services.

#### **2. Service Model**

- 2.1 Secure services provide a comprehensive range of evidence-based care and treatment provided by practitioners, expert in the field of forensic mental health. A range of specialist treatment programmes must be available, delivered either individually or within groups. The aim is for the patient to safely return to the community, to a lower level of security, to prison, to IRC or to transfer out of secure services.
- 2.2 The maintenance of security is crucial to the provision of effective therapeutic interventions in secure services. A key principle underpinning the provision of secure services is that the patient must be managed in the least restrictive environment possible in order to facilitate their safe recovery. Least restrictive refers to the therapeutic use of the minimum levels of physical, procedural and relational measures necessary to provide a safe and recovery focused environment.
- 2.3 Wherever possible patients admitted to secure inpatient care must be placed as close to home as possible. Decisions regards placements in secure inpatient services need to take into consideration victim issues, geographical exclusion zones, patient and family/carer choice (where appropriate) and also access to more specialist services that are provided across larger geographical footprints such as secure deaf services and secure ABI services.

- 2.4 Placement within different levels of the secure pathway is determined by the level of risk of harm to others presented by the patient concerned. Progress and transition along the pathway must be determined by the reduction in assessed risk of harm to others, and a reduction in the need for care and supervision.
- 2.5 Patients must be treated and managed within a whole care pathway approach and services must work collaboratively with each other in order to ensure that the admission and any transfer within the secure care pathway is achieved seamlessly and efficiently. Transition between services must be kept to a minimum in order to provide effective continuity of care.
- 2.6 Low secure services provide care and treatment to a variety of patients. The predominant need for low secure management is related to the patient's assessed risk of harm to others in the context of mental disorder.
- 2.7 Multidisciplinary Team (MDT) working and the Care Programme Approach (CPA) must underpin service delivery. The MDT must include appropriately trained and supervised staff including psychiatrists, clinical and forensic psychologists, mental health nursing staff, occupational therapists and social workers supported by other therapists including for example, art therapists and speech and language therapists.
- 2.8 Low secure services are at interface of secure services and care in the community. Care is provided by multidisciplinary teams (MDT) which must be experienced in both forensic and rehabilitation psychiatry. A range of specialist treatment programmes delivered either individually or within groups must be available. The aim is for the individual to safely return to the community, prison, IRC or transfer out of secure services and benefit from an improvement in quality of life.

### **3. Care Pathway**

- 3.1 The care pathway must be planned in consultation with the patient, their family and carers (where appropriate) and describes the patient's anticipated transition into, through and out of secure care. The indicators and criteria used for assessing progress and transition along the pathway include:
- Nature and degree of mental disorder and its relationship to risk
  - Level of risk to others
  - Level of care and supervision required
  - Need for input from specialist services or staff
  - Need for offence/risk behaviour related therapy
  - Level of engagement with treatment/care plan
  - Level of engagement in structured and meaningful activities
  - Level of misuse of drugs or alcohol

### **3.2 Acceptance Criteria**

3.2.1 The acceptance criteria for admission to low secure services include:

- Presence of a mental disorder which is of a nature and/or degree warranting detention in hospital for medical treatment under the Mental Health Act
- Patients predominantly present a significant risk of harm to others and to manage this risk requires specialist risk management procedures and specialist treatment interventions
- Prisoners suitable for transfer to low secure inpatient care will generally be charged with, or have been convicted of, a specified violent or sexual offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence, such as arson
- Patients may be accepted without criminal charges pending, where there is clear evidence of a significant risk to others in the context of mental disorder. There will generally be a pattern of assaults and escalating threats
- Potential to benefit from the treatment/assessment provided or to prevent deterioration
- The patient is not safely managed in a non-secure environment
- Patient may present a risk of escape
- Patients with a mental disorder directed to conditions of low security by the (MoJ).

### **3.3 Exclusion Criteria**

- Patients who present a grave and immediate risk or serious risk to the general public and must be managed in high or medium security
- Patients who present with disturbed or challenging behaviours during episodes of mental disorder that are likely to be relatively brief. These patients are more appropriately cared for in local generic mental health provision including adult Psychiatric Intensive Care Units (PICU)
- Where the predominant risk is of self-harm and there is no significant risk of harm to others. An exception to this might be for individuals serving long prison sentences for non-violent or non-sexual offences who, because of the risk of escape or as a result of MoJ direction, cannot be transferred to a non-secure environment.

### **3.4 Referral and Assessment**

3.4.1 Access to secure care is determined by an assessment conducted by the Access Assessment Service (see Appendix 2).

### **3.5 Pre-admission**

3.5.1 The pre-admission phase is crucial to orientate the patient, their family and carers (where appropriate) to secure care and includes:

- Introduction to key service staff and other patients
- Visits to the admitting service as appropriate and may include use of digital technology where direct visits are not possible /appropriate



- Provision of information about the admitting service in the form of a Welcome Pack
- Multi-disciplinary formulation of mental health difficulties and risk behaviours identifying treatment goals and interventions required during admission
- Identification of the discharge or transition pathway
- The admission assessment must include:
  - Physical examination and routine investigations
  - Identification of and management plan for physical health conditions

### **3.6 Admission Care and Treatment**

3.6.1 The service must provide evidenced-based specialist assessment, care and treatment for mental disorder including:

- Reduction and/or management of risk, specifically risk of harm to others through the provision of specialist offence-related treatment programmes delivered individually or in groups that address offending and risk behaviours
- On-going risk assessment and proactive risk management strategies
- Appropriate use of escorted and unescorted community leave
- Assessment of fitness to plead/stand trial and provision of advice to courts regarding psychiatric disposal options
- Individualised care and treatment provided in the least restrictive environment
- Development of a recovery and outcomes focussed care and treatment plan within the Care Programme Approach (CPA) reflecting an evidence-based whole care pathway approach that includes transition and engagement with the next service along the pathway
- Access to social, educational, occupational and vocational opportunities that are:
  - meaningful for the patient,
  - reflect the point the patient has reached in the treatment pathway,
  - support rehabilitation and recovery
  - available during the day and evening 7-days per week.
- Establishing the level of support and information required by family and carers (as appropriate) to enable effective engagement
- Full cooperation with the First Tier Tribunal system to ensure timely review of authority for detention of patients
- For patients with additional restrictions, secure services must ensure compliance with the Ministry of Justice (MoJ) requirements and directions.

