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A Mixed Methods Examination of Patient Feedback within Forensic and Non-Forensic Mental Healthcare Services

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Research Portfolio

Trixie Mottershead

1. Research Protocol

Research Protocol: A Service Evaluation of Nottinghamshire Healthcare NHS Foundation Trust.

Background

Patient feedback is very important in improving NHS services. Inpatient care is often a vital part of the care continuum for most mental health service users. Crawford et al (2002) conducted a systematic review on the literature surrounding the involvement of patients in the planning and development of healthcare services. In an examination of 337 studies, only 42 were deemed to describe the effects of patient involvement. A range of different models of involvement, applied in a range of settings, both hospitals and the community were examined. The study was unable to identify any of the reports that had investigated the effects of involving patients on the health, quality of life or satisfaction of the patients whom used the services. In order to deliver efficient and effective patient mental health services, Hopkins et al (2009) suggest that it is important to explore the degree to which patients have reported satisfaction and dis-satisfaction.

In 2012 the Department of Health (DH) funded the NHS Patient Feedback Challenge. The programme was designed to highlight good and innovative practice for the employment of patient feedback to improve healthcare services (Office for Public Management, 2013). The programme funded nine projects across the NHS. 'Partnerships Inspiring Change' within Nottinghamshire Healthcare NHS Trust was one of the funded projects. The project was designed to encourage patient engagement with feedback both internally, across the Trust's diverse services, and externally to other settings (NHS Institute for

Innovation and Improvement, 2013). The NHS Patient Feedback Challenge highlighted best practice in each of the nine projects (see appendix 1).

Feedback is crucial in ensuring that patients and carers are listened to and their feedback used to guide services in order to improve patient experience (Office for Public Management, 2013). Since the Francis Inquiry Report (2013) issues of patient safety, care quality and leadership have been in the public eye. It is important that following this report, researchers contribute to the creation of positive organisational cultures to enable the delivery of high quality care within NHS services (The King's Fund, 2017).

Both the volume and breadth of literature surrounding service user views of patients within forensic settings are limited, particularly when compared to patients of mental ill health in other services (Huband et at, 2017). The literature often assumes that forensic patients within mental healthcare services are homogeneous, with only a small proportion considering diagnostic groups and variation between the securities of forensic settings. Ryan et al (2002) aimed to address the lack of service user literature for populations within a diagnosis, specifically dangerous severe personality disorder (DSPD). A semi-structures interview was used to establish service user views. The study did not examine the results in comparison to a control group of non-forensic patients. Therefore, unfortunately no comparisons can be made to determine any differences in feedback and involvement of this group with other diagnosed populations. Equally research that explores variation in service user feedback between levels of security is insufficient in detail to examine similarities and differences in patient experience between these settings (Morrison et al, 1996). Coffrey (2006) reviewed empirically-based peer-reviewed papers on service

users' views of forensic mental health provision. Interviews featured as the primary data collection procedure. Hopkins et al (2009) argues that quantitative methods in which the degree to which service user's expectations are being met, allow for efficient and effective mental health service improvement. The literature review conducted by Hopkins et al (2009) highlights that research surrounding service user feedback on forensic mental health services lacks a systematic and critical evaluation that represents the multiple perspectives of service users (Coffrey, 2006).

This service evaluation aims to extend and refine the limited previous literature to address forensic patient feedback of their services. An exploration of forensic vs non-forensic comparisons will be made.

Research questions

The following research questions will be addressed in analysis of forensic and non-forensic patient feedback within Nottinghamshire Healthcare NHS Trust:

- Is there a significant difference between the service user feedback scores between forensic and non-forensic mental health services?
- Will coded comments that demonstrate 'institutional practice' and 'interpersonal relationships' significantly predict service feedback scores? Specifically, will 'institutional practice' predict negative feedback scores and 'interpersonal relationships' predict positive feedback scores.

If the researcher is able to access enough data in order to conduct further analysis, the following questions will be explored:

- Is there a significant difference in the **patient feedback** collected in low, medium and high security forensic mental health services?

- Is there a significant difference in **patient involvement** in completing feedback surveys between low, medium and high security forensic mental health settings?
- Is there a significant difference in **patient involvement** in completing feedback surveys between forensic and non-forensic mental health services?
- Is there a significant difference in **patient involvement** in completing feedback surveys between the Directorates at Rampton Hospital?

Proposed methods

Nottinghamshire Healthcare NHS Trust collects patient feedback via the Service User Care Experience form (SUCE), (see appendix 2). This is collected by volunteers every 6 months. The feedback is collected within the wards. As seen by Appendix 2, all the information collected is anonymous and sealed when completed. The form is then sent to Nottinghamshire Healthcare headquarters where the information is transcribed into Excel and made available via the website online.

