Cycle 10 Annual Report
Quality Network for Medium Secure Forensic Mental Health Services

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The Quality Network ran a competition to collect patient artwork to use on its’ materials. The team would like to thank all patients who submitted entries. Some of the artwork entered into the completion can be seen throughout this report.

This image is created by a patient from Tamarind Centre, Birmingham and Solihull Mental Health NHS Foundation Trust.

This image was created by Ben Barker from Ash Ward in Broadway Health Park.

The image is one of the winners of the patient art work competition and was created by a group of service users with support from OT staff and a professional artist from The Lowry Unit at Greater Manchester West Mental Health NHS Foundation Trust.

This piece of artwork was created by a patient working with the Arts Project, Northgate Hospital, Northumberland, Tyne and Wear NHS Foundation Trust.

This piece of artwork was created for the Quality Network art competition.

These pieces of artwork were created for the Quality Network art competition. The piece on the left was created by Gary, a patient at St Mary’s, St George Healthcare Group.

This piece of artwork was one of the winners of the patient art work competition and was created by Ben Barker from Ash Ward in Broadway Health Park: ‘Wagtail’.
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Preface

I am delighted to introduce this Annual Report from the Quality Network for Forensic Mental Health Services, summarising the key findings identified in Cycle 10.

Our core work is summarised in the introduction to this report and underlines the central importance that the Quality Network places on a fully engaged approach to quality improvement with patients, family and friends and staff taking an active role in improving the quality of care in secure units. The outcomes of our peer-review process are discussed in detail throughout the report alongside national benchmarking data.

I would like to take this opportunity to draw your attention to all the examples of good practice highlighted throughout the body of the report. Additionally, the Appendix provides a great resource for services to contact each other to find out more about areas of good practice and initiatives seen throughout this cycle.

Quazi Haque, Chair Advisory Group
Acknowledgements

The QNFMHS project team gratefully acknowledges:

- The staff in member units who attended and hosted peer-reviews.
- All the patients and carers who completed questionnaires, and patients that attended meetings. The Advisory Group for their continuing support and advice.
- The Patient Reviewers and Family & Friends Representatives for their work promoting patient and carer involvement.
Introduction

The Quality Network for Forensic Mental Health Services (QFMHS) was set up in 2006 by the College Centre for Quality Improvement (CCQI). The tenth annual cycle is now complete (2015-2016) and this report summarises the aggregated data of the reviews undertaken across 60 medium secure services in England, Wales, Republic of Ireland, Northern Ireland and Scotland.

Using a multi-disciplinary approach, the Quality Network facilitates quality improvement through a supportive peer-review process. The Quality Network highlights areas of good practice and areas for improvement by promoting a culture of openness and enquiry between peers. A fundamental principle of the Quality Network is that patients, family and friends, and forensic staff are central to sustainable quality improvement; this is reflected in the structures and processes used by the project.

“We benefitted from the experience of the review teams and have formed links with some of the team.”

“The review team were very much centred around sharing good practice and generated lots of ideas.”

“The Patient Reviewer did an excellent job. The meeting with the patients was excellent.”

“I have gained a good understanding of what it is like to be part of a review process.”

“I learnt a lot from the visit and have implemented some of the things I observed from the service.”
The Review Cycle

Self-review stage

Each year the Quality Network asks member services to undergo a self-review process. This requires services to assess themselves against a set of standards and provide commentary as to how they meet each standard. During the self-review period services are also asked to distribute questionnaires to be completed by patients, family and friends of their patients, and staff to drive a holistic approach to quality improvement across all levels.

External peer-review stage

The Quality Network organises a peer-review team to visit each member service. The purpose of these visits is to validate the self-review commentary. The peer-review teams consist of members of staff from different services, including a Patient Reviewer and a representative of the Quality Network. The Network has also piloted Family and Friends Representatives attend eight external peer-reviews.

Local reports

Following the peer-review visit the Quality Network compiles a detailed local report for each member service. This report provides a summary of the number of criteria met, partly met and unmet, which then gives an average score for each area. These averages have enabled the Quality Network to obtain a measure of each unit’s overall performance for all standard areas. Average scores for Cycle 10 are detailed in the key findings.

Figure 1. The Peer-review Process.
Member Engagement

The Quality Network encouraged staff and patients to engage with the self-review and peer-review processes at various points in the cycle.

Distribution of units

A total of 257 wards across 60 medium secure services took part in the review process. Member units were based England, Wales, Scotland, Northern Ireland and Republic of Ireland.

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<th>Region</th>
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Table 1. Number of Units in each region.

Some member units also cater for patients with additional care needs. The Quality Network has produced supplementary standards to support these services.

In total, 31 services reviewed cater for female forensic patients. All services with female patients were additionally reviewed against the standards for Women in Medium Secure Care\(^1\). Additionally, 20 services provide care for patients with learning disabilities and were reviewed against the standards for patients with learning disabilities in secure care\(^2\). There are three members of the Quality Network cater for patients who are deaf. All deaf service were reviewed against the standards for deaf people in medium secure care\(^3\).

Participation

Each Member service completes a self-review. This comprises of the completion of a self-assessment tool along with a range of questionnaires which aim to gather information from patients, their family and friends and staff at the service.

This is followed by a peer-review visit by colleagues from other participating services. The purpose of the peer visit is to validate the self-review, but also to share good practice, highlight areas for continued improvement and celebrate the services strengths and achievements.

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1. Standards for Women in Secure Care
2. Standards for People with Learning Disabilities in Medium Secure Care
3. Standards for Deaf People in Medium Secure Care
Network Activities

Annual forum

Each year a conference is held to highlight the work of the Quality Network. This cycle, the forum focused on encouraging members to share good practice and discuss themes relevant to caring for patients in secure services. Member services led a variety of workshops on: smoking cessation, using outcome data in clinical practice, family and friends involvement, staff support and well-being/effective workforce, IT and technology.

For more information about the workshops and presentations from the day, visit the QNFMHS website.

Newsletter and discussion groups

The Quality Network also produced a regular newsletter, with articles written by staff from member services. This cycle themes included: enhancing transitions and supporting the discharge process, supervision and staff well-being and promoting healthy eating and self-catering opportunities in medium secure services. We also facilitated an email discussion forum to support services in: seeking advice, discussing current issues and policies, debating relevant research articles and advertising upcoming events and conferences. A summary of the email discussion threads and all back issues of the newsletter can be found on our web pages.

Workshops and learning events

This year the Quality Network launched the second edition of the relational security guide ‘See, Think, Act’ (STA). There were three train-the-trainer events held in London, Leeds and Birmingham. All STA events were well attended by members of the Quality Network and created a platform for staff at secure services to discuss relational security. The Quality Network also held an event on Optimising Patient Pathways that focused on the importance of clear pathways for patients.

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4 www.QNFMHS.co.uk
Patient Involvement

Patient Reviewers have a long and established role within the Quality Network. Their input and expertise taken from lived experience helps to bridge the gap between clinicians and patients, and as a result brings a more inclusive approach to quality improvement.

This cycle, Patient Reviewers were allocated to attend all peer-reviews. Their role during the review cycle is an important one in recognising and recommending ways to improve quality of care for patients in secure services. Their input and guidance during review days has been well received by our members, as Patient Reviewers often provide an alternative point of view ensuring the patients’ voice is heard.

Patient Reviewers also have a key position on the Advisory Group. Their role adds diversity to the decisions made in collaboration with Family and Friends Representatives and a range multi-disciplinary professionals.

Our Patient Reviewers were keen to be a part of the learning events and annual forum held this cycle, to share examples of good practice and network with members. During the Annual Forum and Optimising Patient Pathways event, Patient Reviewers presented on a range of topics such as, service environment and patient experience. Feedback from delegates was very positive.

The Quality Network has taken applications and accepted patients who are at various stages in their recovery. Each Patient Reviewer is supported by a named member of the project team. This support includes training and personal development whilst working with the Quality Network.

“I have been a Patient Reviewer for 3 years and I find all the review visits interesting. It is good to give something back, as we are able to promote best practice in the units we visit.”
- Anonymous

“Being a Patient Reviewer has boosted my confidence and widened my outlook on forensic services. I feel being a Patient Reviewer has given me a real purpose and helped with my recovery.”
- Hannah Moore

“Being a member of the Quality Network has given my life a new and more fulfilling purpose. Attending reviews enables me to work alongside professionals and encourage patients to share their experiences.”
- Sue Denison
Family and Friends Involvement

“Working for the Quality Network has allowed me to contribute towards improving quality within services and so restore my personal sense of worth.”
- George Cooley

“I joined QNFMHS as a Family and Friends Representative because I wanted to ‘give something back’ in appreciation of all that had been done for my son. My time with the network has been very enjoyable.”
- Clari East

“The network has given me encouragement that what is debated and discussed has been put into practice. On a personal level it has helped me grow as a person and be in contact with people in a similar situation.”
- Maggie Britton

“I find the peer-reviews enjoyable and interesting. I have felt valued and treated respectfully by the staff. I feel like I can work in partnership with staff to change the culture of care.”
- Maureen Clare

The family and friends involvement in the Quality Network began in 2011 where there were initially two representatives who sat on the Advisory Group. Their involvement in the Network has since expanded and currently we have nine representatives.

During Cycle 10 the Quality Network further developed its engagement by piloting the role of Family and Friends Representatives attending peer-review visits. Eight peer-review visits had a Representative attend. This was well received by member services and Family and Friends Representatives expressed positive experiences of their involvement and spoke about how enjoyable and meaningful the process was.

In the next cycle, the Family and Friends Representatives role will expand to chairing the proposed family and friends meeting during a review visit to identify areas for improvement.

The Quality Network recognises the importance of involving all those who are part of a patient’s journey to recovery. There are still notable challenges regarding family and friends involvement within services. The Network aims to not only improve the quality of care provided to patients but to also help services bridge the gap with regards to engagement of family and friends. Introducing Family and Friends Representatives onto the peer-review visits has allowed reviews to be broader in terms of experiences and knowledge, and the process has been inclusive of all.
This cycle, at the Annual Forum, Family and Friends Representatives led a workshop entitled ‘The benefits and challenges of engaging and involving family and friends’. This provided a platform to encourage services to engage with family and friends and work with them to provide the best quality care. The workshop was well attended and received positive feedback with the session described as thought provoking, allowing services to think of new ways to engage with their family and friends.
How to Read this Report

This annual report is structured around the eleven sections of the QNFMHS Medium Secure standards. The body of the report highlights achievements and provides recommendations to common challenges identified in each standard area. Each section is introduced by a graph depicting overall performance for standards within that area. The graph is arranged by percentage; met, partly met, and unmet for each standard. The standards have been summarised along the vertical axis. The benchmarking graphs provide a national overview of how units scored against the standards with the percentage of standards met, partly met and unmet for that section. Where possible the benchmarking graphs have been ordered by score to show how units lie in comparison with each other. The key contact at each service has been emailed their anonymised data label.

Examples of good practice that have been identified during this cycle are presented in each standard section, to aid information sharing amongst members of the Quality Network.

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5 QNFMHS Standards
Overview

This section provides a brief summary of the findings from medium secure services reviewed during Cycle 10 and common challenges identified during peer-review visits. The figure below (Figure 2) outlines the average percentage of criteria met for each standard area across all member services.

![Figure 2. Average percentage of met criteria by standard area.](image)

On average, services fully met 90% of standards for medium secure care. As depicted above, member services are praised for scoring highly in areas relating to Safeguarding, Procedural Security and Physical Healthcare. In addition, it is commendable that services are working to improve in areas such as Physical Security and Family and Friends Involvement amongst others.
Figure 3. Overall percentage of criteria met, partly met and unmet by services\textsuperscript{6}.

\textsuperscript{6} The key contact at each service has been emailed their anonymised data label.
Section Summaries:
Physical Security
Procedural Security
Relational Security
Safeguarding
Patient Focus
Family and Friends
Environment and Facilities
Patient Pathways and Outcomes
Physical Healthcare
Workforce
Governance
On average services fully met 92% of standards relating to physical security. All services ensure keys are only issued to staff on completion of security induction and keys to medication storage are kept by qualified staff. For a majority of services problems with the perimeter are immediately addressed.

For some services, keys have occasionally been taken out of the secure perimeter due to human error. Additionally, not all gates were fitted with double skinning and in 25% of services gate locks/bolts are not yet designed to prevent climbing.

Figure 4. Overall percentage of criteria met, partly met and unmet by standard.

Recommendations

- Ensure a sensor alarm system is implemented on all keys so they cannot be removed from the secure perimeter.
- Ensure all gates are double skinned.
- Ensure gate locks/bolts cannot be used as a climb aid.
Figure 5. Percentage of criteria met, partly met and unmet for each service relating to Physical Security.
Physical Security: Examples of Good Practice

The key management system tracks the movement of all keys throughout the service.

**Three Bridges**

Key fob wristbands are worn both by patients and staff to support freedom of movement within the secure perimeter.

**Trevor Gibbens Unit**

Patients were granted individualised access to their bedrooms, external areas and internal corridors via a wristband fob system.

**Langdon Hospital**

Key tests are completed on a new member of staff’s first day and signed off by the security lead if satisfied.

**St Mary’s Hospital**

Staff complete an online form to report any issues discovered during perimeter checks.

**Shaftsbury Clinic**
Procedural Security

Overall, services fully met 96% of standards relating to Procedural Security. The majority of services showed evidence that the relevant policies are in place. However, it was observed that some services have not yet developed a policy on the use of computers and internet.

In all services that care for deaf patients polices were translated into BSL and were impact assessed for deafness, except for access to a prohibited items policy which was not in place for all deaf services.

Figure 6. Overall percentage of criteria met, partly met and unmet by standard.

Recommendations

- Ensure all services develop a policy on the use of internet and computers. The MSU email discussion group can be used to share examples of policies.
- Ensure deaf patients have access to a prohibited items policy that meets their communication needs.
Figure 7. Percentage of criteria met, partly met and unmet for service relating to Procedural Security.
Procedural Security: Examples of Good Practice

The service has separate policies in place governing the use of internet access by staff and patients.

Trevor Gibbens Unit

Deaf staff are informed of policies in BSL or a mode of communication that meets their individual needs.

Cygnet Bury

All policies have an Equality Impact Assessment completed which includes provision for patients and staff who are deaf.

St Andrew’s Northampton, Men’s Service

Patients demonstrated a clear awareness of the complaints procedure and how to raise issues.

Arbury Court

Staff reported a robust procedure for reporting complaints, which is fed back to frontline staff and patients to ensure that lessons are learnt.

St Andrew’s Healthcare Birmingham
This cycle, services fully met on average 89% of standards for Relational Security.

A majority of services have a relational security programme in place, with key elements regularly updated.

In all services that care for people with learning disabilities, speech and language therapists, nursing staff and senior clinicians are trained in learning disabilities. Additionally, all deaf services have members of the MDT with expertise in mental health and deafness, and care plans are available in an accessible format.

 Overnight observations for female patients were not always completed by female staff, and have been identified as an area for improvement.

**Figure 8.** Overall percentage of criteria met, partly met and unmet by standard.

**Recommendations**

- Ensure female staff are available to conduct overnight observations of female patients.
Figure 9. Percentage of criteria met, partly met and unmet for each service relating to Relational Security.
Relational Security: Examples of Good Practice

The service has numerous opportunities for skills development and links with community organisations. Patients are fully supported in their work placements and receive supervision every three months.

**Edenfield**

The service holds a communication meeting every morning, whereby a representative from each ward and department attends. This meeting is to review any incidents in the last 24 hours and to make arrangements for any significant events taking place.

A "How is it going?" meeting is held every Friday which looks at planning resources for the weekend.

**Arnold Lodge**

Frontline staff are able to call professional meetings to discuss Relational Security issues.

**Broadland Clinic**

Each ward has staff debrief meetings to relieve some of the stress for individual members after all incidents.

**John Howard Centre**

The service currently has two accredited forensic psychotherapists.

**Llanarth Court Hospital**
On average, services fully met 98% of standards relating to Safeguarding.

All services ensure that a record of any children known to patients is kept, and the relationship of those children and any associated risks are identified on admission.

However, a few services were identified as not having a training plan in place for staff on safeguarding children and vulnerable adults.

**Figure 10.** Overall percentage of criteria met, partly met and unmet by standard.

**Recommendations**

- Ensure all staff receive training in safeguarding children and vulnerable adults.
Figure 11. Percentage of criteria met and partly met for each service relating to Safeguarding.
Safeguarding: Examples of Good Practice

On admission, the Social Worker meets with patients to assess any safeguarding issues, identify any children known to them and associated risks.

**Hellingly**

All staff are trained in Safeguarding Children and Safeguarding Vulnerable Adults through a face-to-face training session and e-learning top up courses.

**The Humber Centre**

There is a Safeguarding Adult Lead within the service for advice and who ensures that all safeguarding issues are raised and resolved.

**Norvic Clinic**

The social work department take a lead on all child and family visits.

**Woodview**
On average 89% of standards relating to Patient Focus were fully met by services.

In the majority of services, advocates are available to all patients and patients have their rights explained to them. Mixed-gender and gender specific activities are provided in nearly all services.

In all deaf services, key information is available in an accessible format and systems are in place to support patients understanding of information.

Some services had difficulties ensuring feedback from patients is used to guide quality improvement. Only 67% of services were identified as providing patients with freshly made, quality meals that offered choice, and reflected cultural and religious needs.

**Recommendations**

- Review patients’ feedback on the quality of food regularly.
- Implement ‘You Said: We Did’ boards to ensure patients receive feedback on issues raised during community meetings.

Figure 12. Overall percentage of criteria met, partly met and unmet by standard.
Figure 13. Percentage of criteria met, partly met and unmet for each service relating to Patient Focus.
Patient Focus: Examples of Good Practice

Patients reported that they felt their views were listened to and changes were made based on their feedback.

**Brooklands Hospital**

A full-time patient advocate is based at the unit.

**Shannon Clinic**

Patients felt the advocate was able to assist with their needs and provide extra support for deaf patients.

**St Andrew’s Healthcare Northampton, Men’s Service**

Staff and patients met regularly to ensure patients were aware of their recovery goals, and what needed to be achieved to move on to the next stage of their pathway.

**St Andrew’s Healthcare Nottinghamshire**

The unit provide a pack for patients which contains essential clothing, toiletries and other items to help with their transition to the service.

**The Spinney**

Patients are able to provide feedback to improve the service and are consulted about changes to the service through community meetings and the ‘speak-up’ group.

**Gisburn Lodge**

The easy-read leaflets and notice boards had been designed specifically for the patient group.

**Eric Shepard Unit**

Patients felt that staff were respectful of their needs as well as being enthusiastic about the care they provided.

**Stockton Hall Hospital**
For criteria relating to Family and Friends, services on average fully met 91% of standards.

The majority of services have links with carer advocacy services. Additionally, most services are working towards involving family and friends in patient recovery.

For some services, patients reported to not have visits with their family and friends in an environment they consider most dignifying.

Some services do not yet have an engagement strategy for carers or provide carers with practical, educational and emotional support.

**Figure 14. Overall percentage of criteria met, partly met and unmet by standard.**

**Recommendations**

- Dedicate a private area for visits to take place.
- Ensure services have an engagement strategy for carers in place. The MSU email discussion group can be used to share examples of carer engagement strategies.
- Develop links with community organisations that can assist in providing carer well-being groups and provide training for staff on providing emotional support to carers.
Figure 15. Percentage of criteria met, partly met and unmet for each service relating to Family and Friends.
Family and Friends: Examples of Good Practice

There is accommodation on site for friends and family to use if they travel a great distance to meet with their loved one.

**Caswell Clinic**

Carer’s group cards are left in the visitor’s lockers.

**Central Mental Hospital**

The service involves the families and friends of patients by hosting meals and events,inviting them to visit the ward. Financial support for travel is also offered to carers.

**Cheswold Park**

Each ward has a Carer Representative and resources to enable carers to access education, support and training related to mental health issues.

**Hellingly**

The hospital has a home leave fund for each patient which enables support with transport and accommodation costs.

**St Mary’s Hospital**

Monthly Carer’s Forums are held and the service involve family and friends in HCR-20 assessments. There is also a friends and family test and the Triangle of Care is used. The Birmingham Citizen Advocacy Service supports carers with access to advocacy.

**Tamarind Centre**

The patient’s carer or relatives are provided with a virtual tour so they are aware of the environment that their relative is in.

**The Spinney**

Two family therapists are employed by the service.

**Tony Hillis Wing**

The service runs psycho-educational focus groups to educate family and friends of patients about mental illness.

**St Nicholas Hospital**

The service organises barbecues, Christmas parties and show family and friends pictures of the ward so they can see where their loved one is living. The service is able to reimburse family and friends’ travel costs when they visit the service.

**North London Clinic**
For Environment and Facilities, services on average fully met 81% of standards. A dedicated secure garden can be accessed by patients in a majority of services and, patient bedrooms have privacy locks that can be operated by patients and overridden by staff.

In over a third of services, staff call buttons were not installed in patient bedrooms and not all services had a clear and visible point on each ward to maintain good lines of sight.

Furthermore, an area for improvement for some services incudes access to an appropriately decorated family visiting room.

![Graph showing overall percentage of criteria met, partly met and unmet by standard.](image)

**Figure 16.** Overall percentage of criteria met, partly met and unmet by standard.

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**Recommendations**

- Work with patients to develop child friendly artwork for the visiting space.
- Manage restricted lines of sight relationally and ensure staff are aware of restricted areas.
- Consider installing staff call buttons in patient bedrooms.
Figure 17. Percentage of criteria met, partly met and unmet for each service relating to Environment and Facilities.
Environment and Facilities: Examples of Good Practice

The Tarnbrook Centre was well-equipped with spaces for patients to take part in art, pottery and other creative activities. Additionally, patients were able to help build a therapeutic garden.

**Guild Lodge**

Patients are able to volunteer at the onsite shop.

**Newton Lodge**

Wards and corridors were decorated with inspirational quotes, patients’ artwork and pictures from social events held at the unit.

**North London Forensic Service**

Patients access a gardening and horticulture area onsite, maintained by a dedicated team of staff working with patients across all wards.

**Northgate**

The service play a video in the reception area entitled ‘A day in the life of’ which was created by patients detailing their experiences. Additionally, there is a cashpoint on site for patients to use.

**Shannon Clinic**

Good child visiting facilities with a very large range of age appropriate toys, facilities for drinks and snacks and easy access to all wards.

**St Andrew’s Healthcare Northampton, Women’s Service**

The general environment of the hospital was very bright, homely and well-decorated with patient artwork on display.

**The Dene**

Cordless phones are provided and patients can take these into quiet rooms/bedrooms depending on individual risk assessments.

**Chadwick Lodge**

There is an activities centre and Hub. The Hub is a gathering area where patients can mix for social events and also work in the shop.

**Ridegway**

The Occupational Therapy department houses a range of purpose built therapeutic spaces including a workshop, art room, gardening room, group room, IT suite/education room, sound studio, sports hall, Astroturf and external sports field, and resident shop.

**Reaside Clinic**

The service use digital display screens throughout the service and within ward areas. These boards are used to provide information to patients and those visiting the service about different aspects of the unit.

**Hatherton Centre**

The artwork at Cygnet Stevenage adds to the warm and light environment.

**Cygnet Stevenage**

A screen has been implemented in the nursing office of each ward for patients to view important ward based information such as: advocacy numbers, ward timetables and recent developments.

**Calverton Hill**
On average, services fully met 83% of standards relating to Patient Pathways and Outcomes.

In nearly all services there is clear evidence that patients have personalised outcomes in key recovery areas, as well as individualised therapeutic activities and vocational opportunities to support them in their recovery.

Involving patients in all aspects of the CPA process continues to be an area for improvement including writing of reports. Information about the service is not always provided to patients prior to admission.

**Figure 18. Overall percentage of criteria met, partly met and unmet by standard.**

**Recommendations**

- All patients should be given a copy of their CPA reports and care plans. Patients should also be able to add their views to their CPA report. If they do not wish to, introduce a way of recording this as standard practice.
- Ensure patients receive information about the service prior to admission, or have a welcome board on display with helpful information about the service.
Figure 19. Percentage of criteria met, partly met and unmet for each service relating to Patient Pathways and Outcomes.
Patient Pathways and Outcomes: Examples of Good Practice

There is a high level of patient involvement at Caswell, with Patient Representatives, regular ward meetings and the User Friendly Forum.

**Caswell Clinic**

Vast outdoor space with an animal area including: a chicken coop, bee keeping and rabbits. There is also a horticulture space with an outdoor seating area.

**Central Mental Hospital**

My Shared Pathway champions hold weekly groups, to communicate and embed this tool.

**River House**

The service has a Risky Business group to improve patients understanding of their risk assessments.

**Trevor Gibbens Unit**

The service has developed vocational opportunities in the local community such as The Railways Project and other voluntary placements.

**Chadwick Lodge**

Patients were creating a stop-motion animation film, which will be used as part of new staff inductions.

**Ravenswood House**

All risk assessments are conducted collaboratively with patients, where possible. There is also a 'My Risk; My Recovery' group.

**Reaside Clinic**

The service runs risk assessment groups where the HCR-20 is discussed and explained to patients.

**Marlborough House**

The service has recently introduced the use of 'My Health Locker' for patients to submit their own clinical notes to be included in all relevant reports.

**The Orchard**

Patients can take part in newspaper rounds and woodwork tasks, which includes making rabbit hutches at the service. Patients are required to take part in an interview before successfully obtaining the role.

**Cygnet Bury**

The service has an onsite farm with pigs and chinchillas. Patients are able to volunteer at the farm to help look after the animals.

**Kneesworth Hospital**

The PathNav has been implemented to involve patients in their care and allow them to visualise their pathway on a timeline.

**Stockton Hall Hospital**

Patients spoke of completing City and Guilds qualifications in a variety of areas including painting and decorating, and catering. The FST workforce undertakes all ward decorating and they have received further funding to enrol 15 other patients onto the workforce.

**Scott Clinic**
Services on average fully met 95% of standards relating to Physical Healthcare. For 98% of services patients have access to health promotion services and information about the range of treatments available to them. In nearly all services, patients’ physical healthcare are reviewed every six months. In all deaf services, patients are supported with their communication needs when accessing physical health services.

An area for improvement for some services includes increasing access to a female General Practitioner/Practice Nurse for female patients and relevant screening programmes.

![Graph](image.png)

**Figure 20.** Overall percentage of criteria met, partly met and unmet by standard.

**Recommendations**

- Ensure all patients have access a GP of the same gender.
- Ensure patients can undergo all relevant screening programmes.
Figure 21. Percentage of criteria met, partly met and unmet for each service relating to Physical Healthcare.
Physical Healthcare: Examples of Good Practice

Each secure garden area has an outside gym to help promote physical activity.

**Hellingly**

Physical healthcare provision in the service is excellent with patients’ health monitored on a regular basis. There is a visiting GP, dentist, podiatrist, optometrist, diabetes nurse specialist and a physical health nurse specialist.

**North London Forensic Service**

The gym and technical instructors were praised in their work to support patients in the community and help promote healthy living.

**St Andrew’s Healthcare Nottinghamshire**

Patients reported that there are regular healthy lifestyle activities, such as male wellbeing clinics.

**St Mary’s Hospital**

Health promotion activities and information were observed around the service, including a board advertising ‘Movember’.

**Wathwood**

The service has a very comprehensive screening programme in place. Virtual clinics take place with a diabetes clinician and a respiratory consultant.

**Tony Hillis Wing**

The health centre is designed to mirror a GP surgery in the community.

**Ridgeway**

Patients are referred to smoking cessation groups as well as food talks on how to reduce sugar in their diet. The service was praised for having a physical health passport for each patient.

**Kneesworth Hospital**
This cycle, services on average fully met 86% of standards relating to Workforce.

In all services teams work together in a multidisciplinary way. In all services that care for people with learning disabilities the aims of valuing people and person centred planning are embedded in their practice.

Access to both managerial and clinical supervision is an area for improvement for most services. Access to service specific training before working with patients including: patient’s perspective, recovery and outcomes approach, relational, physical and procedural security, drug and illicit substance awareness, equality and diversity and first aid training was recognised as an ongoing challenge for some services.

Recommendations

- Consider using supervision passports to capture the informal and formal managerial and clinical supervision meetings.
- Regularly monitor and audit staff training needs.
Figure 23. Percentage of criteria met, partly met and unmet for each service relating to Workforce.
Workforce: Examples of Good Practice

Additional band 6 roles have been developed recently to enhance staff retention and ensure staffing numbers are maintained.

**Ardenleigh**

The service block books agency staff for 4 to 6 month periods and integrate them within their care model. Agency staff are also required to attend supervision on a regular basis.

**Oxford Clinic**

There is a programme of bite-size training offered to all staff in service specific issues. Staff valued their Healing Environment training.

**Hatherton Centre**

The staff council group was praised as a good initiative for staff involvement.

**Kneesworth Hospital**

A session is held every Wednesday for career development learning, specific to each discipline.

The management team have helped Healthcare Assistants enrol onto Access to Nursing courses, and work their schedules around study, or to train them up as Speech and Language Assistants which has helped retain staff.

**Calverton Hill**

Patients provide training to staff on areas such as the management of violence and aggression to give a patient’s perspective of being involved in a restraint.

**St John’s House**
Services on average fully met 87% of standards relating to Governance.

All services have mechanisms in place to learn from incidents and near-misses. Nearly all services have a widely accessible complaints procedure, however patients and carers were not always involved in its development.

In some services contingency plans were not always agreed by the service and the necessary agencies needed to execute the plan and some did not have an eternal stakeholder’s engagement strategy.

Figure 24. Overall percentage of criteria met, partly met and unmet by standard.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>% Met</th>
<th>% Partly Met</th>
<th>% Unmet</th>
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<tr>
<td>Complaints are reviewed quarterly to identify themes, trends and learning.</td>
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<tr>
<td>Patients and families are involved in the development of complaints systems.</td>
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<tr>
<td>There is a widely accessible complaints procedure.</td>
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<tr>
<td>Service contingency plans are agreed with appropriate agencies.</td>
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<tr>
<td>There is a programme of testing service contingency plans.</td>
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<tr>
<td>There is organisation-wide learning from incidents and near-misses.</td>
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<tr>
<td>The service has external stakeholders engagement strategy.</td>
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</table>

**Recommendations**

- Work with patients and carers to review and develop the complaints procedure.
- Ensure all relevant contingency plans are developed with at least one or more of the emergency services.
- Ensure a strategy is in place governing how the service engages with all external stakeholders.
Figure 25. Percentage of criteria met, partly met and unmet for each service relating to Governance.
Governance: Examples of Good Practice

Staff can raise concerns anonymously by using the Dear Derek initiative.

**Guild Lodge**

The service facilitates organisation-wide learning from incidents, complaints and feedback on improving the quality of care. These include Quality and Risk Dashboard or the Patient Safety Board. Information is collected and analysed and is disseminated across the whole charity in electronic form.

**St Andrew’s Healthcare Northampton, Men’s Service**

The service attends monthly police liaison meetings to support contingency planning and address issues within the service as they arise.

**Three Bridges**

The service have arranged for their police contact to come in to the service and provide patients with Judo sessions encouraging a better understanding and relationship between the two.

**Bracton Centre**

The service has been able to involve patients and their family and friends in the development of the complaints system through the patient’s forum and the Family, Friends and Carers Newsletter.

**Arnold Lodge**

The peer-support patients have a responsibility to go through a checklist with new patients, to ensure they understand the policies in place and how to use certain equipment on the ward.

**Thornford Park**

Patients attend clinical governance meetings and are involved in the design of various aspects of the ward.

**Farmfield Hospital**

It was noted that patients attend a steering group where they can give feedback about the services.

**Fromeside**

The Forensic Network Nurse Forum is attended by nurses all over Scotland to share and learn from experiences at different services.

**Rohallion**
Appendices:

Appendix A. Table of Figures
Appendix B. Member unit contact details
Appendix C. Advisory Group
Appendix D. Patient Reviewers
Appendix E. Family and Friends Representatives
Appendix F. QNFMHS Team
# Appendix A. Table of Figures

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## Appendix B. Member Unit Contact Details

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<tr>
<th>Service Name</th>
<th>Key Contact Details</th>
<th>Patient population</th>
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</table>
| Arbury Court         | Sue Taylor  
sue.taylor@partnershipsincare.co.uk                  | Women              |
| Ardenleigh           | Paula Ward  
paula.ward@bsmhft.nhs.uk                       | Women              |
| Arnold Lodge         | Amanda Santaney  
amanda.santaney@nottshc.nhs.uk             | Men & Women        |
| Bracton Centre       | Lisa Dakin  
lisa.dakin@oxleas.nhs.uk                          | Men & Women        |
| Broadland Clinic     | Owen Fry  
owen.fry@hpft.nhs.uk                                    | Men & LD           |
| Brockfield House     | Andy Ward  
andy.ward@sept.nhs.uk                                   | Men & Women        |
| Brooklands Hospital  | Zoe Cockbill  
zoe.cockbill@covwarkpt.nhs.uk                            | Men & LD           |
| Calverton Hill       | Nick Shaughnessy  
nick.shaughnessy@partnershipsincare.co.uk         | Men, Women & LD    |
| Caswell Clinic       | Sian Dolling  
sian.dolling@wales.nhs.uk                              | Men & Women        |
<table>
<thead>
<tr>
<th>Service Name</th>
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<th>Patient population</th>
</tr>
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| Central Mental Hospital            | Harry Kennedy  
harry.kennedy@hse.ie                                      | Men & Women        |
| Chadwick Lodge                     | Malcolm Campbell  
malcolmcampbell@priorygroup.com                               | Men & Women        |
| Cheswold Park Hospital             | David Williams  
dwilliams@cheswoldparkhospital.co.uk                           | Men & LD           |
| Cygnet Hospital Bury               | Charlotte Garvey  
charlotte.garvey@alphahospitals.co.uk                           | Men, Women & LD    |
| Cygnet Hospital Stevenage          | Ignatius Chikambi  
ignatiuschikambi@cygnethealth.co.uk                             | Men, Women & LD    |
| Edenfield                          | Rachel Green  
rachel.green@gmw.nhs.uk                                    | Men & Women        |
| Eric Shepherd                      | Ian Tearle  
ian.tearle@hertspartsft.nhs.uk                                  | Men & LD           |
| Farmfield Hospital                 | Lee Houghton  
leehoughton@priorygroup.com                                    | Men                |
| Fromeside                          | Julie Somerville  
jkulie.somerville@nhs.net                                      | Men, Women & LD    |
| Gisburn Lodge                      | Lynne Kirwan  
lynne.kirwan@calderstones.nhs.uk                                 | Men & LD           |
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<td>Guild Lodge</td>
<td>Lee Drake&lt;br&gt;&lt;a&gt;<a href="mailto:lee.drake@lancashirecare.nhs.uk">lee.drake@lancashirecare.nhs.uk</a>&lt;/a&gt;</td>
<td>Men &amp; Women</td>
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<tr>
<td>Hatherton Centre</td>
<td>Jayanth Srinivas&lt;br&gt;&lt;a&gt;<a href="mailto:jayanth.srinivas@sssft.nhs.uk">jayanth.srinivas@sssft.nhs.uk</a>&lt;/a&gt;</td>
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<td>Hellingly</td>
<td>Janet Woodhouse&lt;br&gt;&lt;a&gt;<a href="mailto:janet.woodhouse@sussexpartnership.nhs.uk">janet.woodhouse@sussexpartnership.nhs.uk</a>&lt;/a&gt;</td>
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<td>Humber Centre</td>
<td>Dave King&lt;br&gt;&lt;a&gt;<a href="mailto:dave.king@nhs.net">dave.king@nhs.net</a>&lt;/a&gt;</td>
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<tr>
<td>John Howard Centre</td>
<td>Deborah Bull&lt;br&gt;&lt;a&gt;<a href="mailto:debbie.bull@eastlondon.nhs.uk">debbie.bull@eastlondon.nhs.uk</a>&lt;/a&gt;</td>
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<td>Kneesworth House Hospital</td>
<td>Linda Ram&lt;br&gt;&lt;a&gt;<a href="mailto:linda.ram@partnershipsincare.co.uk">linda.ram@partnershipsincare.co.uk</a>&lt;/a&gt;</td>
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<td>Langdon Hospital</td>
<td>Ray Lancaster&lt;br&gt;&lt;a&gt;<a href="mailto:ray.lancaster@nhs.net">ray.lancaster@nhs.net</a>&lt;/a&gt;</td>
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<td>Phil Huckle&lt;br&gt;&lt;a&gt;<a href="mailto:phil.huckle@partnershipsincare.co.uk">phil.huckle@partnershipsincare.co.uk</a>&lt;/a&gt;</td>
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<td>Marlborough House</td>
<td>Jo Faulkner&lt;br&gt;&lt;a&gt;<a href="mailto:jo.faulkner@oxfordhealth.nhs.uk">jo.faulkner@oxfordhealth.nhs.uk</a>&lt;/a&gt;</td>
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<tr>
<td>Newton Lodge</td>
<td>Catherine Eaves&lt;br&gt;&lt;a&gt;<a href="mailto:catherine.eaves@swyt.nhs.uk">catherine.eaves@swyt.nhs.uk</a>&lt;/a&gt;</td>
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<td>North London Clinic</td>
<td>Malcolm Campbell&lt;br&gt;<a href="mailto:malcolm.campbell@partnershipsincare.co.uk">malcolm.campbell@partnershipsincare.co.uk</a></td>
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<tr>
<td>North London Forensic Service</td>
<td>Sara Henley&lt;br&gt;<a href="mailto:sara.henley@beh-mht.nhs.uk">sara.henley@beh-mht.nhs.uk</a></td>
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<td>Helen Lawrence&lt;br&gt;<a href="mailto:helen.lawrence@nsft.nhs.uk">helen.lawrence@nsft.nhs.uk</a></td>
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<td>Trevor Gibbens Unit</td>
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<td>Men &amp; Women</td>
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<td>Wathwood Hospital</td>
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<tr>
<td>Woodview</td>
<td>Lynne Kirwan</td>
<td>Men &amp; LD</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:lynne.kirwan@calderstones.nhs.uk">lynne.kirwan@calderstones.nhs.uk</a></td>
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</tr>
</tbody>
</table>
# Appendix C: Advisory Group Members

<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zeba Arif</td>
<td>Chair of Forensic Nursing Forum</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Margaret Britton</td>
<td>Family &amp; Friends Representative</td>
<td>Quality Network for Forensic Mental Health Services</td>
</tr>
<tr>
<td>Nikki Churchley</td>
<td>Mental Health &amp; Programme Lead</td>
<td>South of England South West Team, NHS England</td>
</tr>
<tr>
<td>Sheryle Cleave</td>
<td>Senior Clinical Nurse</td>
<td>Northumberland Tyne and Wear NHS Foundation Trust</td>
</tr>
<tr>
<td>George Cooley</td>
<td>Family &amp; Friends Representative</td>
<td>Quality Network for Forensic Mental Health Services</td>
</tr>
<tr>
<td>Louise Davies</td>
<td>Mental Health &amp; Programme of Care Lead</td>
<td>Yorkshire &amp; Humber Team, NHS England</td>
</tr>
<tr>
<td>Jude Deacon</td>
<td>Head of Forensic Metal &amp; Prison Healthcare Services</td>
<td>Oxford Health NHS Foundation Trust</td>
</tr>
<tr>
<td>Richard Eccles</td>
<td>Programme of Care Senior Manager</td>
<td>NHS England</td>
</tr>
<tr>
<td>Tom Fahy</td>
<td>Consultant Psychiatrist</td>
<td>Chair Forensic Faculty RCP</td>
</tr>
<tr>
<td>Quazi Haque</td>
<td>Chair, Advisory Group Consultant Forensic Psychiatrist &amp; Group Medical Director</td>
<td>Partnerships in Care</td>
</tr>
<tr>
<td>Kerry Hinsby</td>
<td>Lead Consultant Clinical and Forensic Psychologist</td>
<td>Leeds and York Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>Victoria Hitch</td>
<td>Lead Occupational Therapist</td>
<td>St Andrew’s Healthcare, Birmingham</td>
</tr>
<tr>
<td>Michael Humes</td>
<td>Patient Reviewer</td>
<td>Quality Network for Forensic Mental Health Services</td>
</tr>
<tr>
<td>Dawn Jeffries</td>
<td>Director of Clinical Services</td>
<td>Thornford Park Hospital, Priory Group</td>
</tr>
<tr>
<td>Harry Kennedy</td>
<td>Executive Clinical Director &amp; Consultant Forensic Psychiatrist</td>
<td>National Forensic Mental Health Service, Central Mental Hospital</td>
</tr>
<tr>
<td>Jeremy Kenney-Herbert</td>
<td>Clinical Director &amp; Consultant Forensic Psychiatrist</td>
<td>Reaside Clinic</td>
</tr>
<tr>
<td>Mat Kinton</td>
<td>Mental Health Act Policy Advisor</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Seb Pringle</td>
<td>Patient Reviewer</td>
<td>Quality Network for Forensic Mental Health Services</td>
</tr>
<tr>
<td>Mike Wheeler</td>
<td>Forensic Outreach Service &amp; Forensic Social Work Team Manager</td>
<td>South West London and St George’s NHS Trust/ National Group for Social Work Managers in Secure Services</td>
</tr>
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</table>
Appendix D: Patient Reviewers, Cycle 10

<table>
<thead>
<tr>
<th>Patient Reviewers</th>
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<tbody>
<tr>
<td>Kristie Byrne</td>
</tr>
<tr>
<td>Ian Callaghan</td>
</tr>
<tr>
<td>Rebecca Condron</td>
</tr>
<tr>
<td>Sue Dennison</td>
</tr>
<tr>
<td>Michael Humes</td>
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<tr>
<td>Hannah Moore</td>
</tr>
<tr>
<td>Godwin Nkere</td>
</tr>
<tr>
<td>Seb Pringle</td>
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<tr>
<td>James Saunders</td>
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<tr>
<td>Roger Sharp</td>
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<tr>
<td>Helen Slater</td>
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Appendix E: Friends and Family Representatives, Cycle 10

<table>
<thead>
<tr>
<th>Family and Friends Representatives</th>
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</thead>
<tbody>
<tr>
<td>Margaret Britton</td>
</tr>
<tr>
<td>Maureen Clare</td>
</tr>
<tr>
<td>George Cooley</td>
</tr>
<tr>
<td>Clari East</td>
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</tbody>
</table>
Appendix F: QNFMHS Team

Renata Souza
Programme Manager

Samantha Holder
Deputy Programme Manager

Karen Traynor
Project Worker

Sandra Adisa
Project Worker

Madhuri Pankhania
Project Worker

Daniella Dzikunoo
Project Worker

Joanna Parketny
Project Worker

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Royal College of Psychiatrists, 21 Prescot Street,
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Email discussion groups:
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LSU@rcpsych.ac.uk