3.6.2 The service must ensure the patient's physical health care needs are assessed and met through

- the provision of a full range of primary health care interventions including health promotion and physical health screening, ensuring that these are integrated into one patient record
- the effective facilitation of patient's access to secondary physical health care services and treatment where required including the appropriate provision of escorts

### **3.7 Discharge and Transition**

- 3.7.1 Consideration of discharge or transition should start at the point of assessment and an estimated discharge date should be agreed within 4 weeks of admission. Discussions about discharge must include being explicit about the possibility of remission to prison where the patient is a transferred prisoner or return to an Immigration Removal Centre if detained under the Immigration Act.
- 3.7.2 The discharge, transfer or remission must be underpinned by an assertive management approach to ensure that transition to the another secure service, discharge to community, generic mental health services or remission to prison/IRC is carried out in a timely manner.
- 3.7.3 Discharge planning must include as appropriate effective and early liaison with local Forensic Outreach and Liaison Services (FOLS), and other local area mental health and other relevant services including locally commissioned Community Forensic Teams, Community Mental Health and Community learning Disability Teams.
- 3.7.4 A discharge care plan reflecting evidence based whole care pathway approach focusing on transition and engagement with the next service along the pathway must be developed.
- 3.7.5 Wherever possible continuity must be maintained to ensure timely progress through the pathway avoiding unnecessary delays, especially where patients have to repeat assessments or treatments in new settings. This must be avoided.
- 3.7.6 For patients being discharged directly to the community from low security, a comprehensive care plan reflecting a whole person approach to recovery and rehabilitation into the community based on risk assessment and proactive risk management strategies must be agreed.
- 3.7.7 For patients being discharged back to prison or IRC, effective handover to mental health services in prison or IRC, including an end of treatment report, and an updated multi-disciplinary formulation must be provided. Services are expected to actively liaise with the Her Majesty's Prison and Probation Service (HMPPS) and the MoJ in line with the requirements of the national guidance on remission.
- 3.7.8 On occasion transfer is required to a medium secure setting from low secure services. This should be managed through close working with the respective medium secure service.
- 3.7.9 Services must adhere to the requirement to liaise with the bodies responsible for providing after-care services to patients under section 117 of the MHA.

### **3.8 Leave**

- 3.8.1 Well-planned task-orientated leave of absence has an important part to play in rehabilitation and recovery by providing a means for assessment of risk and progress; the development of social, interpersonal and practical skills; providing access to resource promoting physical and mental wellbeing, and supporting community reintegration.
- 3.8.2 Granting of leave, escorted or unescorted, must follow effective risk assessment which must include assessment of risk of absconding and risk of harm to the public while the patient is on leave or should they abscond, and respect the feelings and fears of those who may have been affected by the patient's past actions.
- 3.8.3 Where relevant, leave must be planned taking into account victim support services and Multi Agency Public Protection Arrangements (MAPPA). The care plan must indicate the expected provision of staff resources and non-staff resources required to safely and appropriately minimise any risks during leave and set out clearly a Contingency Management Plan in case of untoward events. Services must comply with the relevant legislation when authorising and granting leave.
- 3.8.4 The care plan should also include how the planned leave supports the patient's recovery. When leave is escorted, the patient must remain in the care of staff with the necessary training and competence to convey and restrain the patient if required.
- 3.8.5 Physical and/or mechanical restraints may be required for the protection of the public and staff and must be used in accordance with the guidance provided in the MHA Code of Practice.
- 3.8.6 Overnight leave may be appropriate close to transition from the low secure service. Unless there are clear clinical or risk reasons trial leave is not usually be necessary as the step down and transition services will be engaged early in the patient's pathway.

### **3.9 Recovery Focused Care**

- 3.9.1 Low secure services must adopt a recovery-based approach to ensure patients in secure care drive their own outcomes and work collaboratively with staff.
- 3.9.2 In keeping with the recovery approach, patients must be encouraged to take as much responsibility as possible for their own wellbeing and progress.
- 3.9.3 Low secure services must encourage patients to be meaningfully involved in all decisions about themselves. This includes being fully involved with MDT meetings, CPA review and CTR meetings, risk assessment processes and other meetings relating to their care and treatment.

3.9.4 All information about the service, treatment and care plans must be in a format that patients can access and understand taking into account individual communication needs.

### **3.10 Observations**

3.10.1 Enhanced observations should only be considered within a framework of support and engagement with patients and staff to minimise risks and prevent the need for prolonged enhanced observation.

3.10.2 The need for enhanced observations must be regularly reviewed and be reduced to the minimum level necessary at the earliest opportunity while maintaining safety in line with Code of Practice requirements.

3.10.3 This must be assured through a policy on observation and engagement, and the maintenance of environmental, procedural and relational safety to uphold dignity, respect and care for the patient and reflect their immediate needs and the needs of others.

### **3.11 Patient Involvement**

3.11.1 Secure services must have a patient involvement strategy and system to enable patients to actively participate decision-making at all levels of the organisation.

3.11.2 The strategy must identify and facilitate patients' representation at and involvement in provider governance structures, policy-making and service development processes.

3.11.3 Services must facilitate and encourage the active, meaningful participation of patients in the planning and delivery of their care and treatment.

### **3.12 Families and Carers: engagement and involvement**

3.12.1 Secure services must have a carer engagement and involvement strategy and a system with protocols to support families and carers to be involved as appropriate in the patients care, treatment and recovery pathway plans. This must be subject to agreement with the patient concerned.

3.12.2 The strategy must define how the needs of families and carers will be addressed and supported by the service.

3.12.3 A key objective of the strategy is to ensure that the maintenance of carer and family relationships is a priority and recognised as a key outcome area.

3.12.4 Services should ensure the following:

- Carers are identified and supported
- That staff are carer aware

- Policies and practice protocols for the sharing of information with carers are in place
- There are identified service staff who take responsibility for carer policies
- Information is readily available for carers including care pathway information and signposting to further information resources
- A range of carer support services are available

### 3.13 Advocacy

3.13.1 An independent Advocacy service including IMHA must be provided for patients in the service and commissioned independently to ensure patients' rights are safeguarded.

3.13.2 Advocacy services must work towards the self-advocacy model and will support patients as necessary and specifically at review CPA and CTR meetings and at transition planning.

### 3.14 Interdependence with other services

3.14.1 In support of the care pathway, secure services must provide advice to referrers or other interested parties on the management of patients as appropriate.

3.14.2 Secure services will establish close working relationships with other services which form part of the patient's care pathway to support and facilitate a move to a less restrictive environment as soon as possible.

## 4. Addressing the needs of specific patient groups

4.1 Low secure services are for adults with mental disorder who present a significant risk to others. There may be instances where individuals require care and treatment in a more specialist service, the specific requirements for these specialist services are set out below.

### 4.2 Patients who are culturally deaf (D) and audiotologically deaf (deaf)

4.2.1 Low secure services must ensure that for D/deaf patients the necessary hearing and communication aids are available for the assessment process.

4.2.2 At the initial assessment a brief communication assessment must be completed by specialised deaf service staff.

4.2.3 Following admission a formal communication assessment must be undertaken by the Speech and Language Therapist and Deaf Support Worker (preferably including a digital recording of the patient) unless already available. This should include a detailed audiometry assessment.

4.2.4 In some cases admission to a specific low secure deaf service will be required.

### **4.3 Patients with Neurodevelopmental Disorders (NDD) including Learning Disability and Autistic Spectrum Disorder (ASD)**

- 4.3.1 NDD present as a spectrum with mild to severe impact on functioning and encompass learning disabilities, pervasive developmental disorders, childhood acquired brain injury and developmental communication disorders.
- 4.3.2 All low secure services must be able to support patients at the mild end of the spectrum in the treatment of their mental disorder and/or personality disorder with only minor adjustments to the care provided making use of advice and expertise provided by more specialist services as and when required.
- 4.3.3 Low secure learning disability services must provide:
- screening for NDD
  - a clear pathway for formal diagnosis delivered in partnership with specialist NDD services
  - access to independent advocacy and external support networks for with experience of managing NDD
- 4.3.4 When such adjustments are insufficient to enable participation in treatment or when the view of specialist NDD services is that treatment is needed for the impact of the NDD itself then treatment may be required in a specialist secure NDD service.
- 4.3.5 Care pathways for patients with NDD might include periods in a specialist low secure service and periods in a more mainstream secure service. This is likely to be a particular consideration at points of transfer between levels of security, or out of hospital into community provision. Where people with NDDs are treated in mainstream secure services, staff should have sufficient skills to meet their communication and treatment needs.
- 4.3.6 Care and Treatment Reviews (CTR) have been developed as part of NHS England's commitment to transforming the services for people with learning disabilities and/ or autism who display behaviour that challenges. All low secure services must support commissioners to host CTRs for patients with a LD and/or Autism. This will be in addition to the CPA process. Guidance can be found using the following link [www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf](http://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf)
- 4.3.7 Services must ensure that people with LD and autism have access to physical healthcare services with professionals able to meet the particular needs of people with NDD, taking account of the recommendations of the Confidential Enquiry Into the Premature Deaths of People With LD. Services are expected to participate in national programmes to monitor unexpected adverse health outcomes for their patients.
- 4.3.8 Although LD may be considered a mental disorder in its own right, typically people with a LD who require low secure care do so due to the presence of

another mental disorder, and in particular PD and/or mental illness. The primary reason for treatment in low secure care is likely be to treat those comorbid disorders which are amenable to treatment, and where treatment of those disorders is likely to reduce the risk of harm to others.

- 4.3.9 Placement of patients with LD is not defined on the basis of global IQ score but on the basis of treatment need. People with very mild or borderline intellectual impairment and/or social functioning may be appropriately placed in a mainstream low secure service.
- 4.3.10 Those with significant intellectual disability or whose presentations are significantly complicated due to the presence of LD may require adapted environments or treatment programmes are better placed in specialist low secure LD services.
- 4.3.11 Patients with more severe intellectual impairment, who are unable to access even highly adapted treatment programmes, or whose risk to others relates primarily to challenging behaviour, will not be appropriately placed in a low secure service.
- 4.3.12 The environment in a specialist LD low secure service must be designed to include appropriate space, adapted signage, decoration, lighting, and access to sensory areas. Patients must have access to adapted information that takes account of their individual sensory and communication needs.
- 4.3.13 Specialist LD low secure services must have a clinical team with skills and competence in working with patients people with LD. There should generally be a higher staff to patient ratio compared to mainstream low secure services. The MDT must include appropriately trained:
- psychiatrists,
  - psychologists
  - occupational therapists
  - speech and language therapists
  - dysphagia specialists
  - sensory integration trained therapists
  - registered learning disability nurses
  - registered mental health nurses
- 4.3.14 Clinical and service pathways must take into account the patient's LD in providing treatment for any offending behaviour and allow maximum participation of the patient in their own care pathway.
- 4.3.15 An adapted care pathway must be provided, including specialist-led access assessment, routine sensory integration, communication, intellectual and adaptive function assessments, and routine diagnostic assessment for co-morbid conditions including mental illness, personality disorder and autism.
- 4.3.16 Positive Behavioural Support (PBS) should be used to understand functional behaviour and arousal cycles to minimise their impact.

4.3.17 Adapted treatment programmes, including group and individual psychological therapies, must be available to address the underlying disorder(s) that contribute to offending and aid rehabilitation. In addition, programmes will be available which support the development of life skills to allow patients to live as independently as possible in the community.

4.3.18 There must be access to teaching professionals providing specialist education within the service. The staff team must be involved in the formulation of need, and training of receiving units/teams and/or community placements.

4.3.19 Low secure ASD services are suitable for patients:

- whose autism has a significant impact on the expression of co-morbid mental disorders and social functioning which is related to a pattern of harmful behaviour requiring treatment
- where specific adaptations are required to treatment programmes in order to take account of the cognitive processing abilities of the patient with autism
- where there is a need for specialist assessment of autism, in a patient where there is significant risk of harm to others and where that assessment requires the daily observation and intervention of a specialist team.

4.3.20 The need for specialist low secure autism services is independent of global intellectual ability, though for those with greater global impairment their needs may be as well served in a specialist LD service.

4.3.21 Specialist low secure autism services must have a purpose-designed environment to meet the needs of patients with autism.

4.3.22 There must be no more than 10 patients per ward. Units must be spacious with clearly demarcated areas and rooms. Lighting, acoustics and ward decorations must be managed in a way that is sympathetic to the sensory needs of this client group.

4.3.23 There must be a high ratio of staff to patients with specific attention to the need for high relational security to support the delivery of a continuous treatment programme that includes providing social scaffolding and modelling of relationships.

4.3.24 Staff must have experience in working with people with autism including working with their families and carers.

4.3.25 Staff must receive ongoing training on autism spectrum disorder, and the team will include staff, of all disciplines, trained in the use of diagnostic tools for autism.

4.3.26 Positive Behavioural Support (PBS) must be used to understand functional behaviour and arousal cycles to minimise their impact. Treatment programmes to address risk and offending behaviours must be adapted to meet the needs of patients with autism.



4.3.27 Integrated into the Multi –Disciplinary Team (MDT) must be the significant provision of speech and language therapy and occupational therapy, to provide the right communications, structure and predictability to support the development of positive relationships and social learning. There must be access to sensory integration trained therapists.

4.3.28 Clinical and service pathways are likely to be highly individual. Minimising the number of transitions is important, and so a significant number of people will be discharged from low security services into the community.

4.3.29 The staff team must be involved in the formulation of need and training of receiving units/teams and/or community placements. The staff team should provide advice and liaison to other secure units.

#### **4.4 Patients with Personality Disorder (PD)**

4.4.1 All staff, including patient facing non-clinical staff must have specific training and competence in working with PD patients, in particular the need to work interpersonally and to manage patients who consistently push boundaries.

4.4.2 Staff selection procedures must take into account the ability to work with such challenging behaviour.

4.4.3 Services should be psychologically informed, including the ward milieu which should focus on opportunities for relating and maintaining optimistic bounded and collaborative relationships between staff and patients.

4.4.4 Sufficient attention must be paid to the environment around the patient as well as the interactions between people, to offer structure support, validation, and opportunities to practice new ways of relating.

4.4.5 All staff should receive support supervision and reflective practice opportunities, led by a clinician with expert knowledge in working with PD.

4.4.6 A holistic psychological formulation should drive the recovery plan. Attention is paid to biological, psychological, social and risk needs; these are seen as part of the whole person and not split off and dealt with separately.

4.4.7 A range of evidenced psychological treatments should be offered as described in NICE guidance; it should be recognized that there is no evidence that any one treatment modality over another offers advantages, but rather it is the eclectic use of tools within the supportive and hopeful relationship between patient and clinician which drives change.

4.4.8 There should be continuity and consistency of relationships with staff over time and in particular with key workers, and during transitions from and to other services.

#### **4.5 Services for Women**

- 4.5.1 There are essential differences in the profiles of women who access low secure mental health services compared to men. Women are more likely to have a borderline personality disorder either as a primary or secondary diagnosis, have a complex trauma history and disordered attachments.
- 4.5.2 Women have different offending patterns and often present with complex behaviours, including serious self-injury or attempted suicide. They also have distinct social and physical health needs.
- 4.5.3 Women's low secure services should provide gender sensitive and specific care reflecting the different needs of women who access these services. In practice this should include an emphasis on dignity, empowerment and relational security so that women feel safe and secure to enable them to engage in treatment.
- 4.5.4 Whether the service is stand alone or part of larger low secure service, wards must be single sex and women should have access to female only therapeutic/activity/outdoor space.
- 4.5.5 There should be dedicated facilities and operational management procedures for child visiting.
- 4.5.6 There should be a mixed gender staff team with female staff available at all times on the ward. Provision of appropriate gender mix must be considered in the planning and delivery of patient escorts.
- 4.5.7 The pre-admission assessment team must include at least one female member of staff and there should be a choice of female keyworker/named nurse.
- 4.5.8 There must be policies for the individualised management of self-harm and violence which take into consideration a woman's trauma history.
- 4.5.9 The service must have a program of training for staff on gender sensitive/specific care, clinical supervision and post incident support/debriefs.
- 4.5.10 Access assessments should take into consideration the range of services within the women's Offender Personality Disorder pathway where the criteria apply.
- 4.5.11 Assessments and treatment plans must be individualised and cover key elements including self-harm, gender specific formulation of risk, cultural needs, physical health, medication, eating disorders, trauma, substance misuse, family and carers.
- 4.5.12 Evidence based psychological treatments must be available for psychosis, trauma, substance misuse and personality disorder (including emotionally unstable personality disorder).

- 4.5.13 The service should provide offending behaviour programs which include those offences more common in women's secure services e.g. arson.
- 4.5.14 The service should provide access to a female General Practitioner, access to health screening programs, secondary healthcare and a program of health promotion focused on needs of women.
- 4.5.15 The service should have links with women's community resources and be part of a clinical pathway for women with links to community mental health services, appropriate step down facilities including low secure and supported housing.
- 4.5.16 In addition to the mainstream low secure provision there are a small number of Women's Secure Blended Services (this applies only to those providers who were previously pilot sites, 2018-21) providing a trauma informed approach to all aspects of the service including environment, staffing, policies and procedures, as well as ensuring access to evidence-based interventions for trauma. They provide physical and procedural security that is to medium secure requirements and may include both medium and low secure wards as part of the blended approach. The relational security can be flexed to enable appropriate adjustments to be made based on patient need. They demonstrate a commitment to coproduction and to implementing paid roles for female peer support workers within the service. The service develops practical plans to maintain, repair and promote relationships with patients' children, family, friends and carers.

## **5. Gender incongruence**

- 5.1.1 Patients in the community and all inpatient settings who are considering their gender identity and have mental health issues or a diagnosed mental health condition have the legal right to access a Gender Identity Clinic (GIC).
- 5.1.2 Until a diagnosis has been given by a GIC a formal diagnosis cannot be given even if the patient states that they have Gender Dysphoria or Gender Incongruence.
- 5.1.3 The placement of patients in low secure services who are considering their gender identity should be informed by a comprehensive risk assessment that addresses the impact and appropriateness of placement in male or female services. This assessment should identify any risks to/from the patient to/from other patients and consider the patient's wishes.
- 5.1.4 Risk assessments should consider and identify any additional safeguarding arrangements required for the patient themselves or for other patients.

## Appendix 2

### Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b Access Assessment Service

#### 1. Introduction

- 1.1 An access assessment is the specialist clinical assessment and formulation of the mental health and risk management needs of an individual. It is used to inform decisions about the most appropriate inpatient placement for the person in terms of their care and treatment needs and the level of security required.