The researcher will have access to the anonymous data that has been collected by Nottinghamshire Healthcare NHS Trust. This data has been made available online to the public. The data has been presented in an Excel spreadsheet with the availability to manipulate the timescale from which the survey was completed. The data has not been collected by the researcher, this limits the extent to which the data collection can be influenced by the researcher (Coffrey, 2006). All data available has been anonymized by Nottinghamshire Healthcare NHS Trust.

For a medium effect size of 0.5 with a probability of 0.05 and a statistical power of 0.95 using a T-test, a population of 210 will ensure that the statistical power of the study will be **α**= 0.95.

For a medium effect size of 0.25 with a probability of 0.05 and a statistical power of 0.95 using an ANOVA, a population of 400 will ensure that the statistical power of the study will be **α**= 0.95

Procedure

The researcher has requested approval from The Research and Innovation Team within the Trust and received support for the Service Evaluation (See Appendix 3). The researcher is interested in both forensic and non-forensic mental healthcare patients, male and female, over the age of 18. The sample represents patients who have engaged in the SUCE form, collected within the Trust. The sample will be taken from the Forensic Directorates: Arnold Lodge, Low secure and Community forensic, High secure LD, High secure mental health, High secure PD pathway, The Peaks, High secure Women's, Wathwood and Offender Health. There is a total of 628 patient responses from these services. The sample of non-forensic services will be taken from the Local Partnerships Division in the Directorate of Adult Mental Health from which there is a total of 705 patient responses. The data collected will be based upon SUCE form collection between 01/01/2017- 30/06/2017 to avoid the collection of repeated patient feedback. Quantitative and qualitative methods will be conducted on the data. The estimated timescale for the data analysis and completion is shown below:

Ethics application deadline	Expected application confirmation	Data analysis to begin	Project draft deadline	Project completion deadline
29/01/2018	**28/02/2018**	**01/03/2018**	**25/06/2018**	**01/08/2018**

Analytical Methods

SPSS will be used to conduct an analysis on the data. Differences between feedback scores between forensic and non-forensic settings will be explored. 210 patient feedback forms are required to meet the statistical power required to conduct a t-test.

Qualitative analysis will be conducted on the patient comments. Specifically, directed content analysis will enable the researcher to extend or refine existing literature regarding patient feedback (Hsieh & Shannon, 2005). Patient comments will be coded using the pre-determined codes; sub-categories may need to be developed depending on the data. The findings will offer supporting or non-supporting evidence regarding the previous literature, specifically for forensic patients.

If the researcher is able to determine that there is enough data, further comparisons will be made such as differences within forensics (low, medium and high secure settings). In order to conduct additional comparisons an ANOVA will be carried out. This requires a population of 400 to ensure statistical power of the tests.

Stakeholder Involvement

On the 16/10/2017 a meeting was organised with Mr Sanguinazzi (Head of the Involvement Team), Nigel Groves (Involvement and Experience Lead in Forensics) and Christopher Beeley (Experience Data Manager). During this meeting the activities and processes were discussed in order to determine the Service's aims and objectives. It was agreed that the Service Evaluation will lead to many service benefits. The researcher attended a meeting with Kayley Whyatt, a representative of the Research and Innovation Team to discuss the proposal of the Service Evaluation. The Trust's Research and Innovation Team has confirmed formal approval following the receipt of University Ethical Approval (see appendix 3)

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Appendices

Appendix 1: Inputs and outputs of the Patient Feedback Challenge within the Nottinghamshire Healthcare NHS Trust.

(from August 2012 to ongoing)

Inputs

Set up

Financial investment

DH PFC funding including:

- ✓**£14,000** staff costs for Project Manager (1.5 days p/w)
- ✓**£7,000** staff costs for data coding, web reports and evaluation (1 day p/w)
- ✓**£41,265** staff costs for Numiko, company responsible for design and deployment of web portal
- ✓**£2000** for website development to allow portal to be integrated into current site
- ✓**£5000** in development funding, for training on experience- based design and for service user volunteers

Delivery and spread

- ✓**£6,000 (3x £2,000)** for three impact workshops- venue and equipment hire
- ✓**£11,080** staff costs for Patient Opinion (PO) expertise
- ✓**£10,000** staff costs for development of e-learning environment to handle HEI work
- ✓**£3,000 (2 x £1,500)** for two workshops with HEI's to develop Patient Experience educational module
- ✓**£3,000 (2x£1,500)** Two Patient Opinion workshops with spread partner to model approach and translate learning
- ✓**£12,005** staff costs for PEN to develop and run a monthly ward scheme
- ✓**£5,000** for promotional materials
- ✓**£3,000** for equipment and materials
- ✓**£2,100** for travel

