Unlocking Service User Involvement Practice in Forensic Settings

Research into the provision of service user involvement in secure settings

nsun

July 2011

WISH
A voice for women's mental health

Acknowledgements

Many thanks to the unit staff who gave of their time in completing the questionnaire, and supporting the process of becoming better informed about service user involvement in forensic settings.

The data collection process was a mammoth task in itself, and I would like to thank the research staff, who were tireless in their effort; in particular Cecelia Dwomoh whose persistence in ensuring contact with people made such a difference to the response rate.

NSUN thanks the Tudor Trust and Comic Relief, for their support in taking forward this project.

Contents

Glossary

CAMHS	Child and Adolescent Mental Health Services
CG	Clinical Governance
CNM	Clinical Nurse Manager
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSIP	Care Services Improvement Partnership
DREEM	Developing Recovery Enhancing Environments Measure
FCAMHS	Forensic Child and Adolescent Mental Health Services
IMHA	Independent Mental Health Advocacy
LGBT	Lesbian, Gay, Bisexual and Transgender
MARD	Making A Real Difference
MDT	Multidisciplinary Team
MHA	Mental Health Act
NCG	National Commissioning Group
NHS	National Health Service
NMHDU	National Mental Health Development Unit
NSUN	National Survivor User Network
OT	Occupational Therapist
PAG	Patient Advisory Group
PALS	Patient Advocacy Liaison Service
PPI	Patient and Public Involvement
QNIC	A Quality Network for Impatient Child and Adolescent Mental Health Services
SCH	Secure Children's Home
SFMHSfYP	Secure Forensic Mental Health Services for Young People
SMT	Senior Management Team
STC	Secure Training Centre
SU	Service User
SUI	Service User Involvement
SUIW	Service User Involvement Workers
WRAP	Wellness Recovery Action Plan
YJB	Youth Justice Board
YOI	Young Offenders Institution

Foreword

When NSUN was being set up, we discussed at length what we wanted to achieve and how this could be done. It was also decided this would happen within a framework of principles. One of those crucial principles is that NSUN would prioritise in its work, those less well served.

We felt that a much neglected area is user involvement amongst users/survivors in forensic settings. User involvement in all its many forms is increasingly seen as vital to the running of modern responsive 'patient led' services. This 'right' has been hard fought for at many levels within mental health services and other areas like research and education. User involvement in forensic settings is also developing, and we wanted to gauge how much activity, and levels of such there are in this very controlled arena where rights of people wider than the user have to be factored in carefully and perceived risks could be barriers to involvement opportunities.

NSUN is very pleased to work with Wish on this project. Wish: A voice for women's mental health, is a small but very significant charity who have been championing the rights of female forensic service users/survivors for many years.

This is just a start. We know of some good practice in forward thinking forensic services, but not how wide spread the practice is and what it looks like. What follows is a snapshot of user involvement activity. What we intend is that this report is a start of more in-depth work to explore the possibilities of meaningful user involvement in forensic settings, to give responsibility to individuals and collectively improve service provision.

Tina Coldham
NSUN Chair
January 2011

1. Executive Summary

1.1 Background

Unlocking Service User Involvement in Forensic Settings underpins NSUN's principle to prioritise in its work, those served less well.

The 2001 Health and Social Care Act required all NHS organisations to engage with users in service planning and evaluation as well as providing opportunities for treatment decision-making. However it is only since the Health and Social Care Act 2008 came into force that independent healthcare providers became obliged to comply with the new Essential Guidelines for Health and Safety, including that the required standards related to service users' views and experiences being taken into account in the way the service is provided and delivered. Service user involvement is especially important in secure settings, which are so heavily influenced by risk factors and security protocols. This research is a first attempt to map provision of service user involvement in secure settings, and gain a better understanding of how service user involvement mechanisms operate and the impact that service user involvement has on both policy and practice.

1.2 Service user involvement in adult prisons in England

From Her Majesty's Prison Service website 131 prisons were mapped. Very little was known about service user involvement on prison settings. Every effort and means was taken to collect information by approaching prisons directly, by making a request under the Freedom of Information Act, and through the Ministerial Correspondence Unit, which has now passed the request onto the Department of Health. Still, the research was unable to gain any information. An official complaint regarding the delay and lack of response has been lodged.

1.3 Forensic services for young people

A comprehensive mapping of young people's forensic units in England has been completed. An overview of forensic services for young people and the organisations which work within these services to promote service user involvement is provided. There are four types of forensic services for young people up to the age of 18: Secure Children's Homes; Secure Training Centres; Young Offenders Institutions; Inpatient Forensic Child and Adolescent Mental Health Services. Each type of unit has specific remits, commissioning arrangements and criteria against which young people are placed. There are few organisations addressing service user involvement in forensic services for young people. In April 2010, there were 3,783 places for young people up to the age of 18 in custodial settings in England. 107 (3%) of these places were in establishments dedicated to girls, 2,960 (78%) in establishments dedicated to boys, and the remaining 716 (19%) are in mixed establishments.

1.4 Service user involvement in adult forensic mental health units in England

A comprehensive mapping exercise of adult's forensic mental health units was carried out using a range of sources. The total number of hospitals mapped was 154. Of this number 71 were NHS hospitals and 83 were hospitals in the Independent Sector. Seventy five hospitals responded (48.7%), with a higher response rate in the Independent Sector. Analysis was performed to assess how representative the data was. Results showed that larger hospitals are over-represented, both NHS and Independent Sector hospitals; gender mix is fairly represented; and security level is biased in favour of low and medium secure hospitals.

The data collection process was an enormous task. It took an excessive amount of time with major difficulties being encountered in identifying the person responsible for service user involvement, even by senior staff, demonstrating that service user involvement holds a relatively low profile in many of the hospitals mapped. In conclusion, service user involvement is not considered high enough priority to warrant a named individual who has responsibility for it within that organisation or setting. When a named post was given the range of those deemed responsible was wide ranging, with more post-specific responsibility within the NHS, due to its statutory responsibility.

Recommendation 1: All adult forensic hospitals should have a named person responsible for service user involvement, which all staff and patients at the hospital are made aware of.

Recommendation 2: Any future research relating to service user involvement should: raise the profile of the project at a senior level, within adult forensic hospital settings, and ask them to identify the appropriate person responsible for service user involvement; gain information about policies and protocols that the hospital has on service user involvement; gain information about patients' perception of service user involvement mechanisms in place.

Recommendation 3: The information gained from this mapping project should be used as a base-line of service user involvement practice in adult forensic hospitals. Funding should be sought to develop a project to improve service user involvement in adult forensic settings, sharing good practice and supporting mechanisms to be more effective. The research should be repeated to measure changed practice in service user involvement.

Recommendation 4: All forensic hospitals should have a specific hospital based post or part post designated as service user involvement lead, with clear responsibilities.

1.5 Service user involvement mechanisms: What is in place?

The most common type of forum in place is the Community Meeting (96%), followed by the Patient's Council (47%). A lower proportion of eligible hospitals have either

Men's (38%) or Women's (17%) Forums in place. There are a similar number of hospitals having an Independent Service User Involvement Worker (47%) and an In House Service User Involvement Worker (51%).

In both the Community Meetings and the Patients' Council there is a very high rate of formal feedback provided; 89% and 92% respectively. The Men's Forums have a relatively high percentage with formal feedback in place at 74% of hospitals, however it is the Women's Forum that has the lowest percentage of formal feedback with just 37%.

Community Meetings are traditionally ward based meetings, more or less universally used with 96% of hospitals having these in place. Patients' Councils are designed to bring different sectors of the hospital together, and there were a lower proportion of these in place (47%); although in smaller hospitals, to which there is a bias, there may be less need for a Patients' Council, as Community Meetings could have a wider remit.

In four mixed gender hospitals where there was a Men's Forum there was no parallel Women's Forum; in addition only 17% of hospitals which had women service users had a Women's Forum in place, despite the fact that it is acknowledged that in mixed gender environments women do not have as strong a voice as men.

In relation to Service User Involvement Workers (SUIW), the majority of hospitals stated that the Independent SUIW role was carried out by the advocate. It should be acknowledged that it may be difficult for an advocate, whose input is time-pressured within limited hours, to have a full role in supporting a collective voice.

With regards to the specific In-house SUIW role the information given was not conclusive. There were 8 hospitals which said that they had a specific In-house SUIW in post. 7 of these were in NHS hospitals, although the information gained in relation to staff member responsibility for service user involvement indicated that there were 17 NHS hospitals with a designated person responsible for service user involvement, possibly differentiating between senior management and front line responsibility. In addition 5 hospitals named advocates, who are in fact independent from the hospital, as the In-house SUIW. The remainder was a mix of MDT staff team members, with the exception of 2 hospitals who stated that patients carried out his role.

Recommendation 5: A definition should be developed for each type of forum so that there is a common understanding of the remit and function of each forum, and clarity for both staff and service users.

Recommendation 6: Involvement should be developed in quality assurance processes designed to ensure that standards of care are maintained and improved and that the service is accountable to those it serves, with reference to existing guidelines and policy such as MARD (Making A Real Difference) 2006 guidance, recommendations and minimum standards on good practice with respect to the process of involvement. These outline the overarching corporate commitments to involvement.

Recommendation 7: There is a need to develop good practice guidelines in relation to the involvement of individual service users at different levels of the service user pathway.

Recommendation 8: Men's and Women's Forums should run in tandem within forensic hospital settings, not only because there may be different issues to be raised, but also because women can find it difficult to speak up in mixed gender groups.

Recommendation 9: There should be a named senior manager responsible for service user involvement, as well as a named staff member on the front line who can support the development and implementation of service user involvement within each setting.

Recommendation 10: If advocates are to have a meaningful role in independent service user involvement work this should be clearly stated and funded, with a job description developed, which is separate from individual advocacy work.

Recommendation 11: Information about identified good practice in service user involvement in forensic settings should be researched and collated to make available on the NSUN web site, for example: My Future Plan; The Essen Climate Evaluation Scheme - Assessing the social climate of forensic psychiatric wards; The SEED project.

1.6 Service User Involvement Forums: How do they work?

The degree of formal feedback is an area of concern, due to its vital importance in terms of successfully involving service users, and it is unacceptable that hospitals operate service user mechanisms which exclude service users. There is an extremely low level of formal feedback in Women's Forums (37%) and even though there is a much higher rate of formal feedback to service users in the other three forums, at 72%, 89% and 92%, it still means that 8-28% of forums are providing no formal feedback whatsoever.

In terms of the frequency of meeting of the various forums, there is little consistency, with the exception of Patients' Councils, all of which meet monthly. Community Meetings tend to meet more frequently with the majority (77%) meeting weekly or more. The majority of both Women's and Men's Forums meet less than once per week.

In terms of information routes into the hospital from the forums, all forums seem to have good routes to senior management within the hospital. However it can not be certain to what degree it is for information only and to what extent it spearheads service user driven change agendas, as part of the governance feedback loop. The number of routes into the hospital varies between 0 and 6 routes. Taking into account all the forums 8% had no route into the hospital, primarily from the Patients' Council, which seems a contradiction in terms, and would prevent the forum having

meaningful input and influencing decision making at SMT level; 46% had one route in, 27% had 2 routes in, 11% had 3 routes in, and 5% of forums had more that 3 routes in.

Regarding information from the forums to service users this varies considerably; only about 25% of both Community Meetings and Patients' Councils profile patients as a route out for information, with Women's Forums being 16% and Men's Forums 45%. Possibly, having given information about formal feedback to service users previously, it was assumed that this question related only to staff by many; although by including service users in the context of routes into the hospital it places them as more equal stakeholders.

Recommendation 12: All service user mechanisms and forums should have formal feedback mechanisms in place to service users, as equal stakeholders, which clearly communicate what has been discussed, what issues are being addressed and what the progress and outcomes are on an ongoing basis.

Recommendation 13: Information from all service user mechanisms and forums should have a direct route to appropriate management, decision making and policy groups.

1.7 Perceived effectiveness of forums and effecting change

In relation to perceived effectiveness of forums, respondents rated effectiveness as above average, with 3 of the 4 forums peaking at a rating of 4. This is obviously a subjective assessment; there is no indication that there was any objective measure of effectiveness, and in this research there was no way of measuring the impact of the forums from the service user's perspective, which has to be seen as a shortcoming. In addition there was no indication that service users views were gained in relation to the effectiveness of forums.

Many of the areas mentioned relate more to day to day issues, rather than change at a more strategic level, which are no less important but will be more open to change and less fundamental. Examples relating to issues around liberties were few, for example the right to smoke.

When examining the areas where there had been a positive outcome in effecting change, throughout the forums the same themes recurred: smoking, activities, menu changes, and environmental changes; mainly ward based and more immediate issues. Even though the forums may have different remits and the potential to scope different areas, the reality seems to be that they operate very much at the same level; in the main addressing the more immediate issues. However it is also evident that more substantive areas of policy are being addressed, for example: CPAs; additional staff being employed; development of policy, procedures and communication channels.

Recommendation 14: Hospital units should have in place an objective measure of the impact of service user involvement mechanisms.

Recommendation 15: Service users should be formally consulted, to gain their views about the impact of the service user involvement mechanism and forums which are in place.

Recommendation 16: There should be written information for service users about the potential scope of the mechanisms and forums available. Also, training should be made available to all service users so that the effectiveness of the mechanisms in place can be maximised.

1.8 Planned developments and further comments

Hospitals profiled what they regard as good practice and demonstrated their commitment to service user involvement, profiling: feedback and the importance of communication; input into regional forums; annual survey - which is acted upon; links with Clinical Governance; addressing person-centred care planning and commitment to better CPA practice; different models of service, for example, Forensic Recovery Model; policy development and service user development; use of a range of service user orientated mechanisms: Essen Climate Evaluation Scheme, DREEM questionnaire, My Future Plan, the WRAP tool. The examples of initiatives and developments are impressive and indicate that there is much activity in relation to future plans regarding service user involvement.

Recommendation 17: The research should capitalise on the information given in this section to develop case studies of those hospital units which have been addressing or are in the process of driving forward a service user agenda; to gain information to disseminate to all hospitals and provide support based on others experience; to include both staff and service users.

2. Background and Introduction

The 2001 Health and Social Care Act required all NHS organisations to engage with users in service planning and evaluation as well as providing opportunities for treatment decision-making, and stated it is there to *"strengthen the way the public and patients are involved in the way the NHS works"*. The 2002 NHS Reform and Healthcare Professionals Act, and 2003 Social Care (Community Health Standards) Act are just some of the policies that help to champion user involvement in health care. Several major pieces of legislation have made service user involvement in UK health and social services a statutory duty. These include: the National Health Service and Community Care Act 1990 and the Community Care (Direct Payments) Act 1996. The recent White Paper: Equity and Excellence: Liberating the NHS proposes to put patients and public at the heart of healthcare.

Since October 2010 both NHS and independent hospitals have had to comply with the new Essential Guidelines for Health and Safety. This includes the requirement that hospitals in both sectors ensure "*service users are enabled to make, or participate in making, decisions relating to their care or treatment*". The guideline goes on to set out the assessed outcome that service users in all hospitals are encouraged to express their views and these views should be accommodated as far as appropriate or reasonably practicable. This has built upon previous requirements that applied to independent, as well as NHS, hospitals.

Service user involvement is especially important in secure settings, which are so heavily influenced by risk factors and security protocols.

Although there has been a growing trend to develop more robust service user involvement mechanisms, as there has been no formal research of service user involvement in either adult forensic hospital settings or within the prison service, little is known about the mechanisms in place in secure settings, how mechanisms operate, or the impact that service user involvement has on policy or practice.

This research is a first attempt to map provision of service user involvement in secure settings, recognising that it is imperative to ensure that both adults and young people in secure settings are supported and enabled to have a collective voice that is a meaningful part of the process of both impacting on service provision on a day to day basis and being enshrined in Clinical Governance. The aims of the research were:

i) To map all adult forensic hospital units and prisons in England, and forensic services for young people in England, as a framework for the research
ii) To find out what mechanisms are in place for service user involvement in secure settings, both adult forensic hospital units and prisons in England
iii) To gain information about the value of different service user involvement mechanisms in place in adult forensic hospital units and prisons in England, and how they impact on Clinical Governance, policy and practice
iv) To carry out initial research in relation to forensic services for young people, in order to identify whether a previous mapping of user involvement in these settings has taken place, and to identify key contacts in these settings to enable future mapping.

The report will be presented in the context of the three settings as stand alone sections

- Prisons
- Forensic services for young people
- Adult Forensic Units

The mapping information has been divided into:

- Prisons **Appendix A**
- Forensic services for young people **Appendix B**
- NHS forensic hospitals **Appendix C**
- Independent forensic hospitals **Appendix D**

3. Service User Involvement in Adult Prisons in England

3.1 Introduction

At the time of writing we know very little about user involvement in prison settings. What we know in ordinary mental health services is that user involvement ranges from innovative, life and system changing to poor or non-existent. There are some good examples of user involvement starting to happen in forensic mental health settings, and this report hoped to access information regarding any user involvement activities found in prison settings too.

We know that there is in-reach psychiatric care provision from mainstream mental health services for prisoners, and also some in-reach work from various community groups on issues that concern them. What is little understood is any systematic approach to user involvement of any kind in prisons. The minimum that could be hoped for would be around involvement in a person's own care within this restricted environment.

3.2 Mapping adult prisons in England

The information about adult prisons in England was obtained via a list published by Her Majesty's Prison Service on their website, located at http://www.hmprisonservice.gov.uk/assets/documents/10004747prisonlist_may_09.doc 131 prisons were mapped **(Appendix A)**

3.3 Methodology

As little is known about service user involvement in prison settings a broad data collection tool was developed **Appendix E**, which aimed to identify which mechanisms were in place and gain qualitative information about how they functioned and perceived effectiveness.

On making telephone contact with the prisons, and trying to identify the appropriate person, it was made clear that the prisons were unwilling to give information on an individual basis. All indicated that a response would have to be sought through the Ministry of Justice via a Freedom of Information request. Despite numerous communications there has been no satisfactory response, and it has recently been learned that the request has been passed on to the Ministerial Correspondence Unit. A response has still not been forthcoming, and it has not been possible to collect information about service user involvement in prison settings. The Ministry of Justice is investigating this unacceptable delay in responding, and a formal complaint will be made. There is still a need to take this forward, and NSUN is considering how this can be achieved.

4. Forensic Services for Young People: An Overview

4.1 Introduction

As part of the mapping of user involvement in forensic services, Wish was asked to do some preliminary research into forensic services for young people, with the intention that this information would be passed onto another organisation commissioned to research user involvement in Child and Adolescent Mental Health Services. This part of the report provides an overview of forensic services for young people currently in existence, and of the organisations who work within these services to promote user involvement.

4.2 Mapping young people's forensic units in England

- Details of Young Offenders Institutions were obtained a list published by Her Majesty's Prison Service on their website: http://www.hmprisonservice.gov.uk/assets/documents/10004747prisonlist_may_09.doc

- The websites of individual prisons designated as YOIs were then visited to find out if they were for juveniles (15-18 years old), young adults (18-21 years old) or both. YOIs for juveniles, or for juveniles and young adults, were included in the database.

- Details of Secure Training Centres were obtained via the Youth Justice Board website: http://www.yjb.gov.uk/engb/yjs/Custody/SecureEstateContactDetails/STCContactDetails/default.htm

- Details of Secure Children's Homes were obtained via the Secure Accommodation Network's service directory, located at: http://www.secureaccommodation.org.uk/unitdirectory.htm

- Details of inpatient Forensic Child and Adolescent Mental Health Services were obtained via the search facility on the website for the Quality Network for Inpatient CAMHS (QNIC): http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qnic/camhsdirectory.aspx, and results narrowed down by using "forensic" and "secure" as keywords.

4.3 Types of forensic services for young people

There are four types of forensic services for young people up to the age of 18. They are:

- Secure Children's Homes (SCH)
- Secure Training Centres (SCT)
- Young Offenders Institutions (YOI)

- Inpatient Forensic Child and Adolescent Mental Health Services (FCAMHS)

As of April 2010, there were 3,783 places for young people up to the age of 18 in custodial settings in England. 107 (3%) of these places were in establishments dedicated to girls, 2,960 (78%) in establishments dedicated to boys, and the remaining 716 (19%) are in mixed establishments.

4.3.1 Secure Children's Homes

There are 12 Secure Children's Homes in England with places commissioned by the Youth Justice Board. There are a further five units that are "welfare only", meaning that young people are placed there under Section 25 of the Children Act 1989 because they are at risk of harm, or of absconding from Local Authority care. Several Secure Children's Homes have a mix of beds commissioned by the Youth Justice Board and welfare placements. They are mostly run by Local Authority social services departments, apart from two which are run by private contractors in partnership with the Local Authority.

Secure Children's homes are mostly small units, and range in size from 6 beds to 40 beds. There is a high ratio of staff to young people. They are generally used to accommodate young offenders of either gender aged 12-14, girls up to the age of 16 and boys aged 15-16 who are assessed as being vulnerable.

4.3.2 Secure Training Centres

There are four secure training centres in England, all run by private contractors. They house vulnerable young offenders up to the age of 17 who have been sentenced to custody or remanded to secure accommodation. STCs are smaller in size than Young Offenders Institutions and have a higher ratio of staff to young people, although not as high as in a Secure Children's Home. They provide a structured education-focused regime and programmes to address the young person's offending behaviour.

4.3.3 Young Offenders Institutions

There are 15 Young Offenders Institutions in England with places for juvenile prisoners aged 15-18. Four of these are small units for young women aged 17 that are on the same site as adult women's prisons. YOIs have a lower staff to young person ratio than Secure Training Centres and are also much larger. Consequently, they are not considered suitable for vulnerable young people with, for example, mental health needs or substance misuse issues.

Somewhat confusingly, a Young Offenders Institution can have units for "young offenders" aged 18-21, "juveniles" aged 15-18, or both. For the purposes of this research, YOIs with places for juveniles only or juveniles and young offenders have been included in the mapping of young people's services, and all YOIs with places for young offenders aged 18-21 have been included in the mapping of adult services. This will lead to a certain amount of duplication.

4.3.4 Inpatient Forensic Child and Adolescent Mental Health Services - FCAMHS

There are eight NHS inpatient FCAMHS units in England, and a further seven run by independent sector providers. They provide services for young people aged 12 – 18 with severe mental health needs who are a danger to themselves or others. They may or may not have committed a criminal offence.

FCAMHS units are generally small with a high ratio of staff to young people. They are staffed by a multi-disciplinary clinical team of healthcare professionals and nurses, rather than by prison officers or less qualified social care staff as in YOIs/STCs and secure children's homes respectively.

The highest level of security for young people is roughly equivalent to the physical security required for an adult medium secure service – there is no "high secure" service for young people, although there are a handful of low secure services, mainly in the independent sector.

4.4 Commissioning arrangements

Places for young people up to the age of 18 in Secure Children's Homes, Secure Training Centres and Young Offenders Institutions are commissioned by the Youth Justice Board (YJB).

Places for young people in Inpatient FCAMHS are mostly commissioned at a national level by the National Commissioning Group (NCG). The national network of inpatient FCAMHS units is called the Secure Forensic Mental Health Service for Young People (SFMHSfYP). There are also a number of units run by independent sector providers that provide secure services for young people and one NHS low secure service that are not in this network.

4.5 How young people are placed in units

The type of custodial establishment that young people are sent to when they are sentenced or remanded to custody depends on their age, gender and vulnerability. The Youth Justice Board uses the following matrix for deciding where to place these young people:

<table>
<tr><th>Gender</th><th>Age</th><th>Vulnerability</th><th>Status</th><th>Type of custodial establishment</th></tr>
<tr><td rowspan="6">Male</td><td>12 - 14</td><td>N/A</td><td rowspan="2">Court-ordered secure remand or sentenced to custody</td><td rowspan="2">SCH or STC</td></tr>
<tr><td rowspan="2">15 - 16</td><td>Vulnerable</td></tr>
<tr><td>Non-vulnerable</td><td>Remanded or sentenced to custody</td><td rowspan="3">YOI</td></tr>
<tr><td rowspan="3">17</td><td>N/A</td><td>Remanded to custody</td></tr>
<tr><td>Vulnerable</td><td rowspan="2">Sentenced to custody</td><td>YOI, SCH or STC</td></tr>
<tr><td>Non-vulnerable</td><td>YOI</td></tr>
<tr><td rowspan="5">Female</td><td>12 - 14</td><td rowspan="4">N/A</td><td rowspan="2">Court-ordered secure remand or sentenced to custody</td><td rowspan="2">SCH or STC</td></tr>
<tr><td>15 - 16</td></tr>
<tr><td rowspan="3">17</td><td>Remanded to custody</td><td>YOI</td></tr>
<tr><td>Vulnerable</td><td rowspan="2">Sentenced to custody</td><td>YOI, SCH or STC</td></tr>
<tr><td>Non-vulnerable</td><td>YOI</td></tr>
</table>

The National Commissioning Group assesses referrals to Inpatient FCAMHS against the following criteria:

- the young person is under 18 years of age at the time of referral

AND

- the young person could be detained under either Part II or Part III of the Mental Health Act 1983

AND
EITHER

- the young person presents a risk* to others of *one or more* of the following:
  - direct violence liable to result in injury to people,
  - sexually aggressive behaviour
  - destructive and potentially life threatening use of fire

OR

- the young person is in custodial care and presents a serious risk of suicide and/or severe self harm

AND

- the referrer can give evidence that serious consideration, and testing where appropriate, of alternatives has already been tried prior to referral, indicating

that the case has exceeded the ability of available mental health services to meet the need.

** It is not necessary that the referred young person should be facing criminal charges for these risk behaviours, but it is necessary that there should be reliable accounts available of such behaviour.*

4.6 User involvement in forensic services for young people

There are a handful of voluntary sector organisations that offer various services within forensic settings to promote the involvement of young people. This can be through individual advocacy, or through schemes such as user forums or young people's councils. These organisations may be able to provide useful information when the mapping of user involvement in young people's services takes place.

A list of these organisations, their contact details and a summary of the services they provide can be found in **Appendix F**

Useful Links to accessing further information is given in **Appendix G**

5. Service User Involvement in Adult Forensic Mental Health Units in England

5.1 Introduction

From experience of working in adult forensic hospitals it is apparent that the level and quality of service user involvement is variable; it has been seen to range from the input of service users at community meetings being completely ignored and the staff agenda being taken forward, to sophisticated cross-hospital mechanisms in place, which are under-pinned by policy, linked to Clinical Governance and where there is a real will to involve service users in a meaningful way. The information gained from the research aims to give an indication of what mechanisms are in place in adult forensic hospitals, how they operate, and what impact they have on policy and practice. Based on the findings, a series of within-reach recommendations will be made, to support hospital units to build on good practice in relation to service user involvement, in settings which are conditioned by risk and security factors, and in which change is a slow, deliberative process.

5.2 Mapping adult forensic mental health units in England

In order to map adult forensic hospitals in England the following process was adopted:

- Wish's database of secure hospitals, developed in 2006, was used as a starting point. The accuracy of the information contained in this database was then confirmed by checking the website of the relevant NHS Trust or independent provider, or by e-mailing or telephoning the unit, and the database updated accordingly.
- This database was then checked against a list of mental health hospitals published as an appendix to *Mental Health and Specialist Care Services 2008/09* published by Laing & Buisson. Any units described as providing forensic psychiatry services or as low, medium or high secure that were missing from the database were added. Details of these units were then obtained via the website of the relevant NHS Trust or independent provider.
- The database was also checked against the CSIP Combined Mapping Framework Service Mapping Directory, located at http://www.mhcombinedmap.org/Directory.aspx. Any units missing from the database were added, and details were confirmed by checking the website of the relevant NHS Trust or independent provider.
- As a final check to make sure that no units had been missed, the online services directories of all NHS Trusts providing mental health services were visited and any units not already on the database were added. Google searches were carried out using the terms "forensic psychiatry hospital" "forensic psychiatry unit", "low secure hospital", "low secure unit", "medium secure hospital" and "medium secure unit", but this didn't reveal any further units that were missing from the database.

- Information about a lead or contact for user involvement at each unit was sought throughout the mapping process, as well as information about the level of security and the gender mix of service users. The Strategic Health Authority region in which each unit is located was also recorded in the database.

5.3 Methodology

5.3.1 The unit

- The mapping information provided a mix of hospital name only and an additional breakdown into wards. In order to be able to gain some consistency the data collection process was based on hospital units, which also comprised a series of wards based at the same address

5.3.2 The contact person responsible for service user involvement

- The contact information collected during the mapping process was variable and in the main for NHS hospitals it was a generic email address, and for independent hospitals this information was rarely available.
- Pre data collection, there was a further stage of trying to identify the appropriate contact person; this turned out to be a research project in itself, with much time being spent on collecting information about who the appropriate contact person was and this was a step in the data collection process which had not been previously identified.
- Not only was the step not identified, but the degree of persistence needed to identify the appropriate person responsible for service user involvement, in many of the hospital units, both NHS and Independent Sector, was under-estimated.
- Having identified the "appropriate" person, which in many cases turned out not to be the person responsible for service user involvement, it was then difficult to gain their email address (in the independent sector), which was to be the preferred mode of data collection, with follow up phone call. In NHS hospitals there were more contact names and details available, and gaining contact information was easier as this is deemed information in the public domain; having said that, once again, many of the named people turned out not to be responsible for service user involvement; in some cases in both sectors it took multiple phone calls to identify the appropriate person – the highest recorded is 10.

5.3.3 Data collection

a) Data collection instrument

The data collection instrument was developed initially to be a tool for identifying the different service user involvement mechanisms in place, with a section for "comments". However when this was piloted it was found that it did not yield sufficient information about the operation or value of different mechanisms in place or how they impacted on Clinical Governance, policy and practice; nor did it prompt people to think about the service user involvement process at their hospital. As a result of this a more comprehensive questionnaire was developed **Appendix H,** which, as well as identifying which service user involvement mechanisms were in place, was more accessible and would yield more pertinent information by guiding respondents to address specific areas:

- How frequently the various service user involvement mechanisms were held

- Where the information from each service user involvement mechanisms was fed into, within the hospital unit
- Whether the patients received formal feedback
- A rating of perceived impact on policy and/or practice
- Examples of how each service user involvement mechanism had effected change

b) Data collection process

- Full information was given about the study either verbally for data collected by telephone, or written information where questionnaires were self-completed by email
- The preferred data collection process was email with a follow up phone call, to remind or to support the completion
- What actually happened was conditioned by what information we could get about who the contact person was
- In the NHS, it was a mix of email contact and phone calls, but predominately email. All recipients received the initial questionnaire and 3 follow up reminders, and because of the lower response rate from the NHS there was a last phone round. 24 people promised to complete the questionnaire, 2 actually did complete it
- In the Independent Sector it was predominantly by phone, with some email, because it was difficult to gain the email address of the designated person
- Ten hospitals requested a hard copy of the information in writing by post
- Whatever the route it was extremely difficult to get information
- Only 3 hospitals point blank refused
- There were 4 hospitals where the appropriate contact person could not be identified. It is likely that in some cases, the contact name given was not the appropriate person, and there was no way of guaranteeing that the questionnaire would actually passed on to the right person.

Overall the data collection process took in excess of 250 hours.

5.3.4 Analysis

An Access database was developed to enable analysis of the data. Data was input and verified to ensure accuracy.

a) Quantitative

i) Response Rate and representativeness of data

This section aims to assess how representative the hospitals which responded to the questionnaire are, when compared to the total number of hospitals mapped. In order to gain this information the data was compared specifically between:

- NHS and Independent Sector overall
- Hospital size overall, and within NHS and Independent Sectors
- Gender mix overall, and within NHS and Independent Sectors
- Security level overall, and within NHS and Independent Sectors

The representativeness is then expressed as a percentage of the proportion occurring within each group, as indicated by the mapping information.

ii) Which mechanisms are in place?

- An analysis of which service user involvement mechanisms are in place in the hospitals as a percentage of the total number of respondents
- The four forums are analysed, separating NHS and Independent hospitals to highlight any variation between the two
- A comparison of the use of Independent and In House Service User Involvement workers

iii) Forums

Data is shown as a percentage so that some cross-forum analysis can be made

- Formal Feedback: analysing what percentage of respondents having each forum in place, have formal feedback
- How often each forum meets: this is analysed, whereby the responses given in the data have been grouped into different time periods in order to present the data quantitatively
- Where the information from the forums goes, within the hospital and the number of routes it takes: This has been analysed individually for each forum. A pie chart shows to whom the information goes, the information has been grouped so that it can be ranked. A bar chart shows the number of routes there are for information leaving the forum into the hospital
- Effectiveness: this has been shown in terms of numbers in a line graph, to show general patterns of how hospitals rated the effectiveness of their forums and an overall average is given for each forum

All percentages are rounded to the nearest whole number.

b) Qualitative

Qualitative data is analysed thematically, within a quantitative framework; quotes are used to give a better understanding.

The following areas are analysed:

- Further information about the In House and Independent Service User Involvement Worker
- Examples of effecting change through each of the four forums
- Further information offered about other mechanisms
- Planned Developments and further comments

5.3.5 Discussion and recommendations

The enormity of the data collection process, the excessive amount of time it took to gain the information, the difficulty in locating the person responsible for service user involvement, and the low response rate of 48.7%, given the time spent on contacting and reminding people to complete the questionnaire, indicates that service user involvement holds a relatively low profile in many of the hospitals mapped. The researchers definitely got the sense of 'What – service user involvement?' from many

of the contacts they spoke to. It is also alarming that, in some hospitals, senior staff did not seem to know who was responsible for service user involvement, and researchers were passed from one senior person to another. It can only be concluded that user involvement is not considered high priority enough to warrant a named individual who has responsibility for it within that organisation or setting. In retrospect, there should have been a pre-research step of writing to the senior person at each hospital, raising the profile of the research and asking them to indicate the person responsible for service user involvement.

The data collection instrument, when completed, yielded rich and relevant information, however the quality of the information gained will have been influenced by both the data collection method, and who completed the questionnaire. A short coming is that staff answered the questionnaire and if service users had we would arguably have seen completely different picture. The qualitative data gained seemed to be fuller and more considered when the questionnaire was emailed and self-completed, however as it was not possible to gain email contact information for many hospitals in the Independent Sector, the questionnaire had to be completed by telephone interview. In relation to the person who completed the questionnaire and person responsible for service user involvement, it can not always be assumed that this was one and the same person. In some hospitals, where there was a main person responsible for service user involvement, it was easy to ascertain who it was, and they were more than happy to complete it; in other hospitals it was just an impossible task, and it may be that because the questionnaire did not reach the right person, if there was a designated person, it was not completed at all, or that if it was completed and returned the data was less well informed.

The research did not gain information on whether hospitals had policies and protocols relating to service user involvement, or whether there was a mechanism in place for patients to say how effective they think service user involvement mechanisms are.

Recommendations

Recommendation 1

All adult forensic hospitals should have a named person responsible for service user involvement, which all staff and patients at the hospital are made aware of.

Recommendation 2

Any future research relating to service user involvement should:

- raise the profile of the project at a senior level, within adult forensic hospital settings, and ask them to identify the appropriate person responsible for service user involvement.
- gain information about policies and protocols that the hospital has on service user involvement.
- gain information about service users' perception of the service user involvement mechanisms in place.

Recommendation 3

The information gained from this mapping project should be used as a base-line of service user involvement practice in adult forensic hospitals. Funding should be

sought to develop a project to improve service user involvement in adult forensic settings, sharing good practice and supporting mechanisms to be more effective. The research should be repeated to measure changed practice in service user involvement.

5.4 Response rate and representativeness of the data

The total number of hospitals mapped was 154. Of this number 71 were NHS hospitals and 83 were hospitals in the Independent Sector. 75 hospitals responded overall (48.7%). In order to assess how representative the data is, and to be aware of any bias which may have been built in, an analysis of the responses has been performed to compare the expected and actual response rate in relation to each of the following variables

- Sector provider;
- Hospital size;
- Gender mix; and
- Security level

Graphs showing the bias in relation to each variable can be seen in **Appendix I.** The most key points in relation to each of the variables are summarized below:

5.4.1 Sector provider

The overall response rate is 48.7%, but is biased in favour of Independent hospitals which made up 59% of the hospitals giving information. This signifies an over-representation of 8.5%, with 41% of responding hospitals being NHS, and under-representation of 11.3%. The higher response from the Independent Sector may be explained by the fact that data had to be collected by telephone interview, as it was difficult to obtain email contact information.

In addition there was a larger proportion of NHS hospitals where neither size (11%), nor gender mix (22%) could be determined in the original mapping, which will have skewed the figures collected for this report.

5.4.2 Hospital size

For NHS hospitals proportionally there was an over-representation of larger hospitals by 50%. Considering the Independent Sector, larger hospitals were also overrepresented but at 29%. Smaller hospitals were underrepresented by 48% for the NHS and medium sized hospitals were underrepresented in the Independent Sector by 11%

5.4.3 Gender mix

The gender mix of hospitals is fairly well represented within the sample. Male hospitals were slightly over represented at 16% and mixed gender at 8%. NHS female hospitals were overrepresented by 100% because they made up 4% of responses but account for 2% of the total of NHS hospitals. Gender bias will be influenced by the original mapping for hospitals which left 11% of the gender mix unknown. This information was later gained for all but 1% of the respondent hospitals.

5.4.4 Security level

The security level of hospitals sampled was skewed in favour of low and medium secure hospitals. In the NHS hospitals low and medium secure hospitals were overrepresented by 35% and high secure hospitals were overrepresented by 100%. There was an underrepresentation of NHS low secure hospitals by 22%. The sample of independent hospitals was a fairly good representation of the different security levels. There was a slight over-representation of low secure hospitals of 10%, and an under-representation of medium secure hospitals of 25%.

5.4.5 Conclusion

There is a range of bias built into the survey responses, this must be borne in mind in the interpretation of the findings. Particular consideration should be made of the skewing of the sample in relation to sector provider, security level and hospital size.

5.5 Person responsible for Service User Involvement

The data collection process was a huge exercise, primarily because it has been extremely difficult to ascertain who was responsible for service user involvement in the majority of hospitals. When trying to locate the person responsible, researchers have had to speak to up to 10 people, being passed around the hospital. This lack of clarity about responsibility was reinforced when the information contact responsible for completing the questionnaire was analysed; it ranges from Unit manager to Housekeeper, and includes almost everything in between!

Table 1: Service user involvement staff responsibility

Responsibility	Independent Sector	NHS	Total
Hospital Director, Unit Manager, Service Manager	18	3	21
Clínical Nurse Manager, Director of Nursing	12	1	13
PPI, SUI, Involvement & Communications, Equality & Diversity	0	17	17
Advocacy	3	0	3
Psychology	2	0	2
OT	1	2	3
Ward Manager/Staff Nurse/Team Leader	1	3	4
Social Work	1	0	1
Housekeeper	1	0	1
Non response	5	5	10

This table shows a distinct difference between the NHS and independent hospitals in relation to responsibility for service user involvement, with responsibility in the Independent Sector being the remit of unit, service, or nursing management in 68% of hospitals, and within NHS hospitals it being the remit of a specific service user involvement staff member in 55% of hospitals. There was an overall non-response of 13%.

5.5.1 Discussion and recommendations

It would appear that the concept of service user involvement within NHS hospitals is further developed, with the majority of NHS hospitals having a specific post allocated to service user involvement. This can be explained by the fact that it has been a statutory duty within the NHS to ensure service user involvement, but this requirement has only recently been extended to the Independent Health Sector. In the Independent Sector the role, in the main, fell to senior unit or nursing managers. In both sectors there was responsibility across other disciplines, but this may have been primarily because there was not a specific role allocated to service user involvement, and the task fell to the person who may know most about it. It is surprising to find that in 3 independent hospitals (7%), the Advocacy service was regarded as being responsible for service user involvement, which demonstrates a lack of ownership within the hospital.

Recommendations

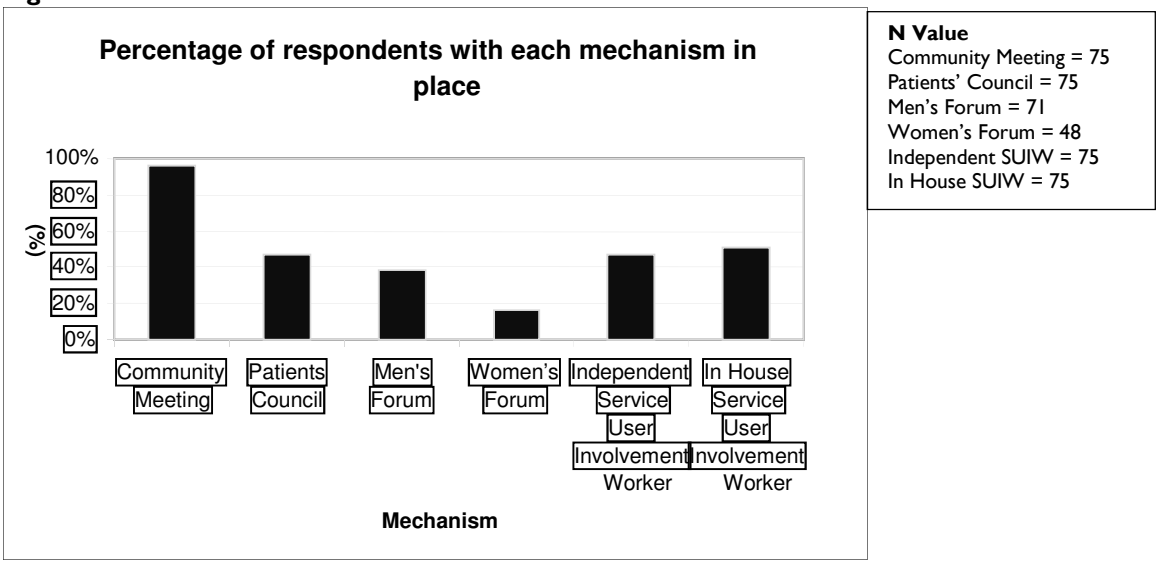
Recommendation 4

All forensic hospitals should have a specific hospital based post or part post designated as service user involvement lead, with clear responsibilities.

5.6 Service User Involvement Mechanisms: What is in place?

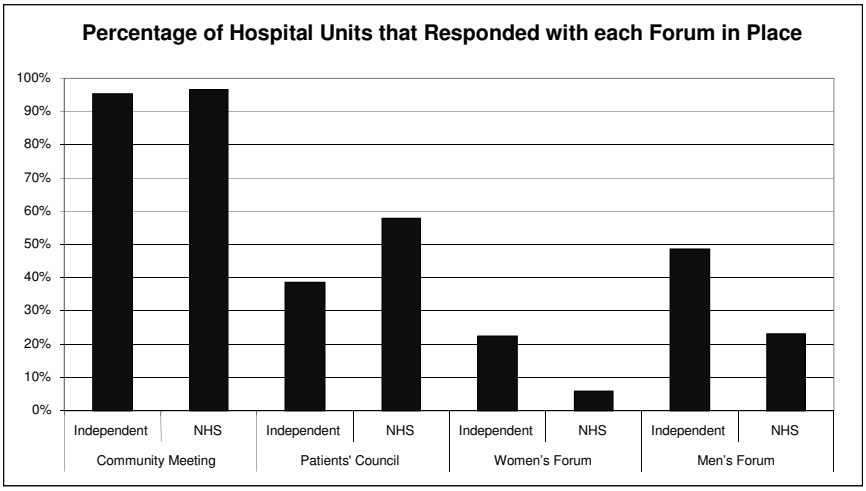
This section assesses how widely service user involvement mechanisms are used in forensic settings, which includes forums and dedicated service user involvement staff.

Figure 11: Overview of forums and dedicated service user involvement staff



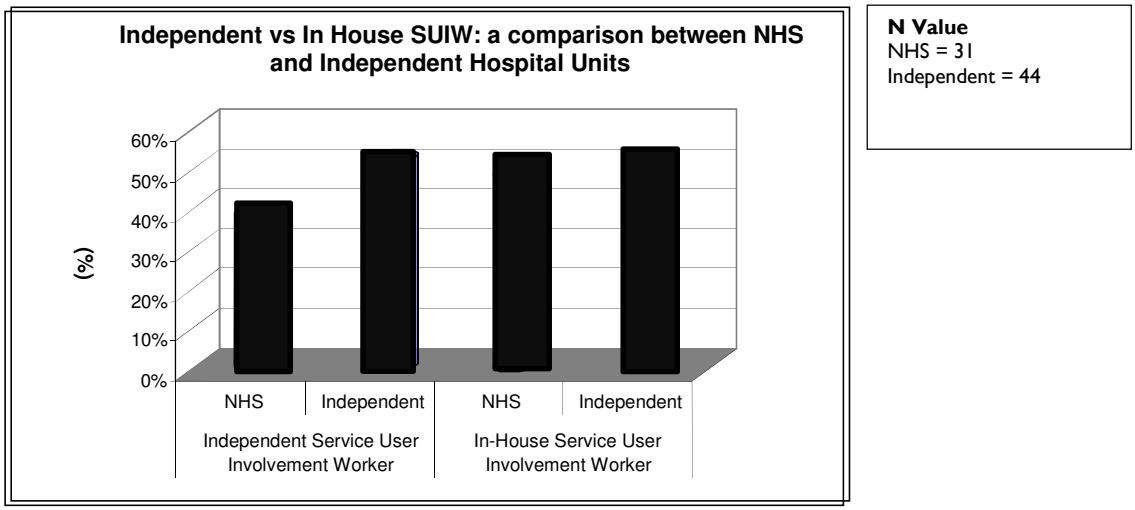
It can be seen that the most common type of forum in place is the Community Meeting (96%), followed by the Patients' Council (47%). A lower proportion of hospitals have either Men's (38%) or Women's (17%) forums in place. There is a similar number of hospitals having an Independent Service User Involvement Worker (47%) and an In House Service User Involvement Worker (51%).

Figure 12: Comparison of forums by sector



Of the hospitals that responded a fairly equal and high percentage, in excess of 90%, of both NHS and Independent hospitals have Community Meetings in place. In terms of the Patients' Council there are a higher percentage of hospitals (+19%) operating this forum in NHS hospital units (58%). For both the Women's and Men's Forums there is a higher percentage of these forums being operated in the Independent Sector, for the Women's Forum 23% (+17%) and the Men's Forum 49% (+26%).

Figure 13: Service User dedicated staff



In both the NHS and Independent sector there is over 50% of hospitals stating that they have an In-house Service User Involvement worker; in relation to an Independent Service User Involvement worker in place the Independent Sector hospitals have 60% in place, 13% more than NHS hospitals.

5.6.1 In-house Service User Involvement Worker

Of the 35 hospitals that responded to this question, there are three ways in which In-house service user involvement is carried out.

a) Specific worker

The majority of hospitals (22/35) have a specific worker that is responsible for in-house service user involvement. There are a range of different staff roles that carry out this work which include:

- Patient and Public Involvement or Service User Involvement staff with 7 being in NHS hospitals (8)
- Advocate (5)
- Occupational Therapist (4)
- Psychologists (4)
- Social Workers (3)
- Patient (2)

b) Group

The next most common form of providing a service user involvement service is through groups and forums. Seven of the thirty five hospitals that responded use groups as a way of obtaining service user involvement. In some cases hospitals have set up groups as well as having a specific worker and a general policy to gain maximum service user involvement.

c) General Policy: No worker

The 3 hospitals that do not have anyone who is specifically responsible for service user involvement instead have a general policy of increasing service user involvement.

5.6.2 Independent Service User Involvement Worker

Of the 30 hospitals that responded to this question the vast majority (25/31) of hospitals stated that they use an independent advocate to provide this service. There are also a small number of hospitals (4/31) that do not have a specific worker and instead use external groups and forums to provide this independent service.

5.6.3 Other mechanisms in place

Information about other mechanisms in place was given by 23 of the 75 hospitals (31%); in the NHS there were 15 hospitals (48%), and in the Independent Sector 8 hospitals (18%).

The information was wide ranging and there were four main themes which were profiled: general inclusion of service users in the process; integrated hospital structures; a mix of surveys, groups, leads and projects; and advocacy.

a) General inclusion of service users

'We have a paid ward representative post, paid at band one salary. That role involves showing visitors round, being a service user link with staff, chairing meetings, liaising with management. We also have a voluntary librarian post which involves a service user running the library for other service users supported by OT Technical instructor. Service users are also continually involved in their treatment and care plans are done collaboratively where possible. Service user questions have been gathered and used when interviewing candidates for jobs'.

'Service users regularly present at conferences and meetings within and outside the trust with appropriate support, e.g. on the subject of human rights. Service users on the unit's Creativity and Innovation group brought about a number of developments'.

The service users in this unit are represented at the Regional Involvement Strategy Group. We contribute to a number of initiatives that arose from their scoping document "Reaching Joint Solutions 2007-2010". Our unit undertook the development of an advanced decision project and designed the tool 'My Future Plan,' a service user written document for service users to individually express their desires and wishes from everything from identifying their shopping preferences and daily needs; cigarettes, drinks and snacks, to their identified coping strategies and preferences regarding placement of treatment and treatment given. We also contribute to the other regional units initiatives including the CPA standards written by service users and to the recent Dining Experience'.

'Patients are members of: Involvement Steering Group; Events Committee; Shop Committee; Library Committee; Healthy Living Group. Hold regular open days for carers to allow them to question staff about treatment and see activities. Patients involved in recruitment, sit on interview panels Involved in training of nursing staff and give presentations about patient views'.

'Are active members in the regional commissioning teams involvement strategy and steering group policy development; have included Development of Commissioning CQUINs including 25 hour activity/CPA standards/dining experience/ leave standards/ service user lead advanced directive formulation (My Future Plan). Leading on Regional Smoking facilities'.

'

b) Integrated structures

'Hospital User Forum has members from each ward. The Hospital then has representatives at the Trust-wide User Forum, chaired by the Chief Executive. This enables a throughput. Service users are also members of Directorate Clinical Improvement Groups. Service users are also involved in other working groups such as Hospital Audit Group, Shop Management Group, Catering Group'.

'There is a lead within High Secure Service for service user and carer involvement and the Allied Services Manager drives involvement at senior governance level. This ensures that involvement is acknowledged at all levels and there is someone responsible for co-ordinating and managing practical issues. The Independent Advocacy Service are heavily involved in the many meetings where patients are involved in service issues to provide support'.

'Ward planning and development teams, meet monthly and report to lead clinician with feedback given. Has high impact, used for changes to meals, ward routines, activities, Xmas'.

c) Survey, groups and leads, and projects

'The service conducts an annual patient's satisfaction survey. Patients are able to give their views on their care and the results are reviewed by the Senior Management Team. Improvement and action points are captured in an action plan which is reviewed regularly'.

'Annual patient's survey'.

'Trust wide lead'.

'A couple of clients attend Patient Involvement meetings on main hospital site'.

'LGB group'.

'Patient Council has twice yearly wider service council meeting'.

'Research & Development are also a key part of service user involvement through SEED project process'. (see page 28 for web link)

'Introducing Essen Climate Evaluation Scheme'. (see page 28 for web link)

d) Advocacy

'Access to IMHA's'.
'Advocacy service'.
'Independent Advocate'.
'PALS and Independent advocacy'.

5.6.4 Discussion and recommendations

Firstly, although the research asked about the existence of specific forums within forensic hospitals, there is no common definition of forums available, or recognized differentiation between forums.

Community Meetings are traditionally ward based meetings, which are more or less universally used with 96% of hospitals having these in place. Patients' Councils are designed to bring different sectors of the hospital together, and there was a lower proportion of these in place (47%). However, consideration needs to be given to the fact that smaller hospitals would not necessarily perceive a need for a Patient's Council, and it may be that in the absence of a Patients' Council, or a specific forum for men or women, the Community Meeting may also fulfill the role of a Patients' Council, thus having a wider than ward remit. 60% (21) of Patients' Councils were in mixed gender units, with 2 units having in addition both a Men's and Women's Forum, and 2 units having in addition just a Men's Forum. Of the remaining Patients' Councils 11 were in male only hospitals, with 7 of these hospitals also having a Men's Forum; and 2 were in women's hospitals. In relation to Men's Forums, in addition to those running in conjunction with Patients' Councils, there were 9 Men's Forums in

male only hospitals, 2 in mixed gender hospitals, without parallel Women's Forums; and 5 in mixed gender hospitals running in tandem with Women's Forums. The remaining Women's Forum was based in a female only hospital. In relation to Women's Forums, the above shows that in 4 hospitals where a Men's Forum was in place there was no parallel Women's Forum; in addition only 17% of hospital which had women service users had a Women's Forum in place, despite the fact that it is acknowledged that in mixed gender environments women do not have as strong a voice as men.

There is a pattern whereby NHS hospitals have a higher percentage (+19%) of Patients' Councils and the Independent Sector have a higher percentage of individual gender forums, Men's (+26%) and Women's (+17%) Given that the single gender forums are designed to meet the specific needs of each group, this could be seen as a gap in NHS provision in relation to gender.

In relation to Service User Involvement Workers (SUIW), the majority of hospitals stated that the Independent SUIW role was carried out by the advocate, but it was not clear what their precise role was. Advocacy is a very specific role within the hospital, and although it may be the remit of the advocate to support patients at specific forums, or attend Community Meetings, it would be unusual for advocates to have a full role in supporting a collective user voice; if not only because providing advocacy is time-pressured within limited hours.

With regards to the specific In-house SUIW role the information given was not conclusive. There were 8 hospitals which said that they had a specific In-house SUIW in post, 7 of these were in NHS hospitals, although the information gained in relation to staff member responsibility for service user involvement indicated that there were 17 NHS hospitals with a designated person responsible for service user involvement. It is difficult to explain this anomaly, other than either service user involvement having such a low profile, or there being somebody at a senior level having responsibility for service user involvement, but there not being a front line SUIW working directly with service users. In addition 5 hospitals named advocates, who are in fact independent from the hospital as the In-house SUIW, the remainder were a mix of MDT staff team members, with the exception of 2 hospitals who stated that patients carried out his role. Also included in the provision of In-house SUIW was the running of a group of service users and the existence of policy relating to service user involvement.

When looking at other service user involvement mechanisms which may be in place, the majority of information provided was profiling either the general ethos of including service users internally, including mention by 2 hospitals of My Future Plan[1], or externally including at a regional level; the second mechanism was ensuring that the structures in place to ensure action were linked to Governance. It was surprising that only 2 hospitals mention an Annual Patient Survey being in place, although this was not asked about specifically, it is a very common way of gaining feedback. Two

1 http://www.nhscentreforinvolvement.nhs.uk/docs/Involvement%20Awards%20-%202009%20-%20Case%20Studies%20-%20NHS%20Barnsley.pdf

hospitals mentioned specific projects, Essen Climate Evaluation Scheme[2] and the SEED Project[3] process. Once again advocacy was cited in the role of service user involvement.

Recommendations

Recommendation 5

A definition should be developed for each type of forum so that there is a common understanding of the remit and function of each forum, and clarity for both staff and service users

Recommendation 6

Involvement should be developed in quality assurance processes designed to ensure that standards of care are maintained and improved and that the service is accountable to those it serves (with reference to existing guidelines and policy such as MARD[4])

Recommendation 7

There is a need to develop good practice guidelines in relation to the involvement of individual service users at different level of the service user pathway

Recommendation 8

Men's and Women's Forums should run tandem within forensic hospital settings, not only because there may be different issues to be raised, but also because women can find it difficult to speak up in mixed gender groups.

Recommendation 9

There should be a named senior manager responsible for service user involvement, as well as a named staff member on the front line who can support the development and implementation of service user involvement within each setting

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[2] http://www.uni-due.de/rke-forensik/EssenerStationsklimafragebogenEssenCes.shtml

[3] http://www.northwest.nhs.uk/document_uploads/MentalHealthNews_July09/Issue053_Seed_CB.pdf

[4] The MARD Good Practice Guidance addresses the following themes:

- Be clear
- Be inclusive
- Treat people equally
- Have a positive attitude
- Ensure good communication and information
- Have good physical accessibility
- Adopt a good procedure
- Ensure support is available
- Have resources available
- Create meaningful involvement
- Consider all practical issues – before, during and after

MARD (Making A Real Difference) 2006 guidance, recommendations and minimum standards on good practice with respect to the *process* of involvement. These outline the overarching corporate commitments to involvement.

Recommendation 10
If advocates are to have a meaningful role in independent service user involvement work this should be clearly stated and funded, with a job description developed, which is separate from individual advocacy work.

Recommendation 11
Information about identified good practice in service user involvement in forensic settings should be researched and collated to make available on the NSUN web site, for example:

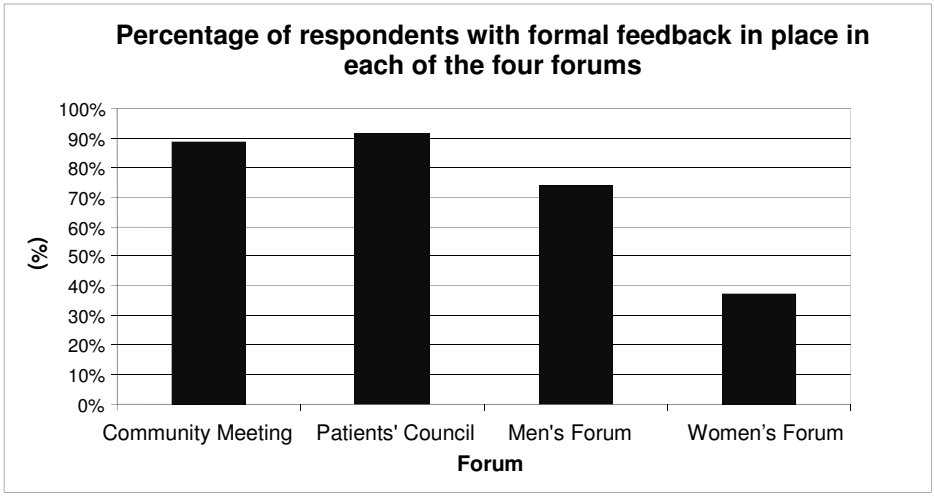
- My Future Plan
- The Essen Climate Evaluation Scheme - Assessing the social climate of forensic psychiatric wards
- The SEED project

5.7 Service User Involvement Forums: How do they work?

This section looks at how the forums operate in terms of formal feedback to service users; frequency of meetings; and the routes back into the hospital staff and processes.

5.7.1 Formal feedback to patients

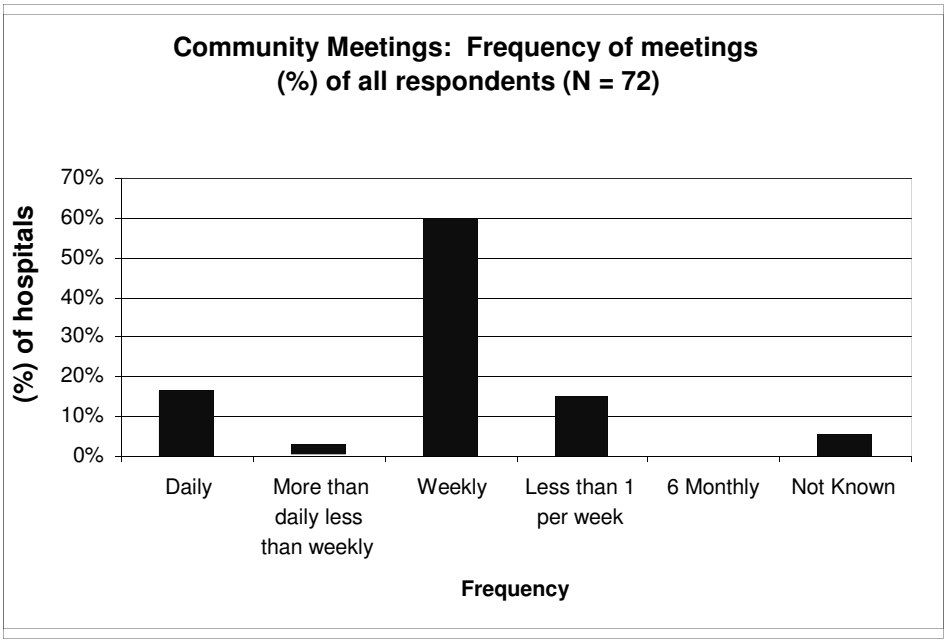
Figure 14: The percentage of hospitals with formal feedback in each forum



It can be seen that within both the Community Meetings and the Patients' Council there is a very high rate of formal feedback provided; 89% and 92% respectively. The Men's Forums has a relatively high percentage with formal feedback in place at 74% of hospitals, however it is the Women's Forum that has the lowest percentage of formal feedback with just 37%.

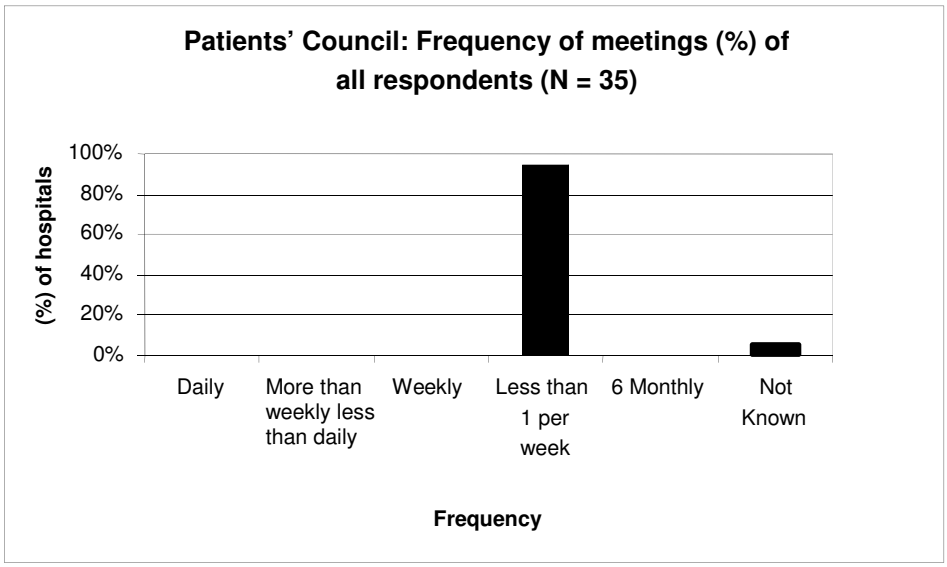
5.7.2 Frequency of forum meetings

Figure 15: Frequency of Community Meeting



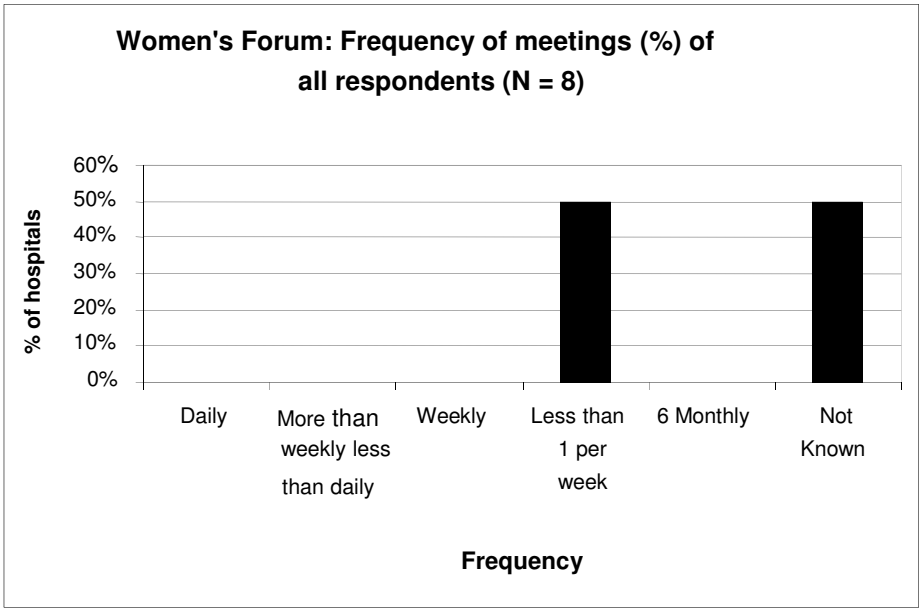
The majority of Community Meetings (60%) meet weekly, 17% of hospitals have Community Meetings on a daily basis, and 15% of Community Meetings take place less than once per week.

Figure 16: Frequency of Patients' Council



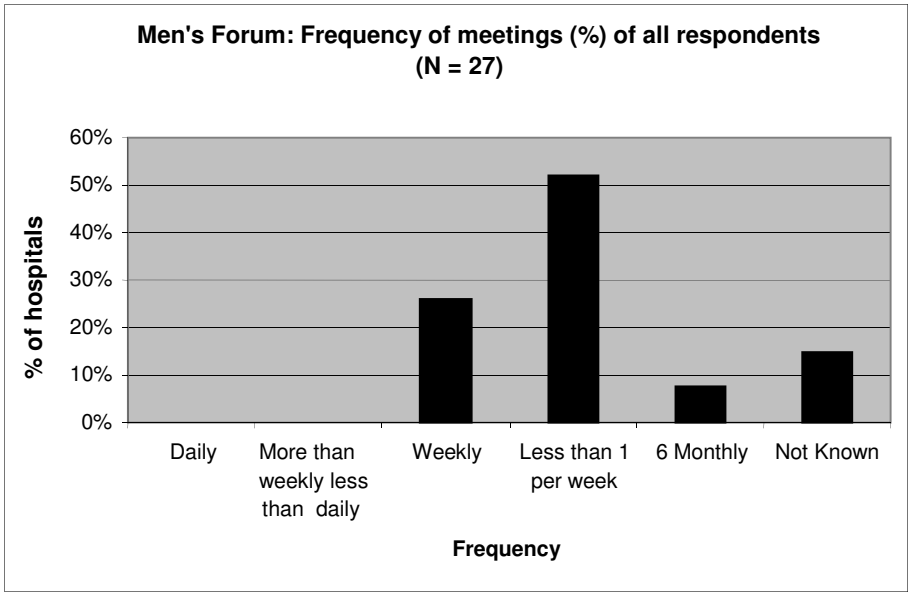
The majority of Patients' Council meetings take place less than once per week, with 94% fitting into this category; the majority of these meetings take place on a monthly basis.

Figure 17: Frequency of Women's Forum



Of the hospitals that operate a Women's Forum 50% of the forums take place less than once per week, the remaining frequencies are unknown

Figure 18: Frequency of Men's Forums

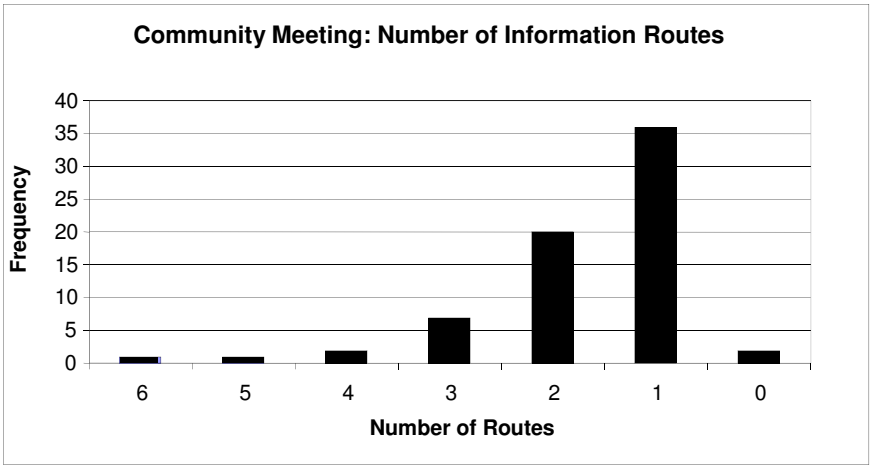


The majority of Men's Forums meet less than once a week (52%), 26% meet on a weekly basis, and a small proportion (8%) meet on a 6 monthly basis.

5.7.3 Information routes and destinations for forum information

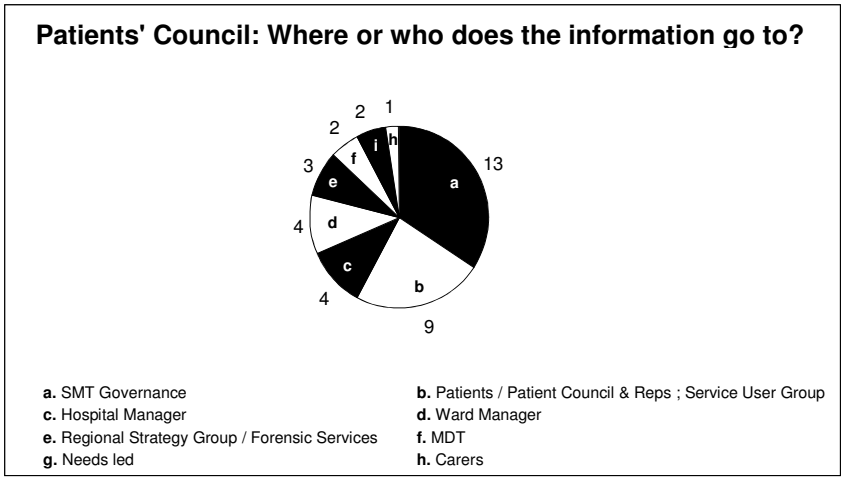
Figure 19: Community Meetings: information routes and destinations

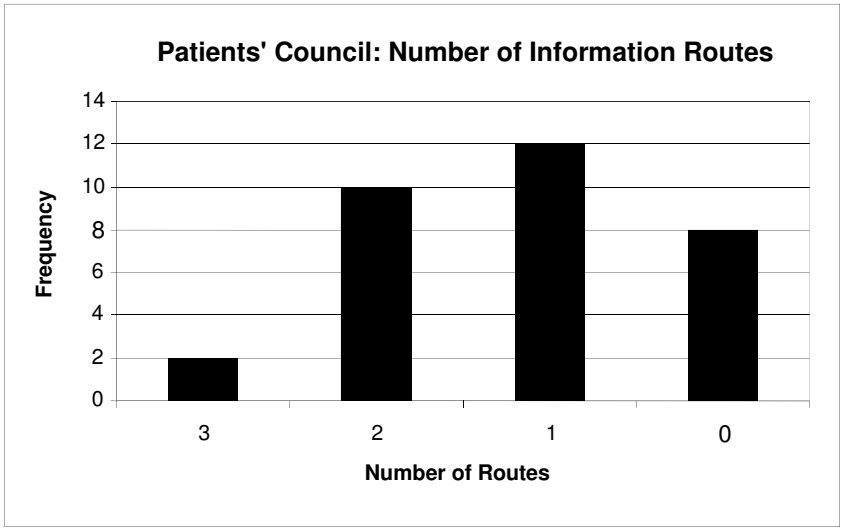
Ward Manager / Nursing staff / ward	31
Patients/Service Users/ SU group PPI / Patients Council	19
Hospital Manager	17
MDT	14
Circulated on Units / Notice Board	10
SMT/ Governance	9
Director of Nursing / CNM / Matron	7
Catering	3
Service Development Group	2
Advocacy Worker / Family member / CQC / Care manager / Social Worker	7



The information from Community Meetings reaches wide ranging destinations, especially in relation to senior management. However only 19 of the 72 hospitals cite patients or patient groups as a destination, although this contradicts the information given in formal feedback (89%). It may be that this question was interpreted as routes into hospital staff and other hospital processes. 35 of the hospitals that operate a Community Meeting have one information route out of the forum, and 20 hospitals have 2 routes. Hospitals that have more than 2 routes for information are a minority. It is worth mentioning that this is the only mechanism that has hospitals with more than 3 information routes out of the forum.

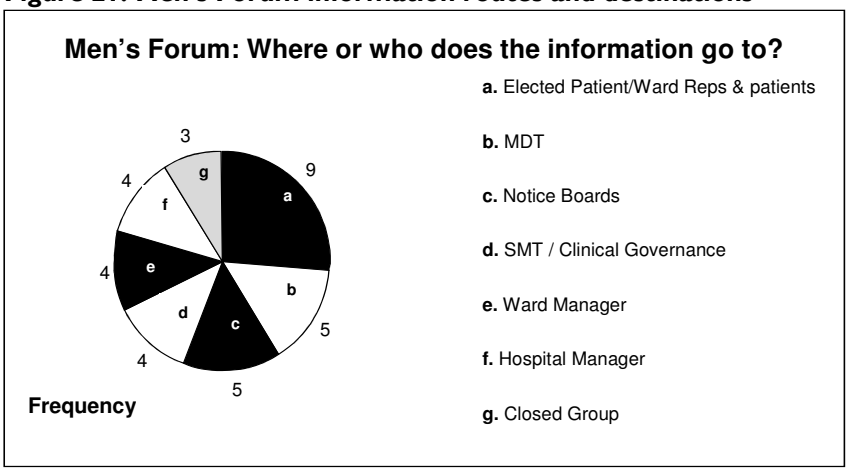
Figure 20: Patients' Council information routes and destinations

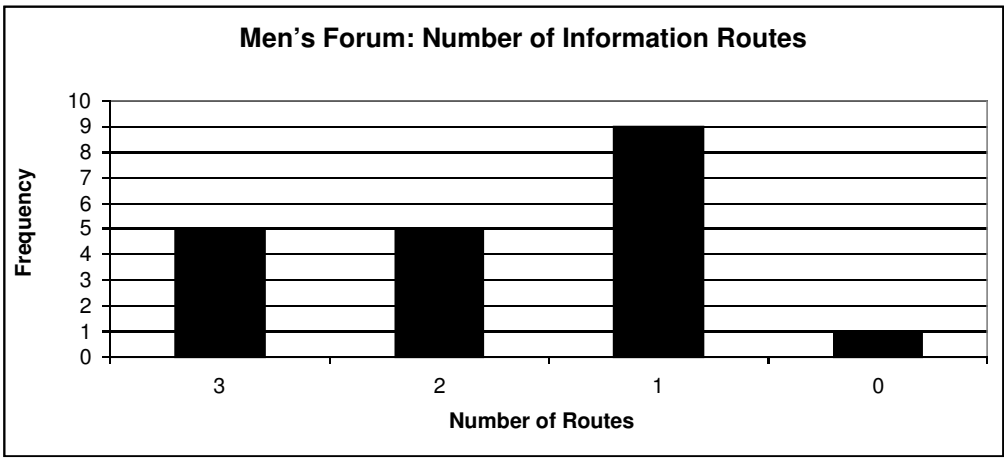




Once again this forum reaches wide ranging senior management destinations, but only 3 hospitals specifically mention patients in terms of information dissemination in contrast to 92% cited as giving formal feedback. Of the hospitals with a Patients' Council, the majority have one or two information routes. However there are a significant number (8 hospitals) with no information route out of the group.

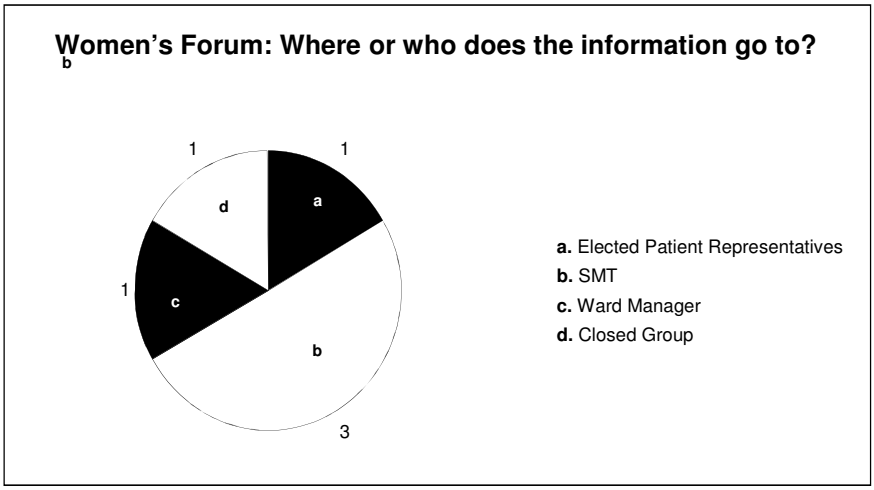
Figure 21: Men's Forum information routes and destinations

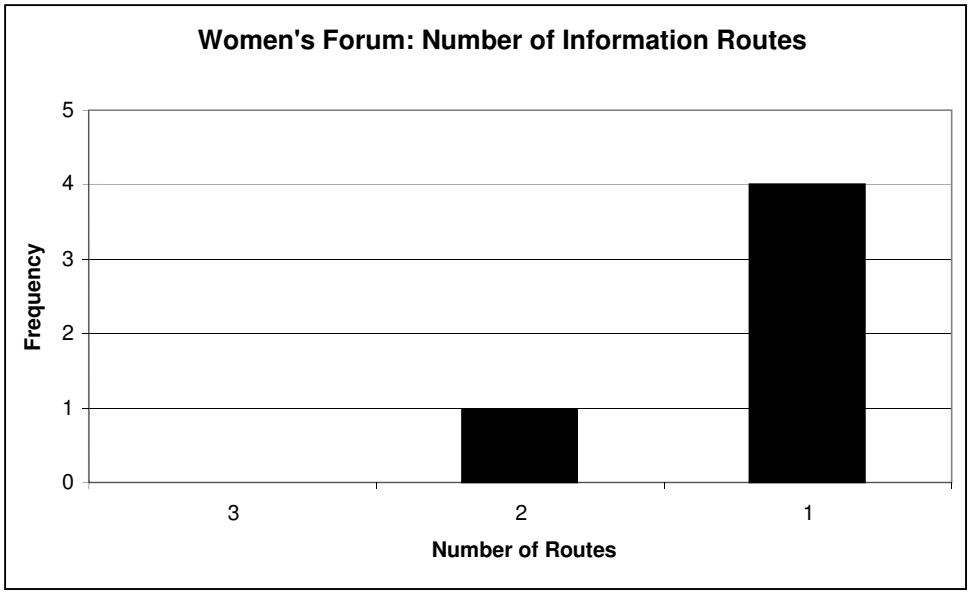




In terms of routes into the hospital the patient and user representatives are the largest destination group with 9 out of 20 hospitals giving this as a destination group. Diverse senior management groups are also destination points. In 3 cases the forum is a closed group. Nearly half of the hospitals that operate a Men's Forum have one information route out of the group, with a quarter having both 2 and 3 routes.

Figure 22: Women's Forum information routes and destinations





Most of the 6 Women's Forums have routes back to senior management, with one hospital including service users and one closed group. The majority, 4 Women's Forums, have one information route, with one hospital having 2 routes.

5.7.4 Discussion and recommendations

The degree of formal feedback is an area of concern, due to its vital importance in terms of successfully involving service users. There is an extremely low level of formal feedback in Women's Forums (37%) and even though there is much higher rate of formal feedback to service users in the other three forums, at 72%, 89% and 92%, it still means that 8-28% of forums are providing no formal feedback whatsoever. Feedback is an extremely important factor in terms of effectively involving service users and it is unacceptable that hospitals operate service user mechanisms which exclude service users.

In terms of the frequency of meeting of the various forums, there is little consistency, with the exception of Patients' Councils, all of which meet monthly. Community Meetings tend to meet more frequently with the majority (77%) meeting weekly or more. The majority of both Women's and Men's Forums meet less than once per week.

In terms of information routes into the hospital from the forums, all forums seem to have good routes to senior management within the hospital. However it can not be certain to what degree it is for information only and to what extent it spearheads service user driven change agendas, as part of the governance feedback loop. This will vary according to the commitment of the hospital and the SMT, to service user involvement. The number of routes into the hospital varies between 0 and 6 routes. Taking into account all the forums 8% had no route into the hospital, primarily from the Patients' Council, which seems a contradiction in terms, and would prevent the forum having meaningful input and influencing decision making at SMT level; 46% had one route in, 27% had 2 routes in, 11% had 3 routes in, and 5% of forums had more that 3 routes in.

Regarding information from the forums to service users this varies considerably; only about 25% of both Community Meetings and Patients' Councils profile service users as a route out for information, with Women's Forums being 16% and Men's Forums 45%. It may be that having given information about formal feedback to patients previously, it was assumed that this question related only to staff by many; although by including service users in the context of routes into the hospital it places them as more equal stakeholders.

Recommendations

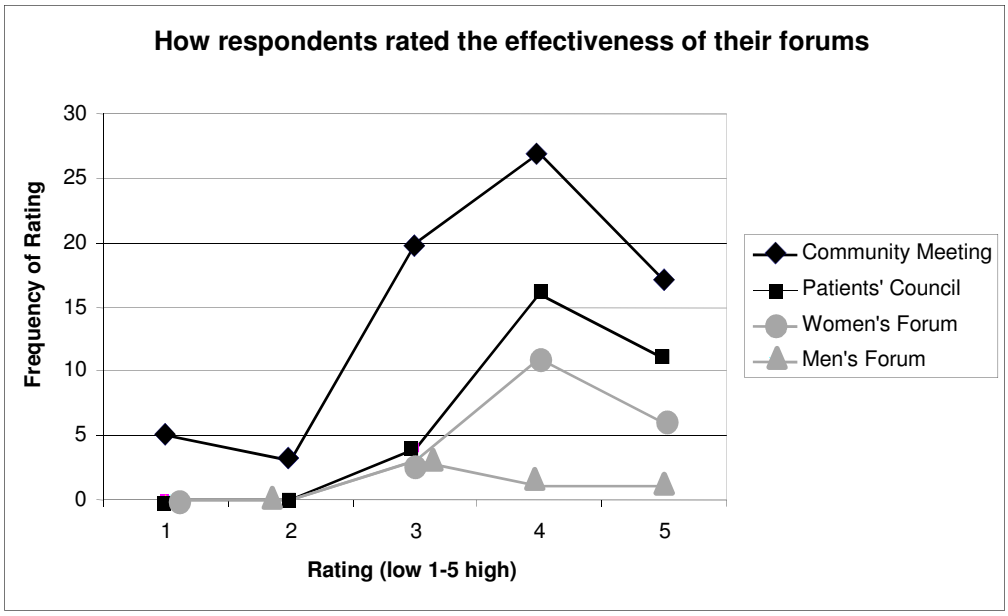
Recommendation 12
All service user mechanisms and forums should have formal feedback mechanisms in place to service users, as equal stakeholders, which clearly communicate what has been discussed, what issues are being addressed and what the progress and outcomes are on an ongoing basis.

Recommendation 13
Information from all service user mechanisms and forums should have a direct route to appropriate management, decision making and policy groups.

5.8 Perceived effectiveness of forums and effecting change

For each forum profiled the hospital was asked to rate its effectiveness. In addition for each of the forums operating at the hospital the respondent was asked to give an example of effecting change.

Figure 23: Perceived effectiveness rating



Very few hospitals rated the effectiveness of a forum below 3; only in the Community Meeting forum did this occur, with 5 hospitals giving a rating of 1, and 3 hospitals a rating of 2. In the three most prevalent forums, the Community Meeting,

Patients' Council and the Men's Forum, there was a peak at 4, meaning that a large proportion of hospitals rated their forum as above average effectiveness.

Forum	Mean Effectiveness
Community Meeting	3.7
Patients' Council	4.2
Women's Forum	3.6
Men's Forum	4.2

This table demonstrates the average perceived effectiveness rating of all responding hospitals, the highest rating being given to the Patients' Council and the Men's Forum of 4.2.

5.8.1 Effecting change: Community Meetings

Number of responses given
Independent Sector: 18/42 responses (43%)
NHS Hospitals: 29/30 responses (97%)
Total hospitals: 47/72 (65%)

In the responses given by 44 of the 72 hospitals with this forum in place, there were four recurring themes in the examples of how community meetings have effected change.

a) Activities

Of the hospitals that responded to this question, just under half (20) of the examples were related to activities in the hospitals. The answers consisted of discussion and changes to daily activities, suggestions of new activities and trips and changes to the time of activities.

'Suggestions are carried out on what the OT does. Also suggested activities are carried out for the service users'.

b) Menu changes and meal times

The second most frequent example was based around menu changes. Just under a third of the respondents (14) made reference to this change.

'Changes made to availability of drinks and snacks in the evening. Patient's garden cleaning roster implemented. Patients have been active in designing new summer menu'.

c) Feedback

Over a quarter of the respondents (13) commented on how feedback had improved through using this mechanism. The examples given mentioned the speed of feedback being given, requests being acted upon and 4 of the 12 respondents explained how this mechanism has provided a link between service

users and the Director/Service Manager. Of the respondents that gave this as an example two thirds were NHS hospitals.

'*On a very simple level that patients should have formal feedback; that if they ask questions there should be a responsible person who is willing (…) to go away and then provide feedback'.*

'*Directorate Management Team rep always present to provide feedback'.*

d) Smoking

Another common example was that of smoking. Of the 44 respondents 9 examples made reference to smoking policies. This consisted of smoking times, designated smoking areas and one respondent explained that this mechanism had led to support with smoking cessation.

'changing times of smoke breaks'.

The following comments are stand alone:

'Increased psychiatric cover increased 1 to 2 Drs'.

'Introduction of changes to MHA & 5 guiding principles - raised awareness & encouraged service users to attend more detailed information sharing events'.

'It helps prevent revolving door'.

'Service user rep has direct link to the director'.

'Patients voices can be heard through this mechanism, and any issues raised are taken to the patient's council. Also allows for daily planning. I would include this in the section of feedback. As due to this mechanism there is a place for raising and resolving issues'.

5.8.2 Effecting change: Patients' Council

Number of responses given

Independent Sector: 15/18 responses	(83%)
NHS Hospitals: 16/17 responses	(94%)
Total hospitals: 31/35	(89%)

In the responses given by 31 of the 35 hospitals with this mechanism in place, there were 3 recurring themes in the examples of how Patients' Council meetings have effected change.

a) Smoking

Of the 31 respondents 8 mentioned that changes to smoking policies and facilities had come about as a result of Patients' Council Meetings. The examples included smoking shelters being installed, smoking areas being designated, times being agreed, amendments to the smoking policy being carried out and help with smoking cessation being provided.

'Patient smoke shelter was put up as a direct result of this group'.

b) Menu Changes

Just over a third of the examples given (11), mentioned menu changes happening as a result of the Patients' Council. More specifically, food quality and menu choice were improved. Nine of the eleven examples of menu changes were from questionnaires completed by NHS hospitals and below is an example of such a response.

'Changes to food within clinic'.

c) Environmental Changes

Six of the respondents mentioned that as a result of the Patients' Council meetings, there had been changes made to the hospital environment. This refers to aesthetic and practical changes made to individual and communal areas of the hospital, for example the purchase of benches for outside communal areas and changes to service users' bedrooms.

'Bench seating supplied for courtyard, smoking policy amended, boilers fixed, and water coolers being fitted. Unit events arranged, bin fitted in hospital grounds'

The following are stand alone

'More staff employed'.

'CPA Standards - set by patients such as reading information before meetings'.

'Patients have complete control'.

'Increases compliance with treatment'.

'Making clear our stance and clearing away rumours'.

'Research opportunities for SU's, job placement, training and group work'.

'This forum can ask for specific agenda items to be considered such as the standardisation of policies and protocols across the service, in addition the care group managers can request information or opinions from the service users for specific work streams, i.e. the development of a low secure women's service'.

'Identified what they consider useful and therapeutic'.

'Action plans completed'.

'Developed admissions booklet for new patients'.

'Additional services - out of hours'.

'Setting up education sessions re bullying'.

'Influencing redevelopment, commenting on Security Directions. Local issues addressed such as estates and facilities'.

5.8.3 Effecting change: Women's Forum

Number of responses given
Independent Sector: 3/7 responses (43%)
NHS Hospitals: 1/1 responses (100%)
Total hospitals: 4/8 (50%)

Four of the eight respondents gave examples of changes as a result of this forum and one respondent stated that it '*was too early to say'*.

The three examples given were pampering evenings, women's health session being set up and communications raised being put into action and progressed.

One had been discontinued as it was thought to discriminate against men.

5.8.4 Effecting change: Men's Forum

Number of responses given
Independent Sector: 9/20 responses (45%)
NHS Hospitals: 7/7 responses (100%)
Total Hospitals: 16/27 (59%)

There was not really a main theme recurring regarding effecting change within this forum. The issues addressed, as in the other forums included changing of policies in relation to smoking and taking hot drinks to bedrooms, environmental changes and menu and food related changes.

'Taking hot drinks into bedrooms: this had not been permitted but clients have successfully argued that this poses no greater risk than having hot drinks in the lounge area'.

The following comments are stand alone

'Provides insight into life styles and choices of clients. Identifies areas for further therapeutic work and support'.

'It helps to organize, to review our policies'.

'Full management support to engage patient's views. Appropriate professionals also attend as required. Issues addressed such as purchase of specific goods. Also review care practices and policy changes i.e. seclusion. Facilities provided, shop, hairdresser, meals'.

'Security issues were amended'.

'Respecting boundaries'.

'Consultation about security issues resulted in changes being made'.

5.8.5 Discussion and recommendations

In relation to perceived effectiveness of forums respondents rated effectiveness as above average, with 3 of the 4 forums peaking at a rating of 4. This is obviously a subjective assessment; there is no indication that there was any objective measure of effectiveness, and in this research there was no way of measuring the impact of the forums from the service user's perspective, which has to be seen as a shortcoming. In addition there was no indication that service users' views were gained in relation to effectiveness of forums. Whilst claiming to have the service users' best interests at heart, and no doubt that is the case for a lot of staff, they will not hold the same views as service users due to the huge difference in power differentials and perceptions of the place they find themselves in. Staff can leave their place of work at the end of a shift, service users cannot leave what could be regarded by some as their home, others not, when they want.

In addition many of the areas mentioned relate more to day to day issues, which are no less important but will be more open to change. It can be argued that as some people are so disempowered by their experience of the forensic mental health system, they operate at a low level, i.e. what affects them, and what affects them now, rather than being actively supported to operate at a more strategic level. For some people, they will not have had this opportunity previously and engagement in service user involvement mechanisms should be prioritised. Examples relating to issues around liberties were few, for example the right to smoke.

When examining the areas where there had been a positive outcome in effecting change, throughout the forums the same themes recurred: smoking, activities, menu changes, and environmental changes; mainly ward based and more immediate issues. Even though the forums may have different remits and the potential to scope different areas, the reality seems to be that they operate very much at the same level; in the main addressing the more immediate issues, but it also being evident that more substantive areas of policy are being addressed, for example:

- CPAs
- Additional staff being employed
- Development of policy, procedures and communication channels

However there is no indication that the service users have an understanding of what is possible through these mechanisms.

Recommendations

Recommendation 14
Hospital units should have in place an objective measure of the impact of service user involvement mechanisms.

Recommendation 15
Service users should be formally consulted, to gain their views about the impact of the service user involvement mechanism and forums which are in place.

Recommendation 16
There should be written information for service users about the potential scope of the mechanisms and forums available and training should be made available to all service users so that the effectiveness of the mechanisms in place can be maximised.

5.9 Planned developments and further comments

The respondents were asked

Do you have any further comments?

Are there any developments planned in relation to service user involvement?

This was given as an opportunity for hospitals to showcase developments and other achievements.

5.9.1 Independent Sector responses

'Community meeting acts as Patients' Council and issues are fed back via Advocacy worker and unit manager to the SE Regional SMT, Members of SE regional SMT also attend the Community Meetings on a regular basis'.

'The service conducts an annual patients' satisfaction survey. Patients are able to give their views on their care and the results are reviewed by the Senior Management Team. Improvement and action points are captured in an action plan which is reviewed regularly'.

'Clinical governance, feel the system of Patient's Council works well'.

'Patients are active in their own care planning'.

'The Advocate also comes to local commissioner groups'.

'The Regional group which shares results nationally. Feel this has been very successful. Also useful for patients from other areas to meet patients from their own area re support'.

'Staff interviews… Audits e.g. first impressions audit'.

'Currently implementing the forensic recovery model across the service. Plans include identification & action of service user identified improvements, service user CPA reports, and completion of the ESSEN ward climate scale & on-going use of the DREEM questionnaire'.

'We developed a service user on site who was going to represent the Patient Advisory Group (PAG) on the Clinical Governance Committee and also chair the group. This individual would have likely become the Independent Service User involvement worker. However this failed due to relapse and put the group back a long way. We have also looked at replicating the PAG within both a women's and men's forum. However due to the nature of the services at X Hospital it is often difficult to gain attendance in the currently mixed forum'.

'My Future Plan not widely used but planning to relaunch, Self injury guide for staff created by staff and patients'.

'We have implemented a service user attending Partnership forums on both adult services, the service user will be nominated on a quarterly basis. We have recently (within the last month) piloted a Clinical Governance agenda for patients, we expect one community meeting a month to be a patients Clinical Governance meeting with mirrors and will feed into hospital Clinical Governance meeting monthly. We will be introducing the Essen climate scale on a weekly basis within the next quarter. We will be implementing the recovery tool WRAP within the next 6 months, tapping into expertise at our other site'.

'We also do anger management and therapeutic groups'.

'As we are a very new site and we are still developing our service. We are committed to meeting the needs of our clients in every possible manner and would welcome being led by them in regards to this area'.

'User involvement goes to the providing Trust'.

'Immediate developments are around the patient's experience of seclusion and advanced directives; CPA meetings and giving the patient more control in this meeting forum; a Patients' Council. Longer term I would like to look at both a men's forum and a women's forum; so that the needs of both genders can be recognised and acknowledged'.

'X hospital is very innovative and creative and actively encourages user participation through Patient forum, generates ideas and motivation for engagement across many areas of operation. More recently P discussed user involvement in training. This is to be incorporated in the next induction programme'.

'Input for offenders, other agencies come in to support'.

'I am in charge of the hire, I chair the Patients' Council, I see every complaint and make many changes in response to those. The community meetings feed into the planning and development teams, which a patient rep attends. Which feed in to the lead clinicians, from that ideas emerge etc and are taken to hospital and clinical governance, which I chair. This is attended by all the team managers, and we act on those ideas/concerns. I regularly walk the site and patients constantly prep me and share ideas - they all have the right to see me and many exercise that right both formally and informally'.

'There is a football team very regular at least once a week started from November 2009'.

'Expanding OT, Education, IT Suite and cooking'.

'High priority to involve patients in training, ward management meetings and strategic Forums'.

5.9.2 NHS Hospitals

'*Over the next year we hope to progress with service user involvement in interviews. Further improvements for vocational opportunities for service users are also high on the agenda'.*

'This is an area we feel needs to develop but it is a slow process. Looking to open stages to address service user involvement and looking at how we can evidence base service user involvement more efficiently The Champions have agreed to set up service user Champions Business Meetings that will meet weekly to develop better understanding of service user involvement. They will coordinate meetings as lead'.

'A small group of service users and staff in the unit are looking at paid employment of service users in involvement activities in accordance with the Trust's procedures, including as involvement champions'.

'We actively include service users at all levels within our service'.

'There is a proposal for a Forensic Service Users Forum but it is still in planning stage. There is a Trust Service User council which a patient from Forensic Services attends'.

'A Service User Council for the Trust exists with user involvement with Trust policy. However X is a 5 bed unit and more discussion and resolution happens as the kettle boils than any other forum. Patients are less relaxed in house meetings preferring informal settings'.

'The Division has made huge changes regarding service user involvement. There is a staff member lead on patient and staff experience who reports to the Director. Made a huge and positive impact as issues are raised are reported through lead on patient experience and then to the director and are then resolved quickly. User involvement is high on the agenda and there is a commitment to improve patient experience and to listen so we can deliver best possible service. Some areas are hard to improve due to other agencies setting guidelines and some risk factors. The Director is committed to attending forums to give updates. From the forums there has been action plans which service users have access to and can raise queries on if they're not happy with progress. We are looking at relevant training for service users who wish to be involved at different levels so they are empowered to represent at a more strategic level'.

'The Trust is working towards being established as the equivalent of a Foundation Trust. As part of this process structures will be developed to enable the engagement and involvement with the Trust Board of service users in the Forensic estate, who by virtue of their status are not allowed to become formal members of the Trust, in the way that other service users and carers are able to do'.

'Over the next 12 month period the forensic directorate is committed to establishing more effective service user and carer involvement. We plan to set up carers meetings for the inpatient and outpatient areas. In addition we will be developing a real-time feedback solution that helps us to monitor patient experience, which may then form part of service provision. We recognise that carer arrangements are less than satisfactory, but hope to remedy this without significant delay'.

'Wish provide regular attendance of a support worker which I'm advised women on X find of benefit. There has been a number of meetings over the years in respect to service user involvement in relation to staff recruitment and whilst there have been a number of

supported projects within the Trust work is still required to promote this as a consistent approach Trust-wide'.

'Engagement and assessment is the initial point of access to the care pathway process. The majority of clients are usually still experiencing acute positive psychotic phenomena. An independent advocacy worker is utilised by the majority of our clients to support and assist and represent them'.

'We will consider a service user involvement lead at next service board'.

'All secure units have an established involvement/development strategy group, established audit and reporting procedure in place with quarterly targets and reports to specialist commissioning team is currently on target'.

'We're currently reviewing service user strategy and standards for community meetings. Service users are also involved in redevelopment workshops for the Hospital'.

'Have just started a diversity group'.

'The hospital audits community meetings and has a service user involvement strategy which is being driven forward'.

5.9.3 Discussion and recommendations

In both Sectors this section profiles what people regard as good practice and gives hospitals the chance to demonstrate their commitment to service user involvement:

- Feedback and the importance of communication
- Input into regional forums
- Annual Survey - which is acted upon
- Links with Clinical Governance
- Addressing person-centred care planning
- Including patients in staff interviews
- Talk about different models of service: Forensic Recovery Model
- Ensuring that people have CPA reports
- Policy development and service user development
- Use of a range of service user orientated mechanisms
    - Essen Climate Evaluation Scheme
    - DREEM questionnaire
    - My future Plan
    - The WRAP Tool
- Various service developments

The examples of initiatives and developments are impressive and indicate that there is much activity in relation to service user involvement.

Recommendations

Recommendation 17
The research should capitalise on the information given in this section to develop case studies of those hospital units which have been addressing or are in the process of driving forward a service user agenda; to gain information to disseminate to all hospitals and provide support based on others experience; to include both staff and patients.

5.10 Conclusion

As there has been a statutory requirement for service user involvement in the NHS for some years, service user involvement seems to be more developed within NHS forensic hospitals; although in October 2010, there is also a statutory requirement for Independent Sector hospitals to take into account service users' views and experiences in the way the service is provided and delivered.

In many hospitals it was difficult to find out who was responsible for service user involvement, indicating that service user involvement was given a low priority. When there was a named post holder the post varied considerably including senior management, specific service user involvement worker, and specific MDT members. Thus, there is an overall lack of both clarity and consistency in terms of hospital ownership of service user involvement.

Most hospitals have Community Meetings, about half had Patients' Councils, an Independent Service User Involvement Worker, and an In House Service User Involvement Worker; with Men's and Women's Forums, in eligible hospitals trailing at 38% and 17% respectively. There is no common definition of the various forums, and they seem to address similar issues in terms of day to day ward issues, with less focus on strategic and policy change. There were, however, a small proportion of hospitals which demonstrated the commitments to and infrastructure for progressive service user involvement. Women's Forums in all relevant settings seem to have been given a lower priority despite the fact that it is acknowledged that in mixed gender environments women do not have as strong a voice as men. There was also an association of Independent Service User Involvement Worker with the advocacy role, despite this already being a pressured role; and confusion as to who provided In-House Service User Involvement.

Although there is a high rate of formal feedback provided to service users by Community Meetings, Patients' Councils, and Men's Forums, Women's Forums had a low rate of formal feedback. In conjunction with this, when asked about routes into the hospital for information in a separate question, information from the forums to service users varies considerably ranging from 16% of Women's Forums to 45% of Men's Forums, with Community Meetings and Patients' Councils in between. The degree of formal feedback to service users as equal stakeholders is an area of concern, due to its vital importance in terms of successfully involving service users, and it is unacceptable that hospitals operate service user mechanisms which exclude service users. All forums seem to have good routes to senior management within

the hospital. However it cannot be certain to what degree it is for information only and to what extent it spearheads service user driven change agendas, as part of the governance feedback loop.

In relation to the perceived effectiveness of forums, respondents rated effectiveness as above average, with 3 of the 4 forums peaking at a rating of 4. This is obviously a subjective assessment; there is no indication that there was any objective measure of effectiveness, and in this research there was no way of measuring the impact of the forums from the service user's perspective, which has to be seen as a shortcoming. In addition there was no indication that service users views were gained in relation to effectiveness of forums.

Hospitals profiled what they regard as good practice and demonstrated their commitment to service user involvement. It was evident that some hospitals are implementing major and progressive developments in relation to the future development of service user involvement.

Appendix A

Mapping: Prisons

Provider	Name of prison	Address
HMPS	HMP Acklington	Morpeth, Northumberland
GSL	HMP Altcourse	Liverpool, Merseyside
HMPS	HMP Ashwell	Oakham, Rutland
HMPS	HMP/YOI Askham Grange	York, North Yorkshire
HMPS	HMYOI Aylesbury	Aylesbury, Buckinghamshire
HMPS	HMP Bedford	Bedford, Bedfordshire
HMPS	HMP Belmarsh	Thamesmead, London
HMPS	HMP Birmingham	Brimingham, West Midlands
HMPS	HMP Blantyre House	Goudhurst, Kent
HMPS	HMP Blundeston	Lowestoft, Suffolk
HMPS	HMP/YOI Brinsford	Featherstone, Wolverhampton
HMPS	HMP Bristol	Bristol
HMPS	HMP Brixton	London, Greater London
Kalyx	HMP Bronzefield	Ashford, Middlesex
HMPS	HMP Buckley Hall	Rochdale, Lancs
HMPS	HMP Bullingdon	Bicester, Oxfordshire
HMPS	HMP/YOI Bullwood Hall	Hockley, Essex
HMPS	HMP Canterbury	Canterbury, Kent
HMPS	HMP/YOI Castington	Morpeth, Northumberland
HMPS	HMP Channings Wood	Newton Abbot, Devon
HMPS	HMP/YOI Chelmsford	Chelmsford, Essex
HMPS	HMP Coldingley	Woking, Surrey
HMPS	HMP Cookham Wood	Rochester, Kent
HMPS	HMP Dartmoor	Yelverton, Devon
HMPS	HMYOI Deerbolt	Barnard Castle, County Durham
Serco	HMP/YOI Doncaster	Marshgate, Doncaster
HMPS	HMP Dorchester	Dorchester, Dorset
Serco	HMP Dovegate	Uttoxeter, Staffordshire
HMPS	HMP Downview	Sutton, Surrey
HMPS	HMP/YOI Drake Hall	Eccleshall, Staffordshire
HMPS	HMP Durham	Durham, County Durham
HMPS	HMP/YOI East Sutton Park	Maidstone, Kent
HMPS	HMP/YOI Eastwood Park	Wotton-under-Edge, Gloucestershire
HMPS	HMP Edmunds Hill	Newmarket, Suffolk
HMPS	HMP Elmley	Sheerness, Kent
HMPS	HMP Erlestoke	Devizes, Wiltshire
HMPS	HMP Everthorpe	Brough, East Yorkshire
HMPS	HMP/YOI Exeter	Exeter, Devon
HMPS	HMP Featherstone	Wolverhampton, Staffordshire
HMPS	HMP/YOI Feltham	Feltham, Middlesex
HMPS	HMP Ford	Arundel, West Sussex
Kalyx	HMP/YOI Forest Bank	Manchester, Greater Manchester
HMPS	HMP Foston Hall	Derby, Derbyshire

Provider	Name of prison	Address
HMPS	HMP Frankland	Durham, County Durham
HMPS	HMP Full Sutton	York, North Yorkshire
HMPS	HMP Garth	Leyland, Preston
HMPS	HMP Gartree	Market Harborough, Leicestershire
HMPS	HMYOI/RC Glen Parva	Wigston, Leicester
HMPS	HMP/YOI Gloucester	Gloucester, Gloucestershire
HMPS	HMP Grendon	Buckinghamshire
HMPS	HMP?YOI Guys Marsh	Shaftesbury, Dorset
HMPS	HMP Haverigg	Millom, Cumbria
HMPS	HMP Hewell	Redditch, Worcestershire
HMPS	HMP High Down	Sutton, Surrey
HMPS	HMP Highpoint	Newmarket, Suffolk
HMPS	HMYOI Hindley	Wigan, Greater Manchester
HMPS	HMP Hollesley Bay	Woodbridge, Suffolk
HMPS	HMP/YOI Holloway	London, Greater London
HMPS	HMP Holme House	Stockton on Tees
HMPS	HMP Hull	Hull, Yorkshire
HMPS	HMP Isle of Wight	Newport, Isle of Wight
HMPS	HMP Kennet	Liverpool, Merseyside
HMPS	HMP Kingston	Portsmouth, Hampshire
HMPS	HMP Kirkham	Preston, Lancs
HMPS	HMP Kirklevington Grange	Yarm, Cleveland
HMPS	HMP Lancaster Castle	Lancaster, Lancashire
HMPS	HMP/YOI Lancaster Farms	Lancaster, Lancashire
HMPS	HMP Latchmere House	Richmond, Surrey
HMPS	HMP Leeds	Leeds, West Yorkshire
HMPS	HMP Leicester	Leicester
HMPS	HMP/YOI Lewes	Lewes, East Sussex
HMPS	HMP Leyhill	Gloucester, Gloucestershire
HMPS	HMP Lincoln	Lincoln, Lincolnshire
HMPS	HMP IRC Lindholme	Doncaster, South Yorkshire
HMPS	HMP Littlehey	Huntingdon, Cambridgeshire
HMPS	HMP Liverpool	Liverpool, Merseyside
HMPS	HMP Long Lartin	Evesham, Worcestershire
HMPS	HMYOI Low Newton	Brasside, Durham
Serco	HMP Lowdham Grange	Lowdham, Nottinghamshire
HMPS	HMP Maidstone	Maidstone, Kent
HMPS	HMP Manchester	Manchester, Greater Manchester
HMPS	HMP/YOI Moorland Closed	Doncaster, South Yorkshire
HMPS	HMP/YOI Moorland Open	Doncaster, South Yorkshire
HMPS	HMP Morton Hall	Lincoln, Lincolnshire
HMPS	HMP/YOI New Hall	Wakefield, West Yorkshire
HMPS	HMP North Sea Camp	Boston, Lincolnshire
HMPS	HMYOI Northallerton	Northallerton, North Yorkshire
HMPS	HMP/YOI Norwich	Norwich, Norfolk
HMPS	HMP Nottingham	Sherwood, Nottinghamshire
HMPS	HMYOI Onley	Rugby, Warwickshire
HMPS	HMP Pentonville	London, Greater London
Kalyx	HMP Peterborough	Peterborough, Cambridgeshire

Provider	Name of prison	Address
HMPS	HMYOI Portland	Portland, Dorset
HMPS	HMP Preston	Preston, Lancashire
HMPS	HMP Ranby	Retford, Nottinghamshire
HMPS	HMP/YOI Reading	Reading, Berkshire
HMPS	HMP Risley	Warrington, Chesire
HMPS	HMP Rochester	Rochester, Kent
GSL	HMP Rye Hill	Rugby, Warwickshire
HMPS	HMP Send	Woking, Surrey
HMPS	HMP Shepton Mallet	Shepton Mallet, Somerset
HMPS	HMP Shrewsbury	Shrewsbury, Shropshire
HMPS	HMP Spring Hill	Aylesbury, Buckinghamshire
HMPS	HMP Stafford	Stafford, Staffordshire
HMPS	HMP Standford Hill	Sheerness, Kent
HMPS	HMP Stocken	Oakham, Rutland
HMPS	HMYOI Stoke Heath	Market Drayton, Shropshire
HMPS	HMP?YOI Styal	Wilmslow, Cheshire
HMPS	HMP Sudbury	Ashbourne, Derbyshire
HMPS	HMP Swaleside	Sheerness, Kent
HMPS	HMYOI Swinfen Hall	Lichfield, Staffordshire
HMPS	HMP The Mount	Hemel Hempstead, Hertfordshire
HMPS	HMP The Verne	Portland, Dorset
HMPS	HMYOI Thorn Cross	Warrington, Chesire
HMPS	HMP Wakefield	Wakefield, West Yorkshire
HMPS	HMP Wandsworth	London, Greater London
HMPS	HMP Wayland	Thetford, Norfolk
HMPS	HMP Wealstun	Wetherby, Yorkshire
HMPS	HMP Wellingborough	Wellingborough, Northamptonshire
HMPS	HMYOI Wetherby	Wetherby, West Yorkshire
HMPS	HMP Whatton	Whatton, Nottinghamshire
HMPS	HMP Whitemoor	March, Cambridgeshire
HMPS	HMP Winchester	Winchester, Hampshire
GSL	HMP Wolds	Everthorpe, East Yorkshire
HMPS	HMP Woodhill	Milton Keynes, Buckinghamshire
HMPS	HMP Wormwood Scrubs	London, Greater London
HMPS	HMP Wymott	Preston, Lancashire

Appendix B

Mapping Forensic Services for Young People in England

Forensic Child & Adolescent Mental Health Services (FCAMHS)

Provider	Name of unit	Location
St. Andrew's Healthcare	Lowther Adolescent Service	Northampton, Northamptonshire
Cygnet Health Care	Fry Unit	Stevenage, Herts
St. Luke's Hospital Group	Cherry Oak Unit	Attleborough, Norfolk
West London Mental Health Trust	Wells Unit	Southall, Middlesex
South London and Maudesley Foundation Trust	Bill Yule Adolescent Unit	Beckenham, Kent
Northumberland, Tyne and Wear NHS Trust	Roycroft Clinic	Newcastle, Tyne and Wear
Northumberland, Tyne and Wear NHS Trust	Stephenson House	Prudhoe, Northumberland
Tees, Esk and Wear Valleys Foundation Trust	Westwood Centre	Middlesbrough, North Yorkshire
Greater Manchester West Mental Health Foundation Trust	Gardener Unit	Prestwich, Manchester
Affinity Healthcare	Meadows & Woodlands	Cheadle, Cheshire
Hampshire Partnership NHS Trust	Bluebird House	Southampton, Hampshire
The Huntercombe Group	Severn Unit & Thames Unit	Maidenhead, Berkshire
Oak View Estates Ltd	Oak View Hospital	Orpington, Kent
Birmingham and Solihull Mental Health Foundation Trust	Ardenleigh	Birmingham, West Midlands
The Huntercombe Group	Thornicroft Unit & Hartley Ward	Wheaton Aston, Stafford

Secure Children's Homes

Strategic Health Authority	Provider	Name of unit	Address
East Midlands	Nottinghamshire County Council	Clayfields House Secure Unit	Stapleford, Nottingham
East Midlands	Lincolnshire County Council	Lincolnshire Secure Unit	Sleaford, Lincolnshire
London	Glen Care Group	Orchard Lodge	Anerley, London
North East	Durham County Council	Aycliffe Young People's Centre	Durham, County Durham
North East	Northumberland County Council	Kyloe House Secure Children's Home	Morpeth, Northumberland
North West	Salford City Council	Barton Moss Secure Care Centre	Manchester, Greater Manchester
North West	St. Helens Borough Council	Red Bank Community Home	Newton-le-willows, Merseyside
South Central	Hampshire County Council	Swanwick Lodge	Swanwick, Southampton
South West	Devon County Council	Atkinson Unit	Exeter, Devon
South West	South Gloucestershire County Council	Vinney Green Secure Unit	Emersons Green, Bristol
Yorkshire and the Humber	Leeds City Council	East Moor Secure Children's Home	Leeds, West Yorkshire
Yorkshire and the Humber	Sheffield City Council	Aldine House Secure Children's Centre	Sheffield, South Yorkshire
East of England	Peterborough City Council	Clare Lodge Secure Unit **(Welfare only)**	Peterborough, Cambridgeshire
East of England	Essex County Council	Leverton **(Welfare only)**	Brentwood, Essex
North West	Nugent Care	St Catherine's Secure Centre **(Welfare only)**	St. Helens, Merseyside
South East Coast	West Sussex County Council	Beechfield Secure Unit **(Welfare only)**	Copthorne, West Sussex
South East Coast	East Sussex County Council	Lansdowne Unit **(Welfare only)**	Hailsham, East Sussex

Secure Training Centres

Strategic Health Authority	Provider	Name of unit	Address
North East	Serco	Hassockfield Secure Training Centre	Consett, County Durham
South Central	GSL	Oakhill Secure Training Centre	Milton Keynes, Buckinghamshire
South East Coast	GSL	Medway Secure Training Centre	Rochester, Kent
West Midlands	GSL	Rainsbrook Secure Training Centre	Rugby, Warwickshire

Young Offenders Institutions

Strategic Health Authority	Provider	Name of unit	Address
East Midlands	HMPS	HMP Foston Hall	Derby, Derbyshire
East of England	HMPS	HMYOI Warren Hill	Woodbridge, Suffolk
London	HMPS	HMP/YOI Feltham	Feltham, Middlesex
North East	HMPS	HMP/YOI Castington	Morpeth, Northumberland
North West	HMPS	HMYOI Hindley	Bickershaw, Wigan
South Central	HMPS	HMYOI Huntercombe	Henley-on-Thames, Oxfordshire
South East Coast	HMPS	HMP Downview	Sutton, Surrey
South East Coast	HMPS	HMP Cookham Wood	Rochester, Kent
South West	HMPS	HMP/YOI Eastwood Park	Wotton-under-Edge, Gloucestershire
South West	Serco	HMP/YOI Ashfield	Pucklechurch, Bristol
West Midlands	HMPS	HMP/YOI Brinsford (closing to juveniles in 2010)	Featherstone, Wolverhampton
West Midlands	HMPS	HMYOI Stoke Heath	Market Drayton, Shropshire
West Midlands	HMPS	HMYOI Werrington	Stoke-on-Trent, Staffordshire
Yorkshire and the Humber	HMPS	HMP/YOI New Hall	Wakefield, West Yorkshire

Strategic Health Authority	Provider	Name of unit	Address
Yorkshire and the Humber	HMPS	HMYOI Wetherby	Wetherby, West Yorkshire

Appendix C

Mapping NHS Adult Forensic Services

Provider	Name of unit	Location
2gether NHS Foundation Trust	Montpellier Unit	Gloucester, Avon
Avon and Wiltshire Mental Health Partnership NHS Trust	Fromeside	Bristol, Avon
Barnet, Enfield and Haringey Mental Health NHS Trust	Camlet One	Enfield, Middlesex
Bedfordshire and Luton Mental Health and Social Care NHS Trust	Robin Pinto Unit One	Luton, Beds
Birmingham and Solihull Mental Health NHS Foundation Trust	Reaside	Birmingham, West Midlands
Birmingham and Solihull Mental Health NHS Foundation Trust	Hillis Lodge	Birmingham, West Midlands
Birmingham and Solihull Mental Health NHS Foundation Trust	Ardenleigh	
Bradford District Care Trust	Moorlands View	Bradford, Yorks
Calderstones Partnership NHS Foundation Trust	Woodview	Clitheroe, Lancashire
Calderstones Partnership NHS Foundation Trust	Gisburn Lodge	Clitheroe, Lancashire
Calderstones Partnership NHS Foundation Trust	Scott House	Rochdale, Greater Manchester
Cambridgeshire and Peterborough NHS Foundation Trust	George Mackenzie House	Cambridge, Cambridgeshire
Cornwall Partnership NHS Trust	Bowman Unit	Bodmin, Cornwall
Devon Partnership NHS Trust	Butler Clinic	Dawlish, Devon
Dorset Healthcare NHS Foundation Trust	Florence Unit	Westbourne, Dorset
Dorset Healthcare NHS Foundation Trust	Studland Ward	Canford Cliffs, Dorset
East London NHS Foundation Trust	John Howard Centre for Forensic Mental Health	London, Greater London
Greater Manchester West Mental Health NHS Foundation Trust	Edenfield Centre	Prestwich, Greater Manchester
Hampshire Partnership NHS Foundation Trust	Ravenswood House	Fareham, Hampshire
Hampshire Partnership NHS Foundation Trust	Southfield	Southampton, Hampshire
Hertfordshire Partnership NHS Foundation Trust	Eric Shepherd Unit	Abbots Langley, Hertfordshire
Hertfordshire Partnership NHS Foundation Trust	Broadland Clinic	Norwich, Norfolk
Hertfordshire Partnership NHS Foundation Trust	Deacon Ward	St Albans, Hertfordshire
Humber Mental Health Teaching NHS Trust	The Humber Centre for Forensic Psychiatry	Hull, Yorkshire

Provider	Name of unit	Location
Humber Mental Health Teaching NHS Trust	Greentrees	Hull, Yorkshire
Humber Mental Health Teaching NHS Trust	County Unit	Hull, Yorkshire
Kent and Medway NHS and Social Care Partnership Trust	Trevor Gibbens Unit	Maidstone, Kent
Lancashire Care NHS Foundation Trust	Guild Lodge	Goosnargh, Lancashire
Leeds Partnerships NHS Foundation Trust	The Beeches	Leeds, West Yorkshire
Leeds Partnerships NHS Foundation Trust	Newsam Centre	Leeds, West Yorkshire
Leicestershire Partnership NHS Trust	Herschel Prins Centre	Leicester, Leicestershire
Lincolnshire Partnership NHS Foundation Trust	Francis Willis Unit	Lincoln, Lincolnshire
Mersey Care NHS Trust	Allerton & Childwall Wards	Liverpool, Merseyside
Mersey Care NHS Trust	Scott Clinic	St Helens, Merseyside
Mersey Care NHS Trust	Ashworth Hospital	Maghull, Merseyside
Norfolk and Waveney Mental Health NHS Foundation Trust	Norvic Clinic	Norwich, Norfolk
Norfolk and Waveney Mental Health NHS Foundation Trust	Highlands	Norwich, Norfolk
Norfolk and Waveney Mental Health NHS Foundation Trust	Meadowlands	Norwich, Norfolk
Norfolk and Waveney Mental Health NHS Foundation Trust	Coastlands	Great Yarmouth, Norfolk
North Essex Partnership NHS Foundation Trust	Cedar Unit	Colchester, North Essex
North Yorkshire and York PCT	Clifton House	York, North Yorkshire
Northumberland, Tyne and Wear NHS Trust	Bamburgh Clinic	Newcastle Upon Tyne, Northumberland
Northumberland, Tyne and Wear NHS Trust	Tweed Unit	Morpeth, Northumberland
Nottinghamshire Healthcare NHS Trust	Rampton	Retford, Nottinghamshire
Nottinghamshire Healthcare NHS Trust	Wathwood Hospital	Wath-upon-Dearne, Nottinghamshire
Nottinghamshire Healthcare NHS Trust	Arnold Lodge	Leicester, Nottinghamshire
Nottinghamshire Healthcare NHS Trust	Wells Road Centre	Nottingham, Nottinghamshire
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	Oxford Clinic	Oxford, Oxfordshire
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	Woodlands House	Aylesbury, Buckinghamshire

Provider	Name of unit	Location
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	Marlborough House	Milton Keynes, Buckinghamshire
Oxfordshire Learning Disability NHS Trust	Evenlode	Oxford, Oxfordshire
Oxleas NHS Foundation Trust	The Bracton Centre	Dartford, Kent
Pennine Care NHS Foundation Trust	Low Secure Unit	Ashton-Under-Lyne, Lancashire
South Essex Partnership University NHS Foundation Trust	Runwell Hospital	Wickford, Essex
South London and Maudsley NHS Foundation Trust	River House	Beckenham, Kent
South London and Maudsley NHS Foundation Trust	Bridge House	London, Greater London
South London and Maudsley NHS Foundation Trust	Ward in Community	London, Greater London
South London and Maudsley NHS Foundation Trust	Hopton Road Unit	London, Greater London
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Wroxeter Ward	Shrewsbury, Shropshire
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Hatherton Centre	Stafford, Staffordshire
South West London and St George's Mental Health NHS Trust	Shaftesbury Clinic	London, Greater London
South West Yorkshire Mental Health NHS Trust	Newton Lodge	Wakefield, South West Yorkshire
South West Yorkshire Mental Health NHS Trust	Newhaven	Huddersfield, South West Yorkshire
Suffolk Mental Health Partnership NHS Trust	Easton House	Ipswich, Suffolk
Sussex Partnership NHS Foundation Trust	Martlet Lodge	Haywards Heath, West Sussex
Sussex Partnership NHS Foundation Trust	Jupiter House	Chichester, West Sussex
Sussex Partnership NHS Foundation Trust	Southview, Ashen Hill and Amber Lodge	Hellingly, East Sussex
Tees, Esk and Wear Valleys NHS Foundation Trust	Hutton Centre	Middlesbrough, North Yorkshire
Tees, Esk and Wear Valleys NHS Foundation Trust	Willow Ward	Darlington, County Durham
West London Mental Health NHS Trust	Broadmoor Hospital	Crowthorne, Berkshire
West London Mental Health NHS Trust	The Orchard	Southall, Middlesex
West London Mental Health NHS Trust	Three Bridges	London, Greater London

Appendix D

Mapping Independent Sector Adult Forensic Services

Provider	Name of unit	Location
Partnerships in Care	Annesley House	Annesley, Nottinghamshire
Partnerships in Care	Arbury Court	Warrington, Cheshire
Partnerships in Care	Elm Park	Colchester, Essex
Partnerships in Care	Oaktree Manor	Tendring, Essex
Partnerships in Care	Burston House	Diss, Norfolk
Partnerships in Care	Calverton Hill	Arnold, Nottinghamshire
Partnerships in Care	Kemple View	Blackburn, Lancashire
Partnerships in Care	Kneesworth House	Royston, Hertfordshire
Partnerships in Care	Lombard House	Attleborough, Norfolk
Partnerships in Care	Richmond House	Harleston, Norfolk
Partnerships in Care	Pelham Woods	Dorking, Surrey
Partnerships in Care	St. John's House	Diss, Norfolk
Partnerships in Care	Stockton Hall	York, Yorkshire
Partnerships in Care	Suttons Manor	Romford, Essex
Partnerships in Care	The Dene	Hassocks, West Sussex
Partnerships in Care	The North London Clinic	London, Greater London
Partnerships in Care	The Spinney	Manchester, Greater Manchester
Partnerships in Care	The Willows	Newark, Nottighamshire
Care Aspirations	Louis Court	Colchester, Essex
Care Aspirations	Chaseways	Sawbridgeworth, Hertfordshire
Cygnet Healthcare	Bewick Ward	London, Greater London
Cygnet Healthcare	Meridian Unit	London, Greater London
Cygnet Healthcare	Milton Ward	Kewstoke, North Somerset
Cygnet Healthcare	Peplau Ward	Stevenage, Herts
Cygnet Healthcare	Bronte Ward	Lower Wyke, Bradford
Cygnet Healthcare	Fairfax Ward	Bradford, West Yorkshire
Cygnet Healthcare	Springs Unit	Harrow on the Hill, Middlesex

Provider	Name of unit	Location
The Priory Group	Chadwick Lodge	Milton Keynes, Buckinghamshire
The Priory Group	Farmfield	Charlwood, Surrey
The Priory Group	Sturt House Hospital	Walton on the Hill, Surrey
The Priory Group	Thornford Park Hospital	Thatcham, Berkshire
Affinity Healthcare	Pankhurst Unit	Cheadle, Chesire
Affinity Healthcare	Pine Unit	Darlington, County Durham
Alpha Hospitals	Alpha Hospital Bury	Bury, Lancashire
Alpha Hospitals	Alpha Hospital Woking	Woking, Surrey
Alpha Hospitals	Alpha Hospital Sheffield	Sheffield, South Yorkshire
Care Principles	Ashley House	Market Drayton, Staffordshire
Care Principles	Beech House	Newmarket, Suffolk
Care Principles	Cedar House	Canterbury, Kent
Care Principles	Linden House	Market Weighton, East Yorkshire
Care Principles	Rowan House	Norwich, Norfolk
Craegmoor Healthcare	Charles House	Salford, Greater Manchester
St Andrew's Healthcare	St. Andrew's Healthcare Northampton	Northampton, Northamptonshire
St Andrew's Healthcare	St. Andrew's Healthcare Essex	North Benfleet, Essex
St Andrew's Healthcare	St. Andrew's Healthcare Birmingham	Birmingham, West Midlands
InMind Healthcare Group	Doulton Lodge	Sleaford, Lincolnshire
InMind Healthcare Group	Waterloo Manor	Leeds, West Yorkshire
InMind Healthcare Group	Battersea Bridge House	London, Greater London
Chancellor Care	The Grange	Cawston, Norfolk
Glen Care Group	Glenhurst Lodge	Maidstone, Kent
Glen Care Group	The Ashwood Centre	Croydon, Surrey
Glen Care Group	Collington Ward	Bexhill on Sea, East Sussex
Glen Care Group	Fairlight Ward	
Healthlinc Individual Care	Bradley Woodlands Independent Hospital	Grimsby, Lincolnshire
Healthlinc Individual Care	HealthLinc House Independent Hospital	Lincoln, Lincolnshire
Riverside Healthcare Ltd	Cheswold Park Hospital	Doncaster, South Yorkshire
Care UK plc	Park Villa Independent Hospital	Macclesfield, Chesire

Provider	Name of unit	Location
Care UK plc	Avesbury House	London, Greater London
Care UK plc	Tariro House	London, Greater London
Equilibrium Healthcare Ltd	Bigfoot Independent Hospital	Manchester, Greater Manchester
Equilibrium Healthcare Ltd	Jigsaw Independent Hospital	Manchester, Greater Manchester
Jedhealth Ltd	Regency Lodge	Blackpool, Lancashire
Jedhealth Ltd	Regency Lodge - Heswall	Heswall, Merseyside
Optima Care Ltd	The Hamptons	Preston, Lancashire
St George Healthcare Group	St Mary's Hospital	Warrington, Cheshire
St George Healthcare Group	All Saints Hospital	Oldham, Lancashire
Four Seasons Health Care	The Huntercombe Hospital - Roehampton	London, Greater London
John Munroe Hospital Group	Horton Unit	Nr Leek, Staffordshire
Raphael Healthcare	The Farndon Unit	Newark, Nottinghamshire
St Luke's Hospital Group	Besthorpe Unit	Attleborough, Norfolk
St Luke's Hospital Group	Ducks Halt	Kirkby Le Stoken, Essex
St Luke's Hospital Group	Old Leigh House	Leigh on Sea, Essex
St Luke's Hospital Group	Thors Park	Thorrington, Essex
St Luke's Hospital Group	Yew Trees	Kirkby Le Soken, Essex
St Luke's Hospital Group	Bostall House	London, Greater London
St Luke's Hospital Group	Knightsbridge House	Fareham, Hampshire
Brookdale Healthcare Ltd	Milton Park Independent Hospital	Wyboston, Bedfordshire
Curate Hospitals	Harts Leap Independent Hospital	Sandhurst, Berkshire
Covenant Churchill	Churchill London Clinic	London, Greater London
Sovereign Health Ltd	Sovereign Health	London, Greater London
Vista Healthcare	Vista Healthcare Independent Hospital	Winchfield, Hampshire
Modus Care Ltd	Penhayes House	Exeter, Devon
Modus Care Ltd	Westbrook Grange	Torquay, Devon

Provider	Name of unit	Location
National Autistic Society	The Hayes Independent Hospital	Pilning, Bristol
English Nursing Homes Ltd	Redlands Hospital	Totnes, Devon

Appendix E

Service User Involvement Survey – Prisons

Name and address of prison	
Provider	HMPS / Independent
Name of contact at unit	
Survey completed by	
Date completed	

Mechanism/ forum	In place at this unit?	Comments
Community Meetings		
Prisoners' Council		
Women's Forum		
Men's Forum		

Mechanism/ forum	In place at this unit?	Comments
In-house Prisoner Involvement Worker		
Independent Prisoner Involvement Worker		
Other (please specify)		

Are there any developments planned in relation to prisoner involvement?

Appendix F

Voluntary Sector Agencies Working in Forensic Services for Young People

Organisation name and contact details	Summary of services provided
Barnardo's Tanners Lane Barkingside Ilford Essex IG6 1QG T: 020 8550 8822 E: info@barnardos.org.uk	Advocacy and participation services for children in custody covering 13 units in the Midlands and North of England.
National Youth Advocacy Service Egerton House Tower Road Birkenhead Wirral CH41 1FN T: 0151 649 8700 E: main@nyas.net	Independent advocacy and participation work with young people, including Ardenleigh (Inpatient FCAMHS)
Voice 320 City Road London EC1V 2NZ T: 020 7833 5792 E: info@voiceyp.org	Individual advocacy at: **Secure Children's Homes** Aldine House, Clayfields House, Eastmoor Children's Unit, Lincolnshire Unit, St Catherines House, Clare Lodge, Vinney Green, Atkinson Unit, Leverton Hall, Beechfield Secure Unit **Secure Training Centres** Medway **Young Offenders Institutions** Ashfield, Downview, Eastwood Park, Cookham Wood, Feltham **Inpatient FCAMHS** Roycroft Clinic, Prudhoe Hospital, Gardener Unit

Appendix G

Useful links: User Involvement in Forensic Services for Young People

Useful links

Barnardo's	http://www.barnardos.org.uk
Her Majesty's Prison Service	http://www.hmprisonservice.gov.uk/
National Commissioning Group	http://www.ncg.nhs.uk/
National Youth Advocacy Service	http://www.nyas.net/
Secure Accommodation Network	http://www.secureaccommodation.org.uk/
Voice	http://www.voiceyp.org/
Youth Justice Board	http://www.yjb.gov.uk/

Appendix H

Wish Survey – User Involvement

Number **Name of main hospital unit**	
Provider	Name of NHS Trust Independent provider
Contact responsible for user involvement	**Is there more than one contact responsible for this unit? If so split the units into contacts but have all questionnaires in one document.** **Name:** **Role:** **Is this contact responsible for any other units? Which ones?** **Telephone No:**

Number of beds **Level of security** **Gender mix**	**Number of beds:** **Gender Mix:** **Levels of security at this Unit, specify all:**
Survey completed by & date	

Mechanism/ forum	**In place at this unit?**	**How often does it meet?**	**Where or who does the information go to?**	**Do the patients get formal feedback?**	**Could you rate how effective the impact of this mechanism is on policy and/or practice Low 1 2 3 4 5 High**	**Could you give an example of effecting change through this mechanism?**
Community Meetings						
Patients' Council						

Mechanism/ forum	In place at this unit?	How often does it meet?	Where or who does the information go to?	Do the patients get formal feedback?	Could you rate how effective the impact of this mechanism is on policy and/or practice Low 1 2 3 4 5 High	Could you give an example of effecting change through this mechanism?
Women's Forum						
Men's Forum						
Wish VAST Project						
In-house Service User Involvement Worker		**Could you please tell me more about this service?**				

Mechanism/ forum	In place at this unit?	How often does it meet?	Where or who does the information go to?	Do the patients get formal feedback?	Could you rate how effective the impact of this mechanism is on policy and/or practice Low 1 2 3 4 5 High	Could you give an example of effecting change through this mechanism?
Independent Service User Involvement Worker		**Could you please tell me more about this service?**				
Other (please specify)	**Could you please give further information?**					

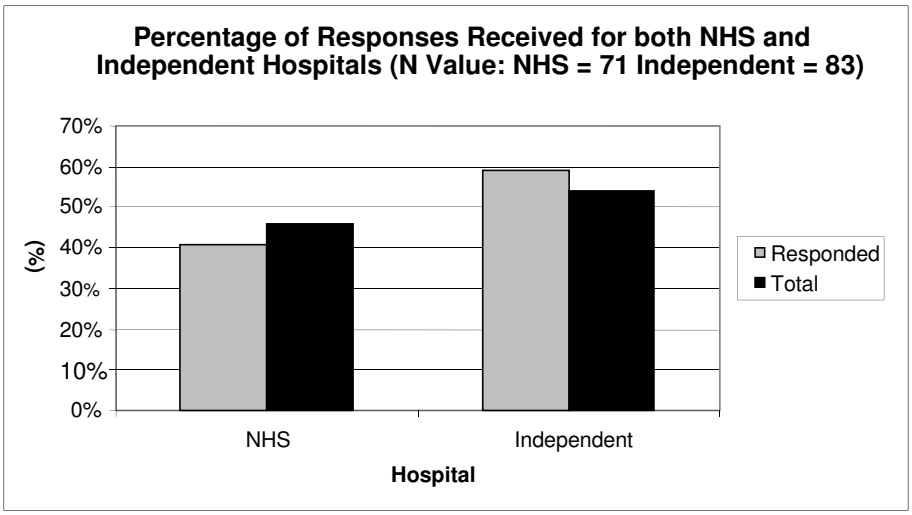
Do you have any further comments?
Are there any developments planned in relation to service user involvement?

Appendix I
Representativeness of the Sample

How representative is the sample of people we spoke to?

How representative? Sector Provider

Figure 1: Response rate NHS and Independent Hospitals



The mapping process identified more Independent Sector hospitals (54%) than NHS hospitals (46%). In terms of the overall response rate there is an over-representation of Independent hospitals 59% (44 hospitals) to NHS hospitals 41% (31 hospitals); proportionally this is an over-representation of 8.5% for Independent hospitals and under-representation of 11.3% for NHS hospitals.

How representative? Hospital size

Figure 2: Response rate: overall hospital size

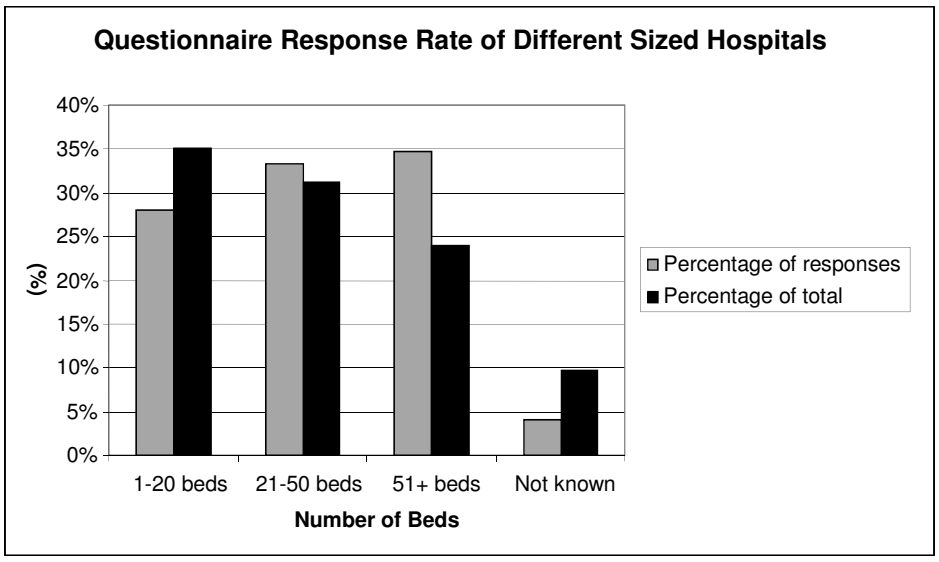


Figure 3: Response rate: independent hospital size

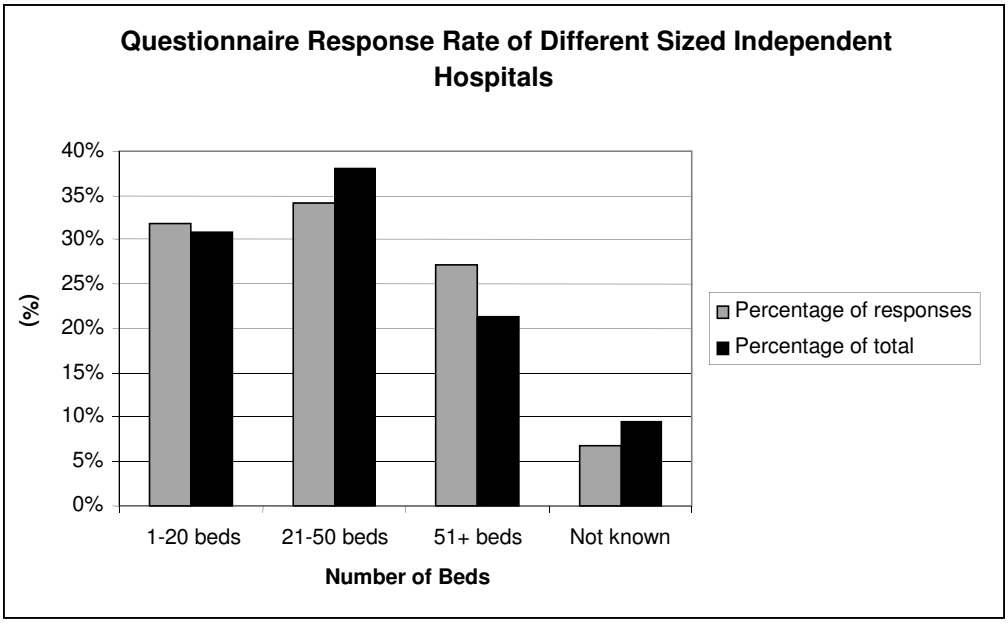


Figure 4: Response rate: NHS hospital size

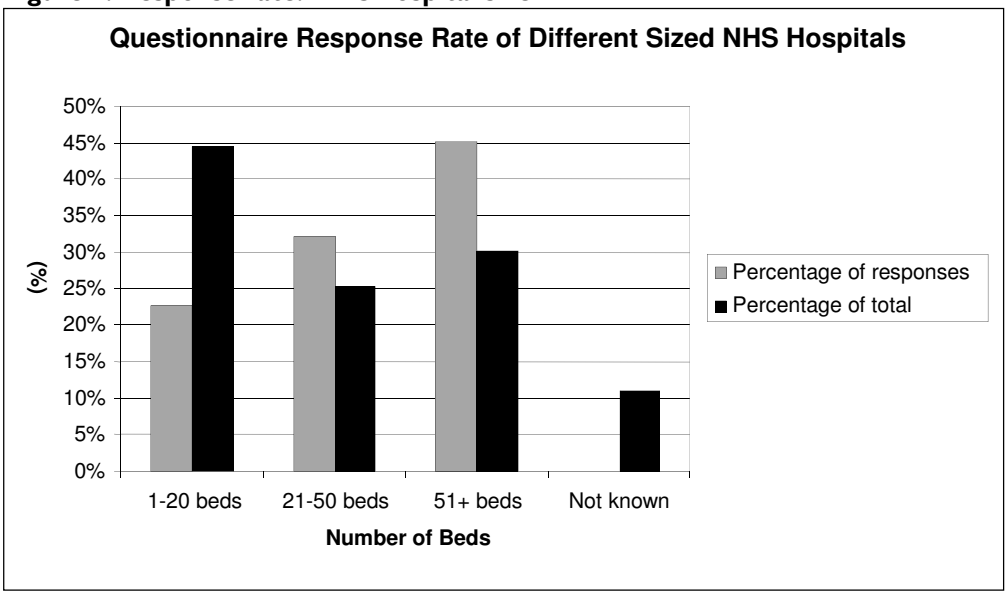


Figure 2: Overall there is a better response from larger hospitals with smaller hospitals being under- represented by 20% and larger hospitals over represented by 46%. Not known has been excluded from the analysis, although of those hospitals responding, there were fewer hospitals whose size was unknown.

Figure 3: This is mirrored to a slightly lesser degree in the Independent Sector with larger hospitals being over-represented by 29%, smaller hospitals being fairly represented; medium sized hospitals being under-represented by 11%.

Figure 4: However, when looking at the response rate from NHS hospitals as it appertains to hospital size this is extremely skewed with small hospitals being under-represented by 48% and larger hospitals being over represented by 50%. This will be influenced by the fact that in the original mapping 11% of hospitals sizes were unknown, but in the respondent hospitals this information was gained.

How representative?: Gender Mix

Figure 5: Response rate: overall hospital gender mix

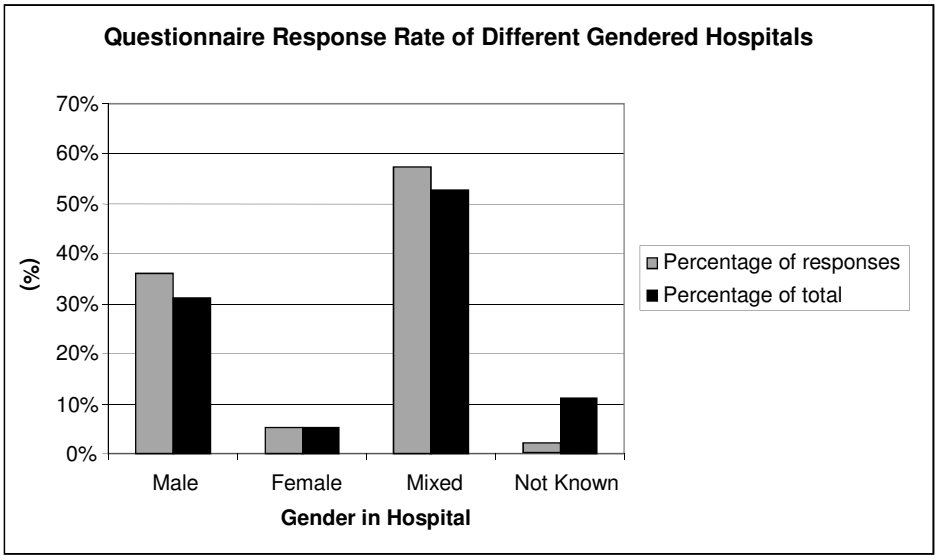


Figure 6: Response rate: independent hospital gender mix

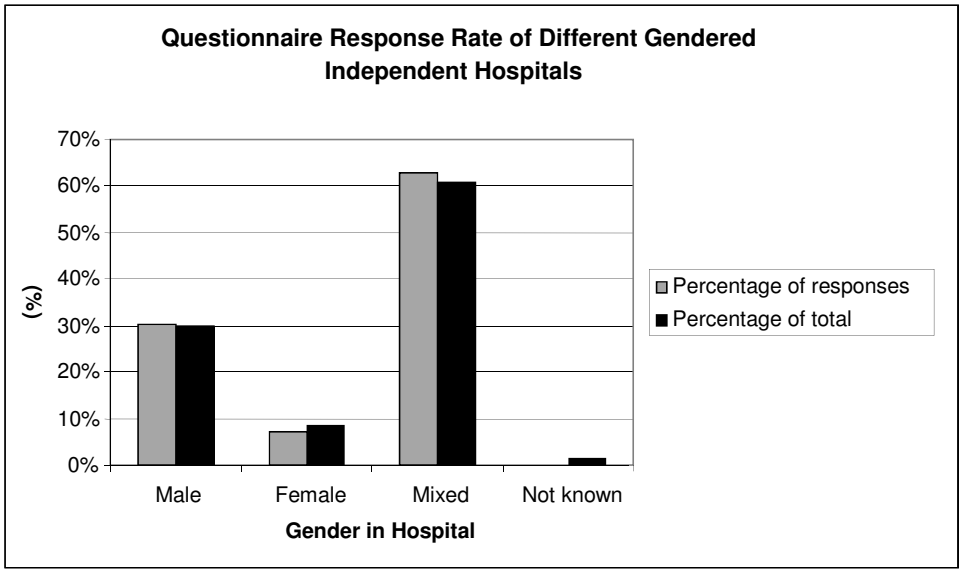


Figure 7: Response rate: NHS hospital gender mix

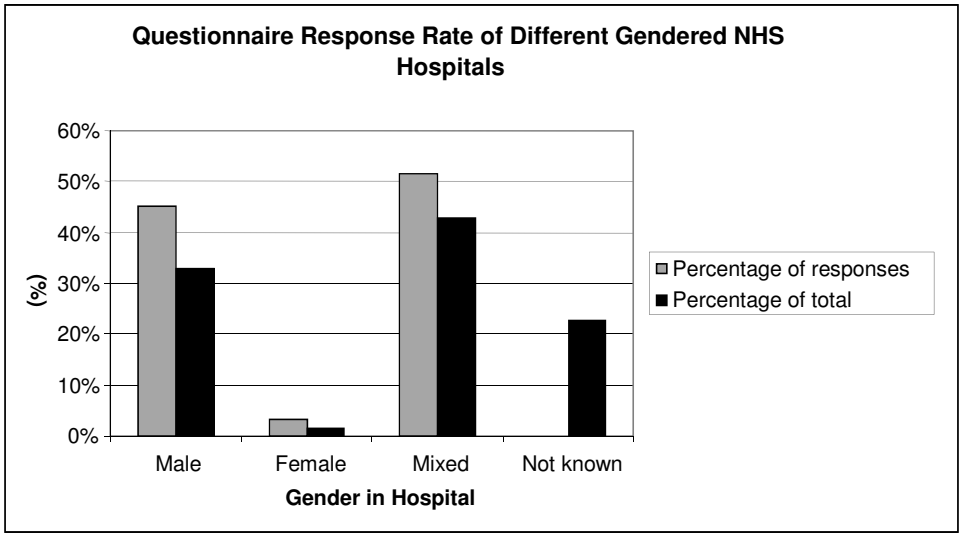


Figure 5: In terms of the gender mix of hospitals, overall these are fairly well represented with male being over-represented by 16% and mixed gender being over-represented 8%. This will be influenced by the fact that in the original mapping for 11% of hospitals the gender mix was unknown, but in the respondent hospitals this information was gained for all but 1%.

Figure 6: The response of Independent Sector hospitals reflects almost exactly the gender mix in this sector.

Figure 7: In terms of gender mix, once again NHS hospitals are skewed with male hospitals being over represented by 36%, female hospitals being over represented by 100% (2% occurring 4% responding), and mixed hospitals being over represented by 21%. These figures are influenced by the fact that in 23% of NHS hospitals mapped, the gender mix could not be determined.

How representative?: Security Level

Figure 8: Response rate: overall hospital security level

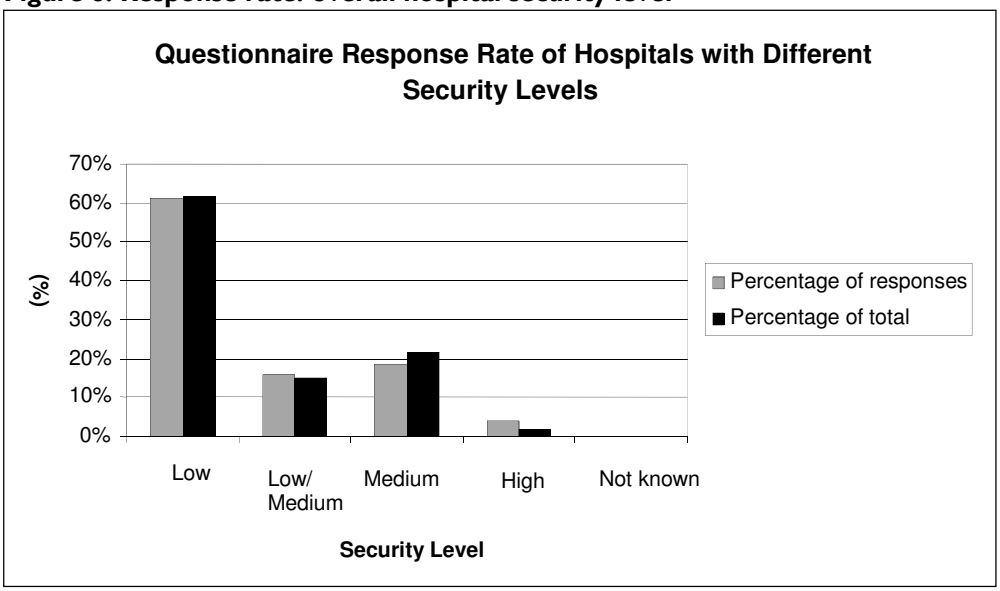


Figure 9: Response rate: independent hospital security level

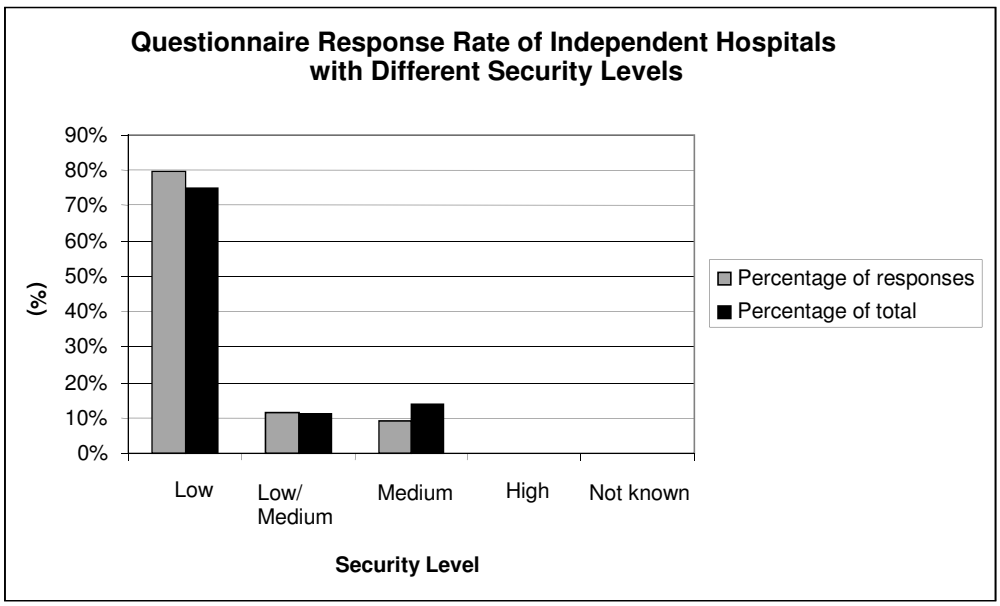


Figure 10: Response rate: NHS hospital security level

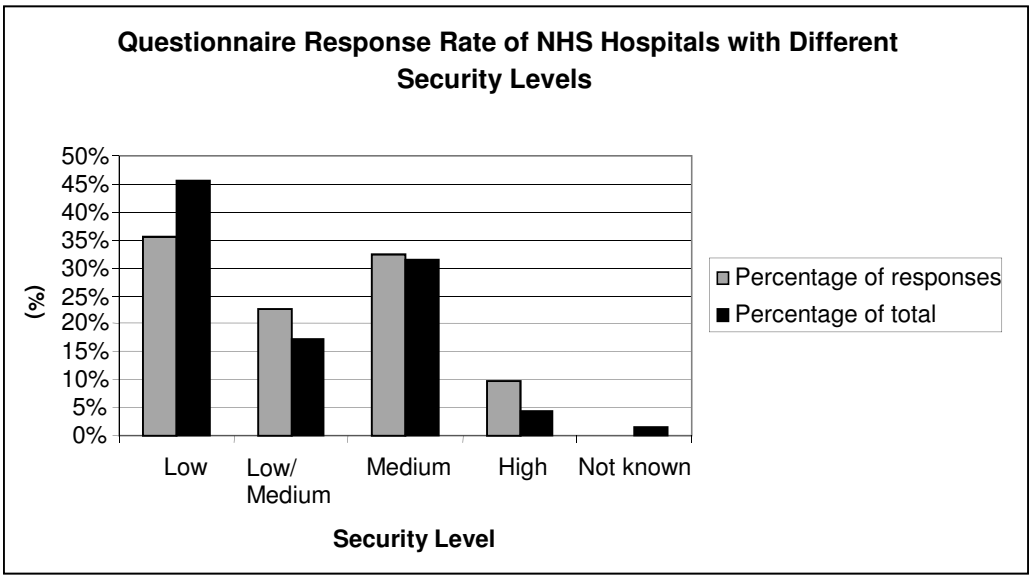


Figure 8: Overall the hospitals that responded reflect the range of security levels within the sector, however as all 3 high secure hospitals responded proportionally this is 100% over-representation within security levels.

Figure 9: Shows that in Independent hospitals, in terms of security level, these are fairly well represented. There was a slight over-representation of low secure hospitals of 10%, and an under-representation of medium secure hospitals of 25%.

Figure 10: The representation of different security levels within the NHS was where the largest discrepancies occurred. Low secure hospitals were under-represented by 22%. In all of the other security levels there was an over-representation, medium/low by 35% and the most notable being 100% in high secure hospitals.

Discussion and recommendations

There is a range of bias built into the survey responses, this must be borne in mind in the interpretation of the findings; it is summarised below:

The overall response rate is 48.7%, but is biased in favor of Independent hospitals which made up 59% of the hospitals giving information, an over-representation of 8.5%, with 41% of responding hospitals being NHS, and under-representation of 11.3%. The higher response from the Independent Sector may be explained by the fact that data had to be collected by telephone interview, as it was difficult to obtain email contact information.

For NHS hospitals proportionally there was an over-representation with regard to size: larger hospitals (+50%); with regard to gender: male hospitals (+36%), mixed-gender (+21%) and female (+100%); with regard to security: low & medium secure (+35%) and high secure (+100%); and an under-representation with regard to size (-48%); with regard to security: low secure (-22%). In addition there was a larger proportion of NHS hospitals where neither size (11%), nor gender mix (22%) could be determined in the original mapping, which will have skewed the figures gained.

For Independent Sector hospitals proportionally there was an over-representation with regard to size: large (+29%); and security (+10%); and an under-representation with regard to size: medium (-11%); and with regard to security: medium (-25%).

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