#### 2. Model of Care

- 2.1 The access assessment service makes decisions and recommendations considering the whole care pathway for the patient including alternatives to admission to secure care, e.g., and particularly the offender personality disorder pathway or community sentencing and management options.
- 2.2 The access assessment service is a crucial part of the care pathway and its function is to:
- Determine if admission to secure care is necessary and to consider alternatives to admission
  - Where admission is indicated identify the appropriate level of security required under the principle of care in the least restrictive option
  - Articulate treatment needs including the need for a more specialist secure service if required
  - Inform clinical decisions regarding the readiness or need for patients to move within the secure care pathway between levels of security e.g. stepping down from high to medium or from medium to low secure services. Similarly this may include patients moving up levels of security due to increase in risk and/or deterioration in mental health
- 2.3 The access assessment service must focus on four key questions:
- I. How clinically urgent is the admission
  - II. Is there a need for admission to secure inpatient services
  - III. Level of security the patient requires?
  - IV. What are the patient's initial assessment/treatment needs?
- 2.4 The access assessment service will not always provide an assessment for admission to a specific hospital/service, however on occasions an

admission assessment may be conducted at the same time by the same team.

- 2.5 In the majority of cases patients should have the opportunity to be engaged with the service in the access assessment process and the outcome should be shared with them. The exception is where this has been assessed as potentially increasing the risk presented by the patient.
- 2.6 The access assessment service must have the clinical skills/experience and authority to make decisions and recommendations. The service will ensure that respective assessments are conducted by the most clinically appropriate individual or team members.
- 2.7 The service must conduct access assessments within a structured framework which includes recognised risk assessment tools.
- 2.8 Access assessment services should provide a service for identified geographical areas. The service may be responsible for undertaking assessments for specified patient groups (male or female, and or diagnostic groups) or with reference to specific levels of security.
- 2.9 Assessments can take place in a variety of ways, most will be face to face, however in some cases digital consultations should be considered, particularly where this enables a comprehensive assessment to take place in a more timely way. The service provider must ensure that they have access to appropriate technology to offer this service where appropriate.
- 2.10 For some urgent referrals there may be overwhelming evidence of need within the referral documentation and from discussion with the referrer, on these occasions both of the options above may lead to delay. In these cases a paper review of the clinical information and telephone consultation with the referrer may be adequate to enable a decision in terms of appropriateness for admission to medium or low secure services.
- 2.11 All options must be considered to ensure the best clinical outcome for the patient and the safety of all those concerned.
- 2.12 For patients with a diagnosed LD and/or ASD pre-admission Care and Treatment Review (CTR) must have been undertaken by the patients originating CCG prior to an access assessment for secure care. This is to determine if hospital admission is required, or if an alternative setting is considered more appropriate. There are some occasions where it is appropriate for an access assessment to be undertaken without a pre-admission CTR taking place, e.g. prison transfers or for patients requiring urgent treatment.
- 2.13 For patients in high secure services the medium secure access assessment service from their home area provides a vital link across the pathway. For these patients the responsible access assessment service should review the patient at least annually as part of the service provided.

The service should contribute to discussions about discharge planning through appropriate meetings.

- 2.14 The service must deliver in line with the National Prison Transfer and Remission Guidance.
- 2.15 Where a patient, subject to a Ministry of Justice (MoJ) restriction or Community Treatment Order (CTO) has been discharged from a secure service and then relapses, their clinical team may consider that they require admission to hospital. The patient is not automatically admitted directly to secure care, unless this is a condition of the recall.
- 2.16 The Access Assessment Service must respond within appropriate timescales based on the clinical urgency. This is to ensure that an admission into secure services is appropriate and the least restrictive environment is always explored.

### **3. Service Delivery**

3.1 The Access Assessment Service must communicate information that contains patient identifiable data and must use secure communication channels in line with Caldecott and Information Governance requirements and standards.

3.2 The Access Assessment service must operate within the following principles:

- The Service is responsible for delivering against specific timescales and prioritising referrals based on their clinical urgency
- The Service must be responsive at all times, including out of hours, particularly in relation to clinically urgent referrals, especially when risks to others are identified by the referrer
- The timescales that the Service will work to are described below; where timescales are stated in days this refers to a 7-day week.

#### **3.2.1 Urgent Assessments**

- A verbal response regarding the appropriateness of the referral must be provided within a maximum of 24 hours of receipt of the referral or sooner if nature of the referral dictates this
- The urgency of the referral is determined by the receiving clinical team but must be informed by discussion with the referrer
- Where a referral is deemed to be urgent an assessment must take place within a maximum of 2 days or less of receipt of the referral

- The outcome of the assessment must be made verbally to the referrer within 24 hrs of the assessment
- An initial brief report containing concise summary of initial findings must be made available within 24 hrs of the assessment
- The final written report must be shared within 5 days of the assessment taking place.

### 3.2.2 Non-Urgent Assessments

- These timescales are dictated on the basis that all information has been sent by the referrer to the access assessment service
- A written response regarding appropriateness of referral must be provided within a maximum of 7 days of receipt of the referral or sooner if nature of the referral dictates
- A proposed time frame in which the assessment will be conducted must be discussed and agreed between the access assessing service and the referrer
- The access assessing service must confirm the time and date of the assessment
- The assessment must take place within a maximum of 21 days
- The final written report must be shared with the referrer within 7 days of the assessment.

## 4. Referrals for Access Assessment

- 4.1 The access assessment service only accepts referrals from a consultant psychiatrist or their delegated clinician, who has assessed the patient in their current setting (e.g. the local mental health unit or community setting) and who considers there is a clinical need for a referral secure care.
- 4.2 The service must work with referrers to ensure that all relevant clinical and other supporting information (e.g. risk assessments, CPA reports, MHRT reports) are provided at the time of the referral to the access assessment service.
- 4.3 In terms of addressing conflict of interest a report prepared for court is not an access assessment but could, as with other available information, form a useful part of the referral information considered in carrying out the access assessment.
- 4.4 The information required from the referrer for the purpose of an access assessment as a minimum must include:
  - Name including any aliases
  - Date of birth
  - NHS number
  - GP

- Last address
- Name and contact details of local care coordinator
- Responsible CCG
- Responsible Local Authority
- Current placement and admission date
- Diagnosis
- MHA section or other detention order
- Reason for referral/ presenting problem
- Relevant clinical and risk history including offending
- Timescales of note e.g. EDR (expected date of release)
- MAPPA level
- Clear recommendation on the least restrictive care option being sought (i.e. recommended security level) and rationale
- Suggested care and treatment plan (including initial thoughts on intended outcome from the secure admission/ discharge destination from secure care)
- For patients with an LD and/or ASD diagnosis, a copy of their pre-admission CTR where this has taken place prior to admission.

## **5. Ensuring Quality and Consistency**

5.1 The access assessment service must work in collaboration with the NHS England Mental Health Case Manager. NHS England reserves the right to appraise or seek clarity about decisions made during the access assessment process and will do this via the resolution processes described below.

### 5.2 Dispute Resolution

5.2.1 On rare occasions, the referring clinical team may not agree with the outcome of, and recommendations made by the access assessment service. In such circumstances the following steps should be taken

- i. The access assessment service must instigate a clinician to clinician discussion regarding any differences of opinion.
- ii. If the respective clinicians are unable to agree an outcome, the referral, clinical information and recommendations made by the access assessment service are reviewed by the Mental Health Lead and Mental Health Case Manager involved in the referral in order to establish the reasons for the dispute. The Access Assessment Service must also provide additional information, which includes information about the patient's current presentation and behaviour, outcomes of recent assessments of the patient and referrals made to other services.
- iii. The Mental Health Case Manager must attend the patient's CPA meeting or other professionals meeting to assist with the decision.



- iv. A decision is made by the respective NHS England Mental Health Lead that the access assessment provided by the service should stand or that the case should go forward to arbitration.
- v. Where a dispute relates to a recall to hospital under the MHA, decisions can be made outside the dispute procedure so recall to hospital is not delayed.

### **5.3 Arbitration Process**

5.3.1 If the Dispute Resolution process fails to resolve the difference of opinion, an arbitration process must commence. The outcome of arbitration determines the final position.

5.3.2 The arbitration process involves NHS England seeking advice from a Forensic Consultant Psychiatrist unconnected to the referrer or access assessment service.

- i. The advising Forensic Consultant Psychiatrist must review all relevant clinical information, including the access assessment report and form a view on the suitability of the recommendations made. This view and subsequent recommendations must be shared with the respective NHS England Mental Health Lead and Case Manager.
- ii. In providing advice, the independent consultant must clearly state the rationale for their decision. The independent consultant's recommendation is final.
- iii. If the final recommendation is for the patient to be admitted to medium or low secure services, NHS England must notify the appropriate secure service. Should the service not be able to admit, an alternative placement must be identified.

## Appendix 3

### **Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b Forensic Outreach and Liaison Services (FOLS) Plus – Specialist Community Forensic Services (SCFTs) – this applies only to providers who were pilots 2018-2021**

#### **1. Introduction**

- 1.1 Forensic Outreach and Liaison Services (FOLS) are a vital component in supporting and facilitating delivery of safe and effective transitions of high risk patients with mental disorders from medium and low secure inpatient care back into the community.
- 1.2 FOLS provide expert advice, a responsive consultation and a liaison service to other mental health services and relevant stakeholders in the management of patients with mental disorders who have offended or are at risk of offending/reoffending.
- 1.3 Making the transition from secure services to the community is recognised as a particularly difficult time for patients. FOLS provide ongoing mental health assessment, formulation and treatment to promote recovery and manage risk during and after transition between services.
- 1.4 FOLS provides ongoing care and support for patients requiring specialist interventions to address psychological and social care needs. The aim of providing these interventions is to reduce the risk of relapse and reoffending.

#### **2. Access Criteria**

- 2.1 Patients accessing FOLS typically but not exclusively include those who are:
  - subject to MoJ restrictions and are Conditionally Discharged
  - subject to license conditions with a mental health disorder
  - subject to Community Treatment Orders (CTOs)
  - not subject to statutory supervision requirements but whose needs indicate a role for FOLS.
- 2.2 The decision to accept a patient for management and intervention by FOLS is based on a comprehensive risk assessment and consideration of how the potential risk and recovery needs identified can be safely and optimally managed, typically as part of a wider multi-agency approach.

#### **3. Model of Care**

- 3.1 The FOLS service must deliver:
  - A service that puts the patient at the centre of all planning and discharge and ensures they are involved and engaged throughout the process
  - Involvement of carers and families (as appropriate) in all aspects of care

- Facilitation of transition to the appropriate Community Mental Health Team or Community Forensic Team
  - A period of outreach care (including care coordination) from the secure inpatient service particularly in respect of the management of risk
  - Sustained and non-time limited outreach for those patients requiring specialist risk management and support from the secure inpatient service. This must be part of a long-term multi-agency risk management approach.
- 3.2 FOLS must engage with patients whilst in secure care at the earliest appropriate opportunity in the care pathway and may start to work with patients through different stages of their pathway before transition into the community.
- 3.3 FOLS have a responsibility to ensure that patients fully understand plans for discharge, including any restrictions or conditions.
- 3.4 FOLS are provided from secure inpatient services and provide specialist and expert advice on the assessment and management of mentally disordered offenders who pose a risk to others.
- 3.5 FOLS provides consultation and advice to and liaison with local mental health services in the assessment and management of risk aimed at avoiding admission to secure care where possible or where necessary expedite admission to and treatment in secure care to manage risk.
- 3.6 Local protocols must set out working arrangements between FOLS and local community mental health services including community forensic teams. The protocol must provide a description of the:
- Arrangements for regular engagement and collaborative working with community forensic or community mental health services
  - Model to support safe transition of patients who no longer require care from FOLS to local community mental health services
  - Approach to consultation and liaison for Multi-Agency Public Protection Arrangements (MAPPA) panels
  - Provision of consultation and liaison to other services.
- 3.7 FOLS must work as part of a network of services within a regional or sub-regional geographic area.
- 3.8 Local area protocols must be in place to take into account the needs of those discharged from secure care in a particular geographical area. The local protocols must set out how the FOLS is commissioned and provided for the respective population.

#### **4. FOLS Team**

4.1 FOLS multi-disciplinary teams must have:

- specialist knowledge and experience of MHA in respect of criminal justice system processes and legal requirements

- specialist and multi-disciplinary expertise in risk assessment and management embedded in recovery-focused CPA arrangements
- expertise in the therapeutic use and delivery of relational and procedural security processes
- close links and protocols with primary and secondary mental health services to facilitate delivery of effective service transitions
- robust and effective relationships with relevant stakeholders in criminal justice, statutory and third sector organisations.

## 4.2 Aim of Service

4.2.1 The aim of FOLS and SCFT is to provide timely, safe and effective transitions from secure inpatient services to the community for high risk patients and to provide expert advice to and liaison with other stakeholders in relation to this population.

4.3 Specialist Community Forensic Services (SCFTs) - this applies only to providers who were pilots 2018-21

4.3.1 SCFTs deliver in line with the following core components:

- Care pathway management out of and occasionally into secure settings, engaging intensively during the pre-discharge period to provide a seamless transition from inpatient services to the community.
- Specialist forensic risk assessment, informing individual and person-centred treatment and support plans which mitigate risk.
- Delivery of effective outcome and evidence-based offence-specific therapeutic interventions, both group and individual, in a community setting.
- Access to peer mentorship and buddying.
- Working with service users to maximise their skills and competencies in activities of daily living, in-reaching into housing providers where appropriate.
- Working effectively and supportively with carers, taking into account their needs.
- Robust and specialist case management, which may need to be long term - years or even lifelong in some cases.
- Clear arrangements for 24 hour 7 days a week response to crisis or other needs of service users by appropriate clinicians, which are accessible by service users, carers, housing providers, and other services.
- Delivery of effective outcome- and evidence-based psychosocial interventions, supporting personalised recovery and maximising social functioning.
- Delivery of effective outcome- and evidence-based interventions to address substance misuse.
- Provision of vocational educational and employment support particularly in regard to access to information technology
- Robust and effective relationships with all other parts of the system, including the criminal justice system, mainstream mental health services, social care and the voluntary sector.

4.3.2 SCFTs can work as part of or alongside FOLS depending on local arrangements.

## Quality Indicators – Master Summary

Number	Indicator	Detail		Data Source	Alert	O.F Domain 1,2,3,4,5	CQC Key question Well-led, responsive, effective, caring, safe
		Descriptor	Evidence documents				
<b>Clinical Outcomes</b>							
101	% of eligible adult medium and low secure service staff who received clinical supervision at least monthly from a forensic clinician.	% of eligible adult medium and low secure service staff who received clinical supervision at least monthly from a forensic clinician.	Annual Report	SSQD		5	safe, effective
102	% of staff who have received annual safeguarding vulnerable adults training.	% of staff who have received annual safeguarding vulnerable adults training.	Annual Report	SSQD		5	safe, effective
103	Number of episodes of physical restraint, including use of rapid tranquillisation, per occupied bed days	Number of episodes of physical restraint, including use of rapid tranquillisation, per occupied bed days	Annual Report	Provider		1, 5	safe, effective, caring
104	% of self-harm incidents per occupied bed days	% of self-harm incidents per occupied bed days	Annual Report	Provider		1, 3	safe, effective, caring

105	% patients with improved HoNOS score on discharge	% patients with improved HoNOS score on discharge	Annual Report	Provider		3, 4	safe, effective, caring
106	Risk Reduction - Average length of time to first escorted community leave	Risk Reduction - Average length of time to first escorted community leave	Annual Report	Provider		3, 4, 5	safe, effective, caring
107	Risk Reduction - Average length of time to first unescorted community leave	Risk Reduction - Average length of time to first unescorted community leave	Annual Report	Provider		3, 4, 5	safe, effective, caring
108	Risk Reduction - Average length of Stay measured in occupied bed days for people who are discharged in the quarter.	Risk Reduction - Average length of Stay measured in occupied bed days for people who are discharged in the quarter.	Annual Report	Provider		3, 4, 5	safe, effective, caring
109	% patients discharged from hospital to a community forensic/outreach team	% patients discharged from hospital to a community forensic/outreach team	Annual Report	Provider		2, 3, 4, 5	safe, effective, caring
110	% of delayed discharges due to the shortage of accommodation in the community	% of delayed discharges due to the shortage of accommodation in the community	Annual Report	Provider		2, 4, 5	safe, effective, caring, responsive
111	% of urgent Access Assessments undertaken and delivered within the timescales as detailed within the service specification.	% of urgent Access Assessments undertaken and delivered within the timescales as detailed within the service specification	Annual Report	Provider		2, 4, 5	safe, effective, caring, responsive
112	% of non-urgent Access Assessments undertaken and delivered within the timescales as detailed within the service specification.	% of non-urgent Access Assessments undertaken and delivered within the timescales as detailed within the service specification.	Annual Report	Provider		2, 4, 5	safe, effective, caring, responsive

113	Physical Health Improvement - % patients with a comprehensive primary care service including GP registration and health clinics	% of patients registered with a GP practice aligned to or provided by the secure inpatient service and able to access/ receiving comprehensive primary care service including health clinics	Annual Report	Provider		3, 4	Effective, caring
114	Physical Health Improvement - % patients registered with local dentist and with access to dentistry	% of patients registered with a dentist aligned to the secure inpatient service and able to access services within the secure inpatient service or at aligned surgery	Annual Report	Provider		3, 4	Effective, caring
115	Physical Health Improvement -% patients receiving annual physical health check	% of patients undergoing annual health checks in line with NHS Health Check requirements <a href="http://www.healthcheck.nhs.uk/">http://www.healthcheck.nhs.uk/</a> <a href="https://www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx">https://www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx</a>	Annual Report	Provider		1, 2, 3, 4	Safe, effective, caring
116	Physical Health Improvement - % patients with physical healthcare improvement plan	% of patients with an annual improvement plan incorporating actions required from annual health check outcome	Annual Report	Provider		1, 2, 3, 4	Safe, effective, caring
<b>Patient Experience</b>							
201	% of completed patient satisfaction surveys	% of completed patient satisfaction surveys	Annual report	SSQD	N	4	effective, caring
202	% patients with a completed PREOM using PREOM Tool reporting an overall improvement in their experience	% patients with a completed PREOM showing improvement in their aggregated scores in line with PREOM Tool guidance	Annual report	Provider	N	4	effective, caring



**Structure and Process**

301	There is a multi-disciplinary team in place as detailed in the service specification.	<p>The multidisciplinary team consists of appropriately trained and supervised staff including a minimum of all of the following:</p> <ul style="list-style-type: none"> <li>- psychiatrists</li> <li>- clinical and forensic psychologists</li> <li>- Registered mental health nurses</li> <li>- occupational therapists</li> <li>- social workers</li> <li>- speech and language therapists</li> </ul> <p>It is understood that depending on patient need, access to other disciplines such as art/music therapists and deaf support workers may also be required to support the patient.</p> <p>For patients with learning disability/autism the specialist MDT will also include provision of: dysphagia assessment and management; sensory integration trained therapists; registered learning disability nurses.</p>	Operational policy	self - declaration	N	1, 2, 3, 4, 5	safe, effective, caring, responsive, well-led
302	All patients have individualised care plans.	Following assessment and formulation patients have a range of care plans matched	Operational Policy	Self-declaration	N	1, 2, 3, 4, 5	safe, effective, caring, responsive

		against their specific needs.					
303	CPA meetings are held within the first three months of admission and then every six months.	CPA meetings are held within the first three months of admission and then every six months.	Operational Policy	Self-declaration	N	1, 2, 3, 4	safe, effective, caring, responsive
304	All patients have estimated date of discharge within 4 weeks of admission	During first 4 weeks of admission comprehensive assessment has enabled an estimated date of discharge from service to be agreed	Operational policy	Self-declaration	N	1,2,3,4	safe, effective, caring, responsive
305	The medium and low secure unit adheres to the standards of the Royal College of Psychiatry Quality Network Standards for Forensic Care (CCQI) and other clinical guidelines within the service specification.	The adult medium and low secure unit meets the standards outlined in the Royal College of Psychiatry Quality Network Standards for Forensic Care (CCQI) which are necessary for accreditation and any national clinical guidelines as detailed within the service specification.	Operational Policy	Self-declaration	N	1, 2, 3, 4, 5	safe, effective, caring
306	Where clinical supervision for adult medium and low secure service staff is undertaken, supervision actions are recorded and regular audits of activity are undertaken.	Where clinical supervision for all adult medium and low secure service staff is undertaken, supervision actions are recorded and regular audits of activity are undertaken.	Operational Policy	Self-declaration	N	5	safe, effective

## Appendix 5

### Change form for published Specifications and Products developed by Clinical Reference Group (CRGs)

**Product name:** Service Specification: low secure mental health services (adult)

**Publication number:** 170041S

**CRG Lead:** Louise Davies

**Description of changes required**

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
The original section did not include reference to those convicted of terrorist offences or connected with terrorist activity.	Low secure services are part of a spectrum of services whose function is to meet the needs of those with mental disorders and/or neurodevelopmental disorders that will benefit from specialist care and treatment within a secure environment. <b>This includes those convicted of terrorist offences or are connected with terrorist activity.</b>	Section 2.3.1 Interdependence with other Services	HMPPS have established a new process that allows for the movement of individuals associated with terrorism into, through and out of the restricted patient system, to be tracked. This work arose as a result of terror attacks in 2019 and 2020.  This method of notification and ongoing tracking of a patient's movement through the restricted patient system allows for all partners to react quickly, and for example adjust patient care plans, resulting in greater protection of the public due to a multi-department response to a	Rebecca Daddow on behalf of the Adult Secure CRG	Dec 2020

<p>The original section did not include reference to the partnerships or partner organisations who must be involved in relation to patients who have been convicted of terrorist offences or connected with terrorist activity.</p>	<p><i>The following text to be added before the first set of bullet points.</i></p> <p>In order to ensure, where clinically indicated, that patients who have been convicted of terrorist offences or connected with terrorist activity have appropriate access to adult secure inpatient services, providers must work closely with all relevant partner agencies to share information at key stages of the pathway to ensure public protection is always a consideration.</p> <p>These partners may vary based on each individual situation but, in addition to those noted above, can include:</p> <ul style="list-style-type: none"> <li>▪ HMPPS</li> <li>▪ MHCS</li> <li>▪ Courts</li> <li>▪ JEXU</li> <li>▪ PREVENT</li> <li>▪ MAPPA</li> <li>▪ HO</li> <li>▪ Tribunals</li> <li>▪ Parole Boards</li> </ul>	<p>Section 2.3.2 Key partnerships include</p>	<p>perceived terrorism threat.</p> <p>As above</p>	<p>Rebecca Daddow on behalf of the Adult Secure CRG</p>	<p>Dec 2020</p>
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## Appendix 6

### Change form for published Specifications and Products developed by Clinical Reference Group (CRGs)

**Product name:** Service specification: low secure mental health services (Adult)

**Publication number:** 170041S

#### Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
The original document did not include any mention of the SCFT or WSBS models as they were commissioned as pilots from 2018.	The new text acknowledges the SCFT and WSBS pilots and the end of the pilot phase and outlines the core components of the model.	<ol style="list-style-type: none"> <li>1. Appendix 1, point 4.5.16 new content added</li> <li>2. Appendix 3 title amended</li> <li>3. Appendix 3, point 4.2.1. new content added</li> <li>4. Appendix 3, point 4.3. new sub-heading added</li> <li>5. Appendix 3, point 4.3.1. new content added</li> </ol>	<p><b>Access for patients:</b> the SCFT and WSBS pilots have been operational since 2018 (during the pilot period) and hold caseloads. The proposed changes will ensure continued access and minimal disruption for these existing patients who are settled and working well with the teams.</p> <p><b>Change to provider landscape:</b> the SCFT</p>	Rebecca Daddow on behalf of the Adult Secure CRG	July 2021

			<p>and WSBS pilots operate within Adult Secure Provider Collaboratives that have delegated commissioning responsibility. Some of the Provider Collaboratives have requested to continue to deliver the SCFT model.</p> <p><b>Cost implications:</b> the SCFT and WSBS pilots were funded through Five Year Forward View Transformation Programme Funds. These came to an end in March 2021, by which point Provider Collaboratives took on the responsibility for paying for the continuation of these models by reinvesting the savings generated through the pilot</p>		
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			period and/or choosing to use their allocations to support the models to continue. Some of the Provider Collaboratives have requested to continue to deliver the SCFT and WSBS models and therefore a change is required to the specification to reflect this. This is supported through the appropriate governance process.		
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