healthwatch Northamptonshire

Enter & View Report

St Andrew's Healthcare, Northampton

Contents

Summary

Healthwatch Northamptonshire (HWN) conducted Enter and View at St Andrew's Healthcare, Northampton (SAH) on 18 and 19 August 2014. We did this so that we could observe the care environment and talk to patients about their care, treatment and quality of life. We decided to do the visits in advance of the inspection of St Andrew's by the Care Quality Commission which commenced on 8 September. We wanted to hear from patients about their views of care and treatment to help inform the CQC inspection. We are very grateful to staff, managers and patients at SAH for facilitating our visit. We were given a warm welcome by most of the wards we visited and we appreciated this. In particular, our thanks to Sue Battams and Lesley Collins at SAH who developed the programme for our visits and the two training days.

We spoke to patients from 13 wards during the 2 days we were at SAH and went onto 9 of the wards. We visited medium secure, low secure and locked wards for adults – separate male and female wards. We visited adolescent units – some were single sex and some were mixed sex units. (Itinerary attached as Appendix 1). We also met patients from other wards in the hospital when we spent time in the Tompkins Centre which is a café for patients. We conducted 4 focus groups with groups of up to 6 patients each time and we also spoke to other patients individually. We had not previously visited secure mental health facilities and we are developing our approach. We piloted a questionnaire (attached as Appendix 2 with summary of responses) to help structure our discussions and we received 39 completed questionnaires. For some patients, it was not appropriate to use the questionnaire and some of the questions were not always appropriate for some of the patients we spoke with. We spoke to an additional 5 patients when we did not use the questionnaire. We also spoke to staff and managers about the care and treatment provided. We met with senior managers at the end of the two day visit to share our initial findings with them. During the course of the two days, we were told about a number of incidents where we felt there was a possible safeguarding issue (ie where a patient might be at risk of harm) and, in line with the HWN safeguarding policy for vulnerable adults, we have reported these instances to senior managers at SAH and to Northamptonshire County Council's safeguarding team to decide whether these instances should be investigated. St Andrew's were aware of 5 of the 6 Safeguarding issues and SAH have advised that these issues had been appropriately reported prior to our visit.

It is important to emphasise that the two days of visits represent a "snapshot" of a proportion of patient experience at SAH and this report is based on our observations and impressions of the environment at SAH and on what the patients we spoke to told us.

Our key findings are:

- Several patients talked to us positively about the care they received at SAH. Some patients said that SAH had provided a structure to their life which they welcomed and several patients said they felt they were getting better.

- Some of the patients we spoke to have a perception that staffing levels are inadequate and they feel this has a knock on effect on the quality of care. In particular, some patients told us that they are encouraged to work towards increased "levels". This means that they will be allowed increased access to activities and items such as ground leave, access to particular items. Alongside this increase in "level", there will be a higher level of potential risk. Some patients told us that on occasions, there were insufficient numbers of staff to facilitate patient access to increased escorted levels. Some patients told us that on the two days we visited, staffing levels had been increased but usually they were lower. Information received from St Andrew's shows that on the wards we visited, in the 6 weeks prior to our visit, 8 of the 14 wards had lower staffing levels than on the days we visited. Church ward had 3.5 additional staff and Pritchard had 2.5 more staff on the days we visited compared to the 6 weeks prior to our visit. 5 wards had between 0.5 – 1 member of staff less and one ward had the same staffing levels.

- Our questionnaire did not include a specific question about staffing levels. However, it was the biggest area of concern which patients raised with us spontaneously. Of the 44 patients we spoke to in total (including the 39 people who answered our questionnaire), 12 mentioned staffing issues without prompting. Comments about the impact of staffing levels from the patients who referred to their perceptions of low staffing levels included views that staffing levels are putting patient safety at risk and also impact on care plans.

- We formed a view that staffing levels impacted on some patient's sense of safety based on the responses to the questionnaire and the comments from around a quarter of the patients we spoke to who commented on staffing levels. While 79% always or often felt safe and secure, we would assume that the figure should be 100% of patients always feeling safe and secure. In response to the question, 'Do you feel safe and secure', we received the following responses from the 39 people who responded :

    - Always feel safe and secure: 41% (16)

- Often feel safe and secure: 38% (15)
- Sometimes feel safe and secure: 8% (3)
- Rarely feel safe and secure 10% (4)
- Never feel safe and secure 3% (1)

- We formed an impression that the mix of staff (sometimes referred to as skill mix) means there are a high proportion of relatively inexperienced and unqualified staff meaning that patients are not always receiving the clinical expertise and knowledge. This was our impression from the comments made by patients and some staff. St Andrew's advise that there is no national guidance on skill mix and staffing levels are defined by the charity as informed by experienced clinical professionals which set out that there are at least two Registered Nurses per ward during the day. St Andrew's state that all employees undergo a comprehensive induction before they go onto the ward and receive specialist training thereafter. St Andrew's state that their approach to workforce planning has been fully informed by the most recent National Quality Board guidance. Prior to this guidance being published, St Andrew's had agreed to increase the ratio of qualified nurses to Healthcare Assistants, as advised by the Director of Nursing, and this continues to be a priority for the organisation.

- 7 patients talked to us about how they felt their physical healthcare needs are being neglected. SAH has provided evidence of how they are meeting the physical healthcare needs of some of those patients we talked to.

- Our impression from our observation of the ward environments in some areas is that more could be done to make the ward environment a better place for patients to live. We are aware that there is a significant programme of new building taking place, including the planned new adolescent unit and re-provision of wards such as Ferguson. SAH told us that there is a plan for Ferguson ward to be re-provided. Part of our visit involved a visit to William Wake building which opened in 2010 which SAH told us has won awards for the building design.

- Based on the responses to the questionnaires and from comments some patients made to us, it was not apparent to us that patients are consistently involved and engaged in influencing their individual care. That said, this was a pilot of the methodology and further engagement would require follow up questions to establish any reasons why a patient might not be involved. In response to the question "Do you help to decide your care plan?", 32 of the 39 people responded:

- 20% (8) said always help decide care plans
- 38% (15) said often help decide care plans
- 3% (1) said sometimes help decide care plans
- 8% (3) said rarely help decide care plans
- 13% (5) said never help decide care plans
- 18% (7 people) didn't answer

Recommendations:

1. We recommend that SAH and the commissioners should work together to deliver an environment and patient experience which aspires to all patients saying they **always** feel safe and secure. Patients should be involved in the development of the action plan.

2. We recommend that SAH regularly ask patients if they feel safe and secure. We recommend that the findings on perceptions of safety and security for individual wards are reviewed to assess how staffing levels impact on a sense of safety and security. We would welcome a conversation with SAH about how the methodology we used, could be developed.

3. We recommend that SAH regularly check care plans to determine whether care plans are being delivered in relation to the agreement with individual patients set out in care plans. This should include assessing whether staffing levels impact on the ability to deliver aspects of care plans such as escorted leave.

4. We recommend that SAH develops a clear process for facilitating patient choice of their care co-ordinator and records this information.

5. We recommend that NHS England includes in the review of physical healthcare, a review of the complaints which have been upheld (38% of 67 complaints) to determine underlying trends. Our expectation is that, as commissioners of the service, NHS England is robustly holding SAH to account for the quality of all aspects of service provision, including physical healthcare.

6. We recommend that SAH reviews the 7 unexpected deaths during 2013/14 to establish whether there were any actions that could have

been taken by SAH to prevent the unexpected deaths. We further recommend that SAH commissions an independent review into the 7 unexpected deaths. A lay summary of the review should be published. We want to be assured that SAH has a culture of continuous review and learning from unexpected deaths.

7. We recommend that SAH invites the charity Rethink, to talk to the senior management team and the Board about Rethink's 2013 report "Lethal Discrimination" which calls for action to tackle premature mortality in secure mental health settings.

8. We recommend that SAH works with patients to look at how the ward environments are rigorously maintained at a reasonable and comfortable level, which both protects patient safety and strives for a more homely atmosphere. This should include:

   - improving the environment on the extra care units on the adolescent units prior to their closure

   - ensuring that robust efforts are made to improve the environment of wards which are scheduled for closure, eg Ferguson ward, for as long as patients remain on those wards

   - exploring the possibility of additional furniture items, other than just sofas and chairs on the medium secure units.

9. We recommend that SAH explores the possibility of enhanced peer support among patients, seeking advice from expert patient organisations about how this could be achieved.

10. We recommend that SAH extends the number of patients involved in patient engagement and leadership at different levels within the organisation.

11. We recommend that SAH develops a process to ensure that suggestions made by patients at community meetings are acted upon and if not, set out the reasons for non-implementation or delay for patients. We further recommend that this process should be regularly checked.

About Healthwatch Northamptonshire

Healthwatch is the independent consumer champion for health and social care. There are 148 local Healthwatch across the country and a national body called Healthwatch England. Healthwatch Northamptonshire covers the county of Northamptonshire. Our funding comes from Northamptonshire County Council and we have established ourselves as a Community Interest Company (form of social enterprise) to ensure that we operate as an independent organisation and secure a firm financial basis. The Community Interest Company is a partnership between the University of Northampton and Northampton Volunteering Centre.

Our rights and responsibilities include:

- We have the power to "Enter and View" health and social care services (with one or two exceptions). Our primary purpose is to find out what patients, service users, carers and the wider public think of health and social care. Our role should not be confused with the role of the CQC or OFSTED. The CQC is the regulator and inspector of health and adult social care and OFSTED is the regulator and inspection of children's social care. Both organisations have a legal requirement to inspect care provision with reference to national standards and guidelines.
- We prepare reports on the Enter and View activity we conduct. We have an Enter and View policy (www.healthwatchnorthamptonshire.co.uk) which sets out our process of delivering Enter and View and the process for developing our reports. Our values include openness and transparency and so all our reports are published. They will only be published on our website once the service providers, in this case SAH, have had an opportunity to comment on the factual accuracy. We will send final copies of our reports to providers (SAH) and commissioners (in this case NHS England Leicestershire and Lincolnshire) asking for their comments on our findings and a response to recommendations which we will also publish a summary version on our website once we have received the comments. We will also send copies of our report to our national body, Healthwatch England and to the Care Quality Commission. As part of our Enter and View, we explained to the patients we spoke to that their comments would be non-attributable but that if we heard about possible harm to individuals then we are obliged to refer those issues to SAH and the safeguarding team at Northamptonshire County Council. We have not detailed the particular issues – 6 in total – as we have referred them confidentially to the relevant agencies who will determine whether there should be safeguarding investigations. 5 of the 6 issues were previously known to SAH and Northamptonshire County Council and are being managed through safeguarding processes.

- We strive to be a strong and powerful voice for local people to influence how services are planned, organised and delivered.
- We aim to be an effective voice rooted in the community. To be that voice, we will find out what local people think about health and social care. We will research patient, user and carer opinion using lots of different ways to find out views and experiences so that the community is effectively represented.
- We provide information and advice about health and social care services.
- Where we don't feel the views and voices of Healthwatch Northamptonshire and the people who we strive to speak on behalf of, are being heard, we will escalate our concerns and report our evidence to national organisations including Healthwatch England and the Care Quality Commission (the independent regulator of health and social care).

Enter and View

In order to enable Healthwatch Northamptonshire to gather the information it needs about services, there are times when it is appropriate for Healthwatch Volunteers to see and hear for themselves how those services are provided. That is why the Government has introduced duties on certain commissioners and providers of health and social care services (with some exceptions) to allow authorised Healthwatch representatives to enter premises that service providers own or control to observe the nature and quality of those services.

Healthwatch Enter and View activity is not part of a formal inspection process, neither are they any form of audit. Rather, they are a way for Healthwatch Northamptonshire to gain a better understanding of local health and social care services by seeing them in operation. Healthwatch Enter and View Authorised Representatives are not required to have any prior in-depth knowledge about a service before they Enter and View it. The representative's role is to observe the service, talk to service users, families, other visitors and staff if appropriate, and make comments and recommendations based on their subjective observations and impressions in the form of a report. All HWN authorised representatives have been through a recruitment process, either as staff or volunteers; had an enhanced Disclosure and Barring check; received Enter and View and safeguarding training. All of the HWN/Together visit team additionally received 2 days training to prepare the visit team for the environment at SAH. The training was delivered by SAH staff prior to the visits.

This Enter and View Report is aimed at outlining what we see and hear during our visits and making relevant recommendation for improvement to the service concerned. The reports may also make recommendations for providers, commissioners, regulators or for Healthwatch to explore particular issues in more detail. Unless stated otherwise, the visits are not designed to pursue the rectification of issues previously identified by other regulatory agencies. Any serious issues that are identified during a Healthwatch Enter and View visit are referred immediately to the service provider and appropriate regulatory agencies for action. HWN has already referred a number of safeguarding concerns to St Andrew's Healthcare, Northampton; Northamptonshire County Council Safeguarding team and the Care Quality Commission (CQC).

Legislation allows 'Enter and View' activity to be undertaken with regard to the following organisations or persons:

- NHS Trusts
- NHS Foundation Trusts
- Local Authorities

- a person providing primary medical services (e.g. GPs)
- a person providing primary dental services (i.e. dentists)
- a person providing primary ophthalmic services (i.e. opticians)
- a person providing pharmaceutical services (e.g. community pharmacists)
- a person who owns or controls premises where ophthalmic and pharmaceutical services are provided
- Providers contracted by Local Authorities or the NHS to provide health or care services (e.g. adult social care homes and day-care centres).

Key Benefits of Enter & View

To encourage, support, recommend and influence service improvement by:

- Capturing and reflecting the views of service users who often go unheard, e.g. care home residents
- Offering service users an independent, trusted party (lay person) with whom they feel comfortable sharing experiences
- Engaging carers and relatives
- Identifying and sharing 'best practice', e.g. activities that work well
- Keeping 'quality of life' firmly on the agenda
- Encouraging providers to engage with local Healthwatch as a 'critical friend', outside of formal inspection
- Gathering evidence at the point of service delivery, to add to a wider understanding of how services are delivered to local people
- Supporting the local Healthwatch remit to help ensure that the views and feedback from service users and carers play an integral part in local commissioning
- Spreading the word about local Healthwatch.

Details of the Visit

Name and address of premises visited	St Andrew's Healthcare, Northampton
Name of service provider	St Andrew's Healthcare, Northampton
Type of Service visited	Adolescent and Adult Mental Health & Learning Disability including locked, low and medium secure
Specialisms	Other services include Neuro-psychiatry, Acquired Brain Injury and Dementia care
Registered Manager	Women's Service: Matthew Afford Men's Service: Richard Clark Adolescent Service: Lisa Cairns
Date and time of visit	18 (2pm – 7.30pm) and 19 August (9am – 5pm)
HWN Authorised representatives undertaking the visit Working in partnership with Together for mental wellbeing (a charity working alongside people with mental health issues in their journey towards independent and fulfilling lives. Together is a service provider.)	Teresa Dobson, Marion Minney, Anne Villegas and Rosie Newbigging HWN conducted the visits and we also worked with Together for mental wellbeing to pilot a method and approach to gain the direct views of service users about the quality of service they are receiving at SAH. Anne Beales: Director Service User Involvement Jess Worner-Rodger: Peer Support Co-ordinator
Contact details of Healthwatch Northamptonshire	enquiries@healthwatchnorthamptonshire.co.uk 01604 893636

Purpose of the visit and relevant background:

HWN decided to visit SAH to inform the forthcoming CQC inspection of the service which takes place during September 2014. Over the last year, HWN has been involved in meetings with SAH, the CQC and NHS England Leicestershire and Lincolnshire (the commissioner of the services) to talk about quality concerns at SAH. HWN has also requested an independent investigation into 4 deaths in an 8

month period of men in their 40s and 50s on a low secure ward, during 2010/11. An internal inquiry was conducted and we have received a confidential copy. However, HWN has asked for an independent investigation. We have asked that the investigation team includes representatives of service users and carer groups. HWN wanted to hear from patients, in particular, and staff about their views of care and treatment and the environment at SAH.

This report relates only to this specific visit and feedback we have received. It is not representative of all service users, only those who contributed within the time available, through our discussions.

Observations and findings in more detail:

1. **Feeling safe and secure:** 39 people who responded to the question "Do you feel safe and secure, 41% said always, 38% said often, 8% said sometimes, 10% said rarely and 3% said never.

   While the majority answered always or often, around a quarter of the patients we spoke to commented, without prompting, on staffing levels being inadequate making patients feel unsafe and at risk of harm and also that their care plans could not be properly followed.

Comments about safety and security from patients received included:

"I never had a good life, till I came here….I always feel safe and secure (at SAH)"

"There is a lot of fighting and shouting on the ward"

"I never feel safe"

Two patients on two different wards talked about their perception that there is a culture of bullying on the wards. One of these patients told us that there had been an incident in the last few weeks, which we understand is the subject of a Serious Incident investigation, which made them feel "terrified". Two patients told us that they were not confident that staff always and consistently acted on concerns patients raised about safety.

2. **Being treated with respect**:

35 of the 39 people answered the question "Do people treat you with respect?" The majority of people - 74% who responded said they always (36%/14) or often (38%/15) felt treated with respect, 5% (2) said sometimes, 8% (3) said rarely and 3% (1) said they never felt treated with respect. 10% (4) did not respond to the question. 9 people made comments in relation to this question and comments included:

“Some people treat me with respect, some don’t”

“A lot of staff do a very good job but some staff don’t……some make sarcastic comments”

3. Patient centred care/care plans: We asked a number of questions relating to people feeling engaged in their care, recovery and quality of life. In response to the question “Do you help to decide your care plan?”, 32 of the 39 people responded: 20% (8) said always, 38% (15) said often, 3% (1) said sometimes, 8% (3) said rarely, 13% (5) said never help decide care plans, 18% (7 people) didn’t answer.

11 patients made comments about care planning, 3 were positive and 8 were negative and included: “very positive involvement”

“Involved (in care plan) but not as much as I would like to be”

“I have a choice over my care plan – what goes in and out”

“I get to see it and can change things in it if I disagree

“I have only seen my care plan recently”

Many patients talked really positively about the activities provided – occupational therapy was referred to as good and therapies such as DBT (Dialectical Behaviour Therapy). Several patients talked about feeling as though they were better than when they arrived at SAH.

In response to the question, “Are you able to practice your religious or spiritual beliefs?” 33% (13) said always, 18% (7%) said often, 3% (1) said sometimes, 5% (2) said rarely, and 5% (2) said never. 36% (14) people didn’t answer or said the question did not apply to them. So, 80% who answered the questions said they were always or often able to practice their religious or spiritual beliefs.

In response to the question, “Are you supported to realise your dreams and goals?” 28% (11) said always, 36% (14) said often, 5% (2) said sometimes, 10% said rarely and 21% (8) didn’t answer of felt the question didn’t apply.

In response to the question, “Do you receive enough support for the process of leaving and moving to your own home?”, 33% (13) said always, 28% (11) said often, 3% (1) said sometimes, 5% (2) said rarely and 3% (1) said never and 28% (11) didn’t answer, didn’t know or said the question did not apply.

In response to the question, “Can you go outside for some fresh air when you need to?” 43.5% (17) said always, 33% (13) said often, 5% (2) said sometimes, 8% (3) said rarely, 2.5 (1) said never and 8% (3) didn’t answer.

People detained under the Mental Health Act have a legal entitlement to an independent mental health advocate. In response to the question “Can you have an independent advocate if you want one?; 77% (30) said always, 13% (5) said often, 2.5% (1) said rarely, 5% (2) said never and 2.5% (1) didn’t answer/said the question didn’t apply. Just under 9% of SAH patients are currently not detained under the MAH.

There were many more positive than negative comments about the advocacy service and several patients referred to their advocate by name:

“works well”…… “there if you need one (an advocate)”

4. **Staffing:**

We asked if people were able to choose their own support worker (referred to as Care Co-ordinators at SAH): 10% (4) said always, 8% (3) said often, 5% (2) said sometimes, 18% (7) said rarely and 41% (16) said never. 18% (7) didn’t answer/didn’t know/question didn’t apply. SAH advise that patients are often allocated their care co-ordinators initially but advise that patients have a right to change them if they wish to do so.

In response to the question, “Is there a staff member you can talk to in confidence?”: 62% (24) said always, 23% (9) said often, 5% (2) said rarely, 2.5% (1) said never, 5% (2) said sometimes and 2.5% (1) didn’t answer

We did not have a specific question about staffing levels in the questionnaire, but staffing levels were referred to around a quarter of the patients we spoke to, in relation to a number of the questions including safety and security, care plans, access to fresh air and about support workers (care co-ordinators).

One patient told us “they only got more staff in so they look good in front of you”. SAH have advised us that this was not the case and we have asked for details of staffing levels.

Another patient talked about perceptions of high levels of agency or bank staff. SAH advise that bank staff are permanent employees of SAH who receive the same induction and training. SAH advise that they try to use bank staff rather than agency to ensure continuity of care. Patients commented that staffing levels have a direct impact in terms of not being able to exercise their care plans for outside access or community leave “don’t always go out because of staffing issues”. Some

patients commented that access to external activities, which are part of care plans, was limited if staffing levels were low.

Other patients talked very positively about the care provided by staff at SAH, individual members of staff were named for praise by patients and that there were real opportunities for meaningful activities which provided structure and purpose which was appreciated and therapeutic. Comments included:

“Staff are brilliant”

“The Healthcare Assistant is very helpful”

Our conversations with some staff indicated concerns about staffing levels which impact on their capacity to provide patients with support for their care plans, including making sure activities are delivered, and also on staff capacity to participate in training and development. Some staff told us that training and career development opportunities are limited beyond the initial induction programme.

SAH advise that staff learning and development includes:

Learning and Development Planning: Every Healthcare Assistant, Senior Healthcare Assistant and Assistant Practitioner has a detailed learning and development plan, offering a range of activities that aspires to support them to deliver excellent and compassionate care. Healthcare Assistants all complete the St Andrew’s welcome programme (5 day programme) followed by a further induction programme. In 2008 a Higher Education module (at Level 4), common known as ‘learning through work’, was co-designed with the School of Health from Northampton University. This is completed during the first six months of employment (for existing staff, an Applying Learning in Practice (APL) module supports competency assessment in this area).

Following the Winterbourne review (2012) and Francis Inquiry (2013) focus is on the skills of Healthcare Workers in the UK. The Cavendish Report (2013) recommended a single educational framework called the ‘Certificate in Fundamental Care’. Currently UK Pilot sites are reviewing this qualification. SAH advise that their ‘Learning Through work Induction programme’ for Healthcare Workers goes beyond the educational requirements recommended and has been embedded for over 5 years.

Career development: Following ‘Learning through work’, St Andrew’s offers a Certificate in Mental Health (Level 4) and a Foundation Degree in Mental Health (Level 5) to Healthcare Workers. We were also told about a wide range of learning and development opportunities available to support the development of

Healthcare Assistants. Healthcare Assistants also access other learning beyond their job role to support the individual needs of their patients alongside their professional and career development.

Awards and recognition: SAH has advised that the organisation has received awards and commendations for its approach to learning and development, including Investors in People (IiP), National Training Award – Regional Winner (2012) and Northampton Business Excellence Award in Training and Development (December 2013)

In terms of the Higher Educational Programmes that support Healthcare Workers, they are accredited by the University of Northampton. Furthermore, several NHS Trusts and other independent providers have visited St Andrew's to learn from the St Andrew's model of professional development for professionals.

5. Physical healthcare:

We heard from 7 patients who felt their physical health needs were not properly taken care of. 80% (31) said they could always tell someone and 10% (4) said they could often tell someone if they were in pain. However, quite a few people who said always or often, also went on to say that they were not confident that staff would act on their concerns or take their physical health complaints seriously. For example, we heard from three patients who had long term conditions which require regular tests (eg blood pressure testing or blood samples) or particular interventions, which the patients told us either did not happen at all or did not happen regularly. SAH have advised that this is not the case following a check of patient records and discussions with staff.

We are aware that an independent review of the management of physical healthcare is due to be commissioned by NHS England and we await the results of the review with interest.

During the preparation of the report, we asked SAH to provide figures for the past 12 months on deaths at SAH. From 1st September 2013 until 31st August 2014, there were been 12 recorded deaths across the 4 SAH sites, half are deaths of patients aged under 75 which is the agreed definition of premature mortality:

Essex:	1
Men's:	2
Neuropsychiatry:	8
Women's:	1

SAH advise that 5 have been expected deaths, with patients provided with end of life care. There were 7 unexpected deaths, including 4 deaths of patients age under 75. In requesting the information, HWN was advised initially by SAH that 5 of the deaths were over the age of 63. We were surprised by this statement as under 75 is recognised to be a premature death. There is a growing recognition that the high numbers of premature deaths of patients detained under the Mental Health Act is not acceptable. SAH advise that inquests have taken place for 8 of these deaths, with the Coroner returning conclusions of natural causes.

SAH provided information about complaints from patients about their physical healthcare complaint:

Analysis of complaints linked to physical healthcare in the last 12 months; 67 have a link to physical healthcare. 38% of complaints were either fully or partially upheld.

Top themes are:

- 21 expressions of an unmet need (i.e. physical symptoms noted, requested for consultation etc.)
- 11 complaints regarding medication
- 10 complaints about not facilitating a basic need (toileting, food, drinks)
- 8 complaints about cancelled or missed appointment
- 6 general expressions of lack of support or understanding related to a physical healthcare need
- 5 complaints about physical observations (either not being done or not being done well)
- 4 complaints referred to concerns about weight management – These issues relate to the Charity offering food choices which are dietetically balanced to reduce the impact/risk of obesity, which is an important and fundamental part of healthcare
- 4 complaints specifically refer to management of a specific condition, e.g. asthma, angina, diabetes, Huntington's

56 of the 67 complaints have been closed:

- 20% were local resolution

- 33% were not upheld
- 38% were upheld (14% fully and 23% partially)
- 8% were diverted to a longer tem resolution process

Those complaints fully upheld relate to medication errors or delays (5), dental appointments not being facilitated (2) and lack of parental consent to MMR vaccination (1).

Those partly upheld mainly relate to physical health appointments not being facilitated (6), delays in referrals for physical health issues (3), delays in blood testing (2), problems with glasses being fixed or replaced (2).

6. Ward environment:

A vast majority of patients, who responded, felt their individual rooms were comfortable. 35 people responded to the question "Does your room feel comfortable?" and 85% (33) people responded by saying their rooms felt comfortable always or often. We were invited to view one or two bedrooms by patients and we could see that these patients had taken pride in making their rooms more individual and personal, subject to the safety level they were on. Our observations included:

- The quality of the environment on different wards is very variable ranging from outdated and very unsuitable wards such as Ferguson (due to be closed) to modern more appropriate wards on William Wake House which is 4 years old and more attractively designed. However, on the more modern wards such as Sunley, in William Wake House (opened 2010) and Stowe (opened 2007), the provision in the day area consists solely of large chairs and sofas, but no other furniture because of the reported need to minimise risk of harm. SAH advise that these wards meet the requirements of Department of Health medium secure unit standards although in our opinion, this does not create a homely atmosphere or one of warmth or energy and we observed several patients fast asleep on one ward around 9.30am on the chairs and sofas during the day on one of the women's medium secure wards.

- We observed some stained torn and ripped furniture in Sunley ward and in John Clare Unit which some patients told we had been like that for some time. We also observed some tatty and scuffed walls and floors, for example on John Clare Unit. SAH advise that wards score highly on monthly cleanliness audits and there is a planned programme of maintenance across the hospital, although in our opinion, some of the wards looked dirty and

one patient told us there had been fleas on the ward (Sunley) and that chairs and sofas were not always cleaned properly when a patient had bled or discharged other body fluids. SAH have advised that there is an established schedule for ensuring all damaged fixtures, fitting and furnishings are replaced if damaged.

- The extra care units (units where patients are individually cared, for periods of time, for in separate accommodation) on secure wards vary significantly in quality. The unit on Stowe ward seems less bleak compared to the units on John Clare and Malcom Arnold which felt, in our opinion, to be particularly grim. SAH advise that these units meet the Department of Health standards for Extra Care Units.

- 3 patients commented on the communal ward environment. 1 patient said the courtyard on their ward is pleasant, 1 patient referred to the environment as "stark", another patient said the temperature can be stiflingly hot.

- Some patients told us that the heat on the ward can make the ward very hot and stuffy and the air conditioning doesn't always work.

- We noted that several of the wards have sensory areas.

7. Patient engagement and leadership:

We have received copies of the patient engagement strategy and we are due to meet the Head of Patient Engagement. Our questionnaire included a number of questions related to collective engagement of patients:

We noted that there is a high level of engagement in ward (known as community meetings). Most of the patients we spoke to attended community meetings (these are regular meetings held on the wards) – 75% told us they always attend community meetings. By contrast, only 13% (5) of the 39 people asked always thought decisions taken at patient meetings were implemented. St Andrew's explained that they have a dedicated team of trained patients who are actively involved in clinical and senior non-clinical recruitment, including the appointment of their new CEO. SAH also advised that some patients will be unable to leave their wards because of the section under the Mental Health Act that they are detained under or because of Ministry of Justice restrictions.

We welcome information from the Head of Patient Experience that during this year, some patients have become more involved at a strategic level including:

- approximately 14 patients (3 are ex-patients now living in the community) attend Management Board and other key senior meetings to share their experience and have conversations about care and services at St Andrew's. (To inform and influence service and quality improvement).

- an established patient meeting, Birmingham, Essex, Northampton, Nottinghamshire Patients Recovery Forum (BENNS) operating at a strategic level, reporting to the Central Quality and Compliance meeting, which reports directly to the Management Board. BENNS is the group that makes decisions on behalf of patients and signs off and sanction many different aspects in relation to patients.

- patients also speak on induction programmes, train staff, interview staff, including very senior roles (there are approximately 20 -25 regular patients participating); patients also provide inputs to medical students and are involved in service re-design at the start of projects a recent example is design of recovery centre expansion.

- patients are engaged at national level, influencing commissioners through recovery and outcomes meetings, Implementing Recovery through Organisational Change project and presenting nationally.

- a new Central Carer, Families and Friends forum has been established which also has community representation and for the first time carer and family voice is featuring at a strategic level. SAH advise that this "work is young but it is a start. These are only some of the strategic activities and we want to increase and extend the range and numbers of people engaged at this level."

Acknowledgements

Healthwatch Northamptonshire would like to thank:

- All the patients we spoke to who told us about their experiences as patients at SAH
- SAH staff and managers in planning, organising and the delivery of the visit and the two days training delivered the week before the visits
- Anne Beales, Jess Worner-Rodger and Mandy Chainey from Together for mental wellbeing. Together for mental wellbeing provided advice and practical support in working with service users and gathering information from them. Anne Beales to expand this section and develop a recommendation.
- Healthwatch Northamptonshire Board vice-chair Teresa Dobson and volunteer Marion Minney for their time and commitment.

APPENDIX 1 – Programme of Enter and View

DAY 1 - Monday 18 August 2014

TIME	ACTIVITY/ AREA	LEADS	LOCATION
10:00 - 12:00	Together Arrival - Report to Cliftonville House Reception, then Informal Conversations - Patients & Staff Cafe	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ TBA	Cliftonville House/ Tompkins Centre
13:15	HWN Arrival - Report to Lowther Reception	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Theresa Dobson, Vice Chair, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Marion Minney, Volunteer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN	Lowther
13:30 - 13:45	Hospital Director Introduction	Lisa Cairns, Adolescent Service	Lowther
14:00 - 15:00	Focus Group: Heritage ▪ Adolescent Secure. Mental Health Pathway. Female treatment, rehabilitation & recovery. ▪ Max 6 patients	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Theresa Dobson, Vice Chair, HWN ▪ Jessica Worner-Rodger, Peer	Lowther

		Support Co-ordinator, Together ▪ Alison Carr , Lead Nurse	
14:00 - 15:00	Ward 1 : John Clare Unit ▪ Adolescent Secure. Mental Health Pathway. Female admission, assessment, treatment & rehabilitation.	▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Marion Minney, Volunteer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Brendan Blaylock, Ward Manager	Lowther
15:00 - 16:00	Ward 2: Richmond Watson ▪ Adolescent Secure. Mental Health Pathway. Male admission, assessment, treatment & rehabilitation.	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Alison Carr, Lead Nurse	Lowther
15:00 - 16:00	Informal Conversations - Patients & Staff Café	▪ Theresa Dobson, Vice Chair, HWN ▪ Marion Minney, Volunteer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Joe Duncanson, Lead Nurse	Tompkins Centre
18:15	HWN Arrival - Report to Malcolm Arnold House Reception		Malcolm Arnold House

18:30 - 19:30	Focus Group: Bayley & Heygate ▪ Adolescent Medium Secure. Neurodevelopment Disorder Pathway. Male neurodevelopmental admission, treatment & rehabilitation (including forensic). ▪ Adolescent Medium Secure. Neurodevelopmental Disorder Pathway. Male neurodevelopmental treatment, rehabilitation and recovery (including forensic) ▪ 6 patients	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Alison Carr, Lead Nurse or Lisa Cairns, Hospital Director	Malcolm Arnold House
18:30 - 19:30	Ward 3: Church ▪ Adolescent Secure. Neurodevelopment Disorder Pathway. Mixed gender neurodevelopmental admission, treatment, rehabilitation & recovery.	▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Marion Minney, Volunteer, HWN ▪ Peter Wilson, Ward Manager	Malcolm Arnold House

DAY 2 - Tuesday 19 August

TIME	ACTIVITY/ AREA	LEADS	LOCATION
09:15	HWN Arrival - Report to William Wake House Reception	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Theresa Dobson, Vice Chair, HWN ▪ Marion Minney, Volunteer, HWN	William Wake House
09:30 - 09:45	Hospital Director Introduction	▪ Lynn Baxter (Men's Service)	William Wake House
09:45 - 10:45	Ward 1: Robinson ▪ Men's Medium Secure. Mental Health Pathway. Adult (working age) admission, assessment and rehabilitation.	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Theresa Dobson, Vice Chair, HWN ▪ Marion Minney, Volunteer, HWN	William Wake House

TIME	ACTIVITY/ AREA	LEADS	LOCATION
		▪ Steve Arden, Ward Manager	
11:00 - 12:00	Ward 2: Prichard ▪ Men's Medium Secure. Mental Health Pathway. Young adult transitional (18-25 years) admission, assessment and rehabilitation.	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Theresa Dobson, Vice Chair, HWN ▪ Marion Minney, Volunteer, HWN ▪ Steve Arden, Ward Manager	William Wake House
09:15	HWN Arrival - Report to Smyth House Reception	▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together	Smyth House
09:30 - 09:45	Lead Nurse Introduction	▪ Matt Afford (Women's Service)	Smyth House
09:45 - 10:45	Ward: Stowe ▪ Women's Medium Secure. Mental Health Pathway. Mental illness admission, treatment & rehabilitation. To include the opportunity to meet with patient MH.	▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Matt Afford, Lead Nurse	Smyth House
11:00	Ward: Hereward Wake	▪ Rosie Newbigging,	Main

TIME	ACTIVITY/ AREA	LEADS	LOCATION
- 12:00	▪ Women's Low Secure. Learning Disability Pathway. Treatment, rehabilitation & recovery.	Chief Executive Officer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Matt Afford, Lead Nurse	Building
12:00 - 13:15	Lunch	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Theresa Dobson, Vice Chair, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Marion Minney, Volunteer, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN	Workbridge
13:15	Return to William Wake House Reception	▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Theresa Dobson, Vice Chair, HWN ▪ Marion Minney, Volunteer, HWN	William Wake House
13:30 - 14:30	Ward: Sunley ▪ Women's Medium Secure. Mental Health Pathway. Admission and assessment ward for personality disorders, mental illness and mild learning disability. To include the	▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Theresa Dobson, Vice Chair, HWN ▪ Marion Minney,	William Wake House

TIME	ACTIVITY/ AREA	LEADS	LOCATION
	opportunity to meet with patient HW.	Volunteer, HWN ▪ Matt Afford, Lead Nurse	
13:15	Return to Main Building Reception	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together	Main Building
13:30 - 14:30	Focus Group: Foster ▪ Men's Locked. Mental Health Pathway. Older male (55yrs+) rehabilitation. ▪ Max 6 patients	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ *Lynn Baxter*	Main Building
14:40	Meet at Main Building Reception - Refresh Groups		Main Building
15:00 - 16:00	Focus Group: Spring Hill House ▪ Women's Low Secure. Personality Disorder Pathway. Specialist borderline personality disorder DBT treatment programme.	▪ Anne Beales MBE, Director of Service User Involvement, Together ▪ Marion Minney, Volunteer, HWN ▪ Jessica Worner-Rodger, Peer Support Co-ordinator, Together ▪ Matt Afford, Lead Nurse	Spring Hill House

TIME	ACTIVITY/ AREA	LEADS	LOCATION
15:00 - 16:00	Ward 3: Ferguson ▪ Men's Low Secure. Learning Disability Pathway. Enhanced rehabilitation & recovery for challenging behaviour.	▪ Rosie Newbigging, Chief Executive Officer, HWN ▪ Theresa Dobson, Vice Chair, HWN ▪ Anne Villegas, Development & Delivery Manager, HWN ▪ *Lynn Baxter*	Main Building

16:30 - 17:00	HWN & Together De-Brief		Meeting Room 5, Cliftonville House
17:00 - 17:30	HWN Enter & View De-Brief with St Andrew's		

APPENDIX 2 – Analysis of responses to questionnaires

	Summary of responses to questions Question	ALWAYS	% of ALWAYS	OFTEN	% of OFTEN	RARELY	% of RARELY	NEVER	% of NEVER	SOMETIMES	% of SOMETIMES	Not applicable/don't know/didn't answer	% of Not applicable/don't know/didn't answer
1	Do you feel safe and secure	16	41.03%	15	38.46%	4	10.26%	1	2.56%	3	7.69%	0	0%
2	Do you feel safe with any personal care?	14	35.90%	4	10.26%	0	0%	1	2.56%	0	0%	20	51.28%
3	Do you have your own privacy?	18	46.15%	10	25.64%	4	10.26%	1	2.56%	2	5.13%	4	10.26%
4	Do you choose what time you get up?	13	33.33%	6	15.38%	5	12.82%	11	28.21%	1	2.56%	3	7.69%
5	Does your room feel comfortable?	25	64.10%	8	20.51%	4	10.26%	0	0%	1	2.56%	1	2.56%
6	Can you have a hot drink when you want?	4	10.26%	4	10.26%	4	10.26%	22	56.41%	0	0%	5	12.82%
7	Can you move around the building easily?	17	43.59%	11	28.21%	4	10.26%	2	5.13%	2	5.13%	3	7.69%
8	Can you go outside for some fresh air when you need to?	17	43.59%	13	33.33%	3	7.69%	1	2.56%	2	5.13%	3	7.69%
9	Are you able to practice your religious or spiritual beliefs?	13	33.33%	7	17.85%	2	5.13%	2	5.13%	1	2.56%	14	35.90%
10	Can you see family and friends regularly?	12	30.77%	10	25.64%	6	15.38%	4	10.26%	2	5.13%	5	12.82%
11	Can you spend your own money?	25	64.10%	10	25.64%	3	7.69%	0	0%	0	0%	1	2.56%
12	Do you have the opportunity of paid employment in the hospital?	3	7.69%	4	10.26%	1	2.56%	13	33.33%	1	2.56%	17	43.59%
13	Do you take part in activities outside the hospital?	5	12.82%	14	35.90%	4	10.26%	6	15.38%	4	10.26%	6	15.38%
14	Do people treat you with respect?	14	35.90%	15	38.46%	3	7.69%	1	2.56%	2	5.13%	4	10.26%
15	Can you have an independent advocate if you want one?	30	76.92%	5	12.82%	1	2.56%	2	5.13%	0	0%	1	2.56%
16	Can you tell someone if you are in pain?	31	79.49%	4	10.26%	0	0%	1	2.56%	2	5.13%	1	2.56%
17	Is there a staff member you can talk to in confidence?	24	61.54%	9	23.08%	2	5.13%	1	2.56%	2	5.13%	1	2.56%
18	Do you help to decide your care plans?	8	20.51%	15	38.46%	3	7.69%	5	12.82%	1	2.56%	7	17.85%
19	Are you supported to realise your dreams and goals?	11	28.21%	14	35.90%	4	10.26%	0	0%	2	5.13%	8	20.51%
20	Are you happy with the way your review is held?	18	46.15%	9	23.08%	2	5.13%	1	2.56%	1	2.56%	8	20.51%
21	Are you happy with the support you get from your support worker?	20	51.28%	10	25.64%	2	5.13%	1	2.56%	0	0%	6	15.38%
22	Do you choose your own support worker?	4	10.26%	3	7.69%	7	17.85%	16	41.03%	2	5.13%	7	17.85%
23	Do you go to patient meetings?	26	66.67%	3	7.69%	3	7.69%	2	5.13%	0	0%	5	12.82%
24	Do the things that get decided at patient meetings get done?	5	12.82%	14	35.90%	8	20.51%	1	2.56%	4	10.26%	8	20.51%
25	Do you write induction packs so new people will know what to expect?	2	5.13%	4	10.26%	2	5.13%	19	48.72%	2	5.13%	10	25.64%
26	Are you involved in staff recruitment? (Writing jobs interviewing, awareness raising etc.)	2	5.13%	3	7.69%	2	5.13%	22	56.41%	2	5.13%	8	20.51%
27	Do you have the opportunity to talk to the Hospital Director if you want to?	4	10.26%	7	17.85%	3	7.69%	11	28.21%	3	7.69%	11	28.21%
28	Is it easy to make complaints about the service you receive?	19	48.72%	9	23.08%	2	5.13%	2	5.13%	0	0%	8	20.51%
29	Do you receive enough support for the process of leaving and moving to your own home with support?	13	33.33%	11	28.21%	2	5.13%	1	2.56%	1	2.56%	11	28.21%

APPENDIX 3 - proposed methodology for gaining feedback from people who use services about the quality of the service that they receive

Together's background

Together is a national charity that works alongside people with a range of mental health needs during their journey of recovery. This includes offering personalised support in the community, supported living and residential services, advocacy services within secure settings and specialised support for people in contact with the criminal justice system.

We are trusted for our expertise in service user involvement, leadership and peer support. The voices of people using services are placed at the heart of Together's philosophy and at every level of our service delivery. Together has a unique Service User Involvement Directorate which guides, promotes and develops service user leadership and involvement both within the organisation and externally.

Together is experienced in developing and delivering service user-led initiatives, including accredited peer support and service user leadership training courses that have been developed for and by people with direct experience of using mental health services.

Development of the methodology

During 2010 the Mental Health Foundation and Together worked with a variety of people who access services, with a commitment to hearing their direct collective voice. This included:

- Children and adolescents who accessed mental health and/or eating disorder services
- People with addiction issues
- Working age adults who had accessed acute units
- People who were within low and medium secure forensic services
- People with dual diagnosis – learning and/or physical disabilities and mental health
- People with long term physical conditions who remained on section some of whom were nearing the end of their lives

The purpose of meeting people was to ascertain a meaningful, user-led and empowering way in which people could comment on the quality of the service they were receiving.

Based on these meetings (focus groups), we agreed a methodology that we were confident would meaningfully capture the views of people using services in a way that would contribute to the improvement of those services. Service users worked with Together and the Mental Health Foundation to design and pilot the questionnaire. The conclusion of all those present was that involving service users was crucial, as they are the most qualified people to give insight into the quality of a service they use. The questions can be used on a one to one basis or, provided service user safety issues are addressed, can be answered within groups.

The approach was designed to ensure that the views or assumptions of facilitators does not influence the collection of feedback and data, therefore allowing only the views and experiences of those participating (who access the service) to be represented in the feedback. In some circumstances, people may be required to be escorted by staff whilst participating. Where this is the case, it is important that facilitators are transparent with regards to whether this impacts on the ability of participants to answer questions without fear of repercussion. The methodology is designed with consideration that individuals' views and feedback may be influenced by the presence of staff, and aims to identify and account for this. In light of all of the above, the how, the who and the where all have to be thought through carefully to achieve the best insight possible into service users' views.

All of the above is a commitment to hearing the direct collective voice of those who use services. We are suggesting that service providers and 'regulators' triangulate evidence to gain a holistic view of the quality of services, in a way that prioritises the views and experiences of service users. In the case of forensic services, we would argue that this can be achieved via:

- inspections - CQC
- scrutiny of services by other people using similar services – quality network
- the direct voice of those currently using the service – local Healthwatch

Use of the methodology at St. Andrews Healthcare

Following a 2 day induction with St Andrew's Healthcare (SAH) training and development department, Together worked with Healthwatch Northamptonshire (HWN) at the SAH Northampton site for 2 days. Together's role was to provide advice and practical support in working with service users and gathering information through the methodology described in this report. This methodological approach refers only to engaging with and collecting feedback from services users and not to how such feedback may be analysed and interpreted.

Together is now exploring the potential benefit of rolling out the use of questionnaires with individuals and within focus groups in other SAH sites. This is with the aim of gaining direct feedback from service users about the quality of the

service they receive in a way that could contribute to improvements to those services.

In this first application of the methodology, 39 people completed questionnaires either individually or in a focus groups. The questionnaire was presented in two different formats that people could choose from: a standard written format and an ‘easy read’ version that also contained visual aids and symbols. People were also encouraged to write any clarifying information onto the questionnaire that they felt was relevant to their answers.

Approximately half of the people who completed questionnaires did so individually with support from one or two of the visitors from HWN or Together. A variety of people, including women and men, adolescents and adults, completed questionnaires within a number of low and medium secure settings. Some people chose to complete the questionnaires in a private room, whilst others provided the feedback in a communal area. Staff presence was minimal whilst people were completing the questionnaires and engaging in conversation with visitors from Together or HWN.

Four focus groups were held. Each group included 5 to 6 people currently using services either in a women’s adolescent low secure ward, men’s adolescent medium-secure ward, a women’s locked ward, or a men’s low-secure ward. The focus groups were facilitated by two people from Together who disclosed their own lived experiences of using mental health services, and one person from HWN. Between one and two staff members from St. Andrews were present while the focus groups took place.

The ways that people completed the questionnaire within the groups varied, and facilitators adapted to the wishes, strengths and needs of the group. In two groups people completed the questionnaires individually, some with support from facilitators. Group interaction and participation were also encouraged. For example, in one group, one person read the questions out loud, initiating some group discussion, whilst people recorded their own individual responses. In another group, people answered the questionnaires in pairs. Facilitators and St Andrew’s staff supported individuals who required assistance reading the questions or ticking the boxes.

Before and after inviting people to complete the questionnaires within the focus groups, ‘ice-breaker’ activities and further discussion topics were introduced with the intention of encouraging group discussion and feedback and facilitating an enjoyable experience for participants. Advice was sought from St Andrew’s staff regarding the appropriateness of – and adaptations to – some of these based on their familiarity with individuals in particular groups. Furthermore, people who participated in two of the groups were asked whether they would consider offering

peer support to others. A large number responded positively with willingness to support their peers. People in one focus group were also asked whether there was anything they would like to thank staff for. This initiated a range of responses that demonstrated the positive value placed on staff support by service users who participated in this group. Moreover, people in this group seemed to appreciate the opportunity to express their views and gratitude.

Evaluation of the piloted methodology

It is appreciated that we were engaging with and seeking feedback from people who are facing highly troubling experiences in their lives. Despite these challenges, people generously contributed their views and feedback about the quality of the services they receive. Overall, people who completed the questionnaires appeared to enjoy having their voices heard in this way, indicated by the way in which they engaged with facilitators and visitors whilst providing feedback. The group dynamics within the focus groups, which were created by service users who participated in those groups, appeared to facilitate a particularly positive experience for all involved.

Based on comments from people who completed questionnaires, we would recommend some amendments if their use is extended to other St. Andrew's sites. This includes the addition of a "sometimes" response option to the questions; splitting and qualifying some questions, for example dividing "do people treat you with respect?" so that it applies to experiences of staff behaviour and other service users' behaviour separately; and editing some wording to be consistent with language that is more commonly used within St. Andrew's, such as replacing the term "service user meeting" with "community meeting". Some questions also need to be considered in the wider contexts of the lived experiences of people using services within a secure setting. For example, several people stated that they did not wish to see their family and/or friends when responding to the question "can you see family and friends regularly".

The impact of staff presence on people's responses during focus groups has been considered. However it is notable that, in addition to providing much positive feedback about the services that they use, people appeared to be comfortable sharing some feedback that could be interpreted as less positive. This suggests that staff presence did not have a significant impact on the views that service users felt safe and able to express, although this would require further consideration if extending the methodology to other settings. Additionally, the level of comfort with which people appear to provide less positive feedback in the presence of staff may also be an indicator of how empowered they feel to express their views of the service.

Many of the people who completed questionnaires, either individually or within focus groups, voluntarily shared information about their personal journeys, including their experiences within a secure setting, where they had come from, and their plans for the future. People seemed to appreciate having their voices heard. Many people seemed keen to provide feedback on the service that they use and indicated informally that they had enjoyed participating in the focus groups or engaging individually whilst completing the questionnaire.

It is therefore our recommendation that this methodology could be further utilised in similar settings to gain insight into people's views of the quality of services that they receive in a way that genuinely respects and hears their voices. We will be taking forward an evaluation with SAH and HWN to look at how the methodology could be further improved and adapted.