In Kind contribution by lead organisation and partners:

- ✓Staff time and expertise from Nottingham NHS Trust, Patient Opinion and the Institute of Mental Health
- ✓Existing patient / carer involvement networks and volunteers
- ✓Monthly steering group
- ✓Office space and appropriate IT to facilitate and support patient involvement

Additional support

- ✓NHS Institute staff time, expertise and resources
- ✓NHS Institute Web Channel

Total DH PFC funding to Nottinghamshire Healthcare NHS Trust = **£124,450**

Outputs

Marketing and promotion

- ✓NHS Institute Hot house events (x3)
- ✓A launch event, attended by 65 people including senior executives
- ✓Develop materials to encourage use of PO and other feedback mechanisms

Workstream 1

- ✓10 teams from across the Trust are linking with service users, carers and governor members to develop excellence in patient experience including capturing and sharing feedback in innovative ways
- ✓Info sheets developed for teams re: patient experience feedback
- ✓Three impact Workshops with PO to inspire teams to listen and respond to feedback
- ✓One Experience-Based Design workshop, delivered by NHS Institute staff
- ✓10 case studies developed showcasing the involvement and feedback approaches adopted and their impact

Workstream 2

- ✓Coding developed to collate patient feedback
- ✓Local and national practice share events to spread the approach and learning arising
- ✓Web portal being developed to provide mechanism by which patients can give feedback and to triangulate feedback from different sources into an accessible site for clinicians, managers and members of the public.
- ✓Web portal informed by two workshops held by the Trust

Workstream 3

- ✓Produced a flyer illustrating how patient feedback can be used as a learning tool
- ✓Flyer now included in all EMLA delegate packs
- ✓Toolkit developed to support service improvement in partnership
- ✓Patient involvement features in HEI and EMLA training programmes for aspiring NHS leaders
- ✓PO worked with Nottinghamshire Healthcare to develop virtual clinical placement that embeds learning from Trust
- ✓Ongoing monitoring and self-evaluation

Anticipated outcomes

For patients

- ✓Patients and carers feel engaged and involved with their services
- ✓Patients and carers are listened to and shape services
- ✓Improved patient experience

For lead organisation, partner organisation and staff

- ✓All 10 participating teams and services have a better understanding of their users – what they need, want and prefer
- ✓An increasing number of teams who are passionate and committed to listening and responding to feedback as part of their daily practice
- ✓Greater clarity regarding what constitutes good patient experience – across all teams
- ✓Improved staff wellbeing and motivation
- ✓More (and increased quality) patient feedback captured
- ✓Increased staff recognition, across Nottingham NHS and wider spread partners, of the importance of patient involvement
- ✓Sustainable approach
- ✓Changes to the organisation's services and culture
- ✓Future leaders and clinicians who are clear on the importance of listening and responding to patient feedback, and how to use patient experience to inform service improvement
- ✓Transparency of patient feedback – at service and organisational level

Appendix 2: SUCE form dispersed by Nottinghamshire Healthcare Trust patients in order to collect feedback.

Your Feedback

We would like to ask you some questions about the services you have received to help us to improve them.
Please note: some questions may not apply to you. If this is the case then please ignore these questions.

I am a: ☐ service user/patient
☐ carer/relative/friend

Please circle the appropriate answer in the following questions:

1. How likely are you to recommend this service to friends and family if they needed similar care or treatment?

Extremely likely | Likely | Neither likely nor unlikely | Unlikely | Extemely unlikely | Don't know

What could we do better?

What did we do well?

2. How good was the service you received?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

How good were our services at:

3. Listening to you?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

4. Communicating with you?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

5. Showing you respect?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

6. Involving you in decisions about your care or treatment?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

7. Making a positive difference to your health and wellbeing?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

☐ Please tick this box if you DO NOT wish your comments to be made public

How else can you let us know what you think?
You can:

- post your stories online via feedback.nottinghamshirehealthcare.nhs.uk or patientopinion.org.uk
- contact the Involvement Team on 0115 993 4567 or 0115 956 0845

Disability:
Do you have a disability or a long-term health condition which affects your day to day activities?

☐ Yes ☐ No ☐ Do not wish to say

Religion/Belief:

☐ Christian ☐ Buddhist ☐ Hindu ☐ Jewish
☐ Muslim ☐ Sikh ☐ Other ☐ No religion
☐ Do not wish to say

Sexual Orientation:

☐ Heterosexual/Straight ☐ Gay man
☐ Lesbian/Gay woman ☐ Bisexual
☐ Do not wish to say

Age (ranges):

☐ Under 12 ☐ 12-17 ☐ 18-25 ☐ 26-39
☐ 40-64 ☐ 65-79 ☐ 80+ ☐ Do not wish to say

What is your relationship status?

☐ Single ☐ Civil partnership ☐ Widowed
☐ Married ☐ Separated ☐ Other
☐ Co-habiting ☐ Divorced ☐ Do not wish to say

Are you pregnant at this time?

☐ Yes ☐ No ☐ Do not wish to say

Have you had a baby within the last 26 weeks?

☐ Yes ☐ No ☐ Do not wish to say

Thank you for completing this survey.

We would really like some more information to help us to provide good services to all the people we care for. You do not have to complete this part but it would be great if you could.

Please tick the appropriate boxes below:

Gender:

☐ Male ☐ Female ☐ Other

Ethnic Group:

White
☐ British
☐ Irish
☐ Other (please specify)

Black or Black British
☐ Caribbean
☐ African
☐ Other Black (please specify)

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Other Asian (please specify)

Dual Heritage
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other Mixed (please specify)

Chinese
☐

Gypsy/Roma/Traveller
☐

Other Ethnic Group
☐ (please specify)

Do not wish to say
☐

Please turn over...

Appendix 3: Research Innovation Team Service Evaluation Support Letter.

positive ☑

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: Randlenquiries@nottshc.nhs.uk

Date of letter: 19/12/2017

Trixie Mottershead
Division of Psychiatry and Applied Psychology
University of Nottingham

Dear Trixie

Study title: Service Evaluation of Patient Feedback within Nottinghamshire Healthcare NHS Foundation Trust.

Nottinghamshire Healthcare NHS Foundation Trust Research and Innovation team have reviewed the documentation associated with the project listed above. I can confirm that the project is classified as a Service Evaluation. The project will be formally approved following receipt of University Ethical Approval.

Yours Sincerely

Lindsey Peggs
Research & Development Support Officer

Research Portfolio

Trixie Mottershead

2. University Ethical Approval Letter

University Ethical Approval Letter

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

22nd February 2018

MsTrixie Mottershead
MSc Forensic and Criminological Psychology Student
c/o Professor Birgit Vollm
Chair in Forensic Psychiatry/Hon Consultant Forensic Psychiatrist
Forensic Mental Health, Division of Psychiatry and Applied Psychology
Room B18 Institute of Mental Health Building
University of Nottingham
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Ms Mottershead

Ethics Reference No: 237-1802 **– please always quote**	
Study Title: A Service Evaluation of Nottinghamshire Healthcare NHS Foundation Trust	
Chief Investigator/Supervisors: Professor Birgit Vollm, Forensic Mental Health, Division of Psychiatry and Applied Psychology, Dr Najat Khalifa, Associate Professor and Forensic Psychiatrist, Institute of Mental Health/Nottinghamshire Health Care NHS Trust	
Lead Investigators/student: Trixie Mottershead, MSc Forensic and Criminological Psychology Student, School of Medicine	
Other Key Investigators:	
Type of Study: Service Evaluation, Anonymised secondary database analysis	
Proposed Start Date: 01/03/2018	**Proposed End Date:** 01/08/2018 5 mths

The Committee considered this straightforward application at its meeting on 16 February 2018 and the following documents were received:

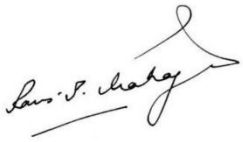
- FMHS/DPAP REC Application form and supporting documents version dated 20.12.2017
- Letter from Research and Development Nottinghamshire Healthcare NHS Foundation Trust dated 19/12/2017.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Research Portfolio

Trixie Mottershead

3. Research Innovation Team Service Evaluation Support Letter

Research Innovation Team Service Evaluation Support Letter

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Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: Randlenquiries@nottshc.nhs.uk

Date of letter: 19/12/2017

Trixie Mottershead
Division of Psychiatry and Applied Psychology
University of Nottingham

Dear Trixie

Study title: Service Evaluation of Patient Feedback within Nottinghamshire Healthcare NHS Foundation Trust.

Nottinghamshire Healthcare NHS Foundation Trust Research and Innovation team have reviewed the documentation associated with the project listed above. I can confirm that the project is classified as a Service Evaluation. The project will be formally approved following receipt of University Ethical Approval.

Yours Sincerely

Lindsey Peggs
Research & Development Support Officer

Research Portfolio

Trixie Mottershead

4. Research Paper

Word Count:6,840

ACKNOWLEDGEMENT

I would first like to thank my thesis supervisors' Dr Birgit Völlm and Dr Najat Khalifa of the School of Medicine at the University of Nottingham for their invaluable guidance and support throughout.

I would also like to thank Nottinghamshire Healthcare NHS Foundation Trust's Involvement, Experience and Volunteering Team, specifically the Involvement and Experience Lead within Forensic Services, Nigel Groves, the Head of Involvement and Experience, Paul Sanguinazzi and the Experience Data Manager, Christopher Beeley. Their passionate participation and input has inspired me to critically analyse the way in which patients are listened to and involved with service delivery.

A Mixed Methods Examination of Patient Feedback within Forensic and Non-Forensic Mental Healthcare Services

Abstract

Background: The literature surrounding patient feedback is limited, despite government policy integrating patient feedback into how the care quality of the National Health Service (NHS) is assessed. Notably, previous literature neglects to examine the detailed contextualised accounts of the service user through qualitative alongside quantitative analysis.

Methodology: A mixed methods approach was adopted to explore patient feedback data. The data was collected by volunteers on behalf of Nottinghamshire Healthcare NHS Trust. Quantitative analysis was used to analyse Likert Scare responses which reflected positive or negative/neutral overall feedback. Qualitative analysis was conducted to explore patient free-text comments. A comparison was made between forensic and non-forensic patient populations.

Analysis: Chi-Square tests were performed to investigate forensic and non-forensic patient feedback. Conventional content analysis was conducted to derive codes from the data. The codes were distributed into categories that represented the explicit views of the patient in order to understand and support quantitative findings.

Findings: The findings revealed that forensic patients were more likely to give negative feedback of mental healthcare services than non-forensic patients. A significant difference was found between patient involvement and the level of security within forensic services. Furthermore, the level of security within forensic services did not reveal any significant differences in patient feedback. Qualitative analysis provided further insight into these differences. The institutional practice of the service, staffing quality and the power differential between patient and staff, reflected more negative comments within the forensic population.

Conclusion: Forensic mental healthcare practice should operative within a framework of values and standards of both personal and ethical considerations alongside balancing public protection and patient care. The study reveals important differences with regard to the practice environment of forensic and non-forensic mental healthcare services. The findings of the present study contribute to knowledge within mental healthcare practice, highlighting the challenges faced by staff and volunteers when collecting patient feedback. The study makes recommendations to practice-based interventions to reduce the consequence of these challenges and explores recommendations for future research.

Key Words: patient feedback, forensic, non-forensic, mental healthcare, satisfaction, NHS

Introduction

Exploring patient involvement and satisfaction is central to government policy in health service provision. Patient satisfaction has been identified as a valuable measure of NHS service performance (Department of Health, 1997, 2002). The concept of the 'service user' as an evaluator rather than a passive recipient of healthcare is becoming an important aspect of service evaluation (Carlin, Gudjonsson & Yates, 2005). Patient feedback has been used to describe various aspects of the patient's views and opinions towards the care they receive (Baldie, Guthrie, Entwistle & Kroll, 2017; Picker Institute, 2009). Patient feedback is routinely collected by the service provider and therefore differs from the method of data collection within research exploring patient satisfaction (The Health Foundation, 2013). The relationship (and perhaps the power differential) between the interviewer/ survey collector and the interviewee/ patient has important implications for the results of feedback studies in comparison to satisfaction research, which will be explored later.

Public enquiries into failing services, such as the Francis Enquiry, have highlighted the adverse consequences of a service that is unresponsive to patient needs and wishes (Bamford & Benton, 2015). Several countries (including the UK, USA, Ireland, Australia, New Zealand and Canada) have encouraged a partnership approach between mental health practitioners and patients of mental health services (Wallcraft et al, 2011). This collaborative strategy has embraced recovery-orientation into mental health policy.

Since 2002, government policy in the UK has integrated patient feedback into how the care quality of all NHS services is assessed. NHS Trusts are required to collect and report patient feedback to the Care Quality Commission (CQC) as a regulatory body (Brookes & Baker, 2017). These reports are becoming increasingly important due to reductions in government funding, thereby encouraging healthcare providers to demonstrate the quality,

efficiency and financial viability of the services they provide (Greaves et al., 2012). The Department of Health funded the NHS Patient Feedback Challenge nationally in 2012. This programme aimed to illuminate good and innovative practice for the employment of patient feedback to improve healthcare services (Department of Health and Social Care, 2012). 'Partnerships Inspiring Change' was one of the nine funded projects in the UK, implemented within Nottinghamshire Healthcare NHS Foundation Trust. The project was designed to capture and collect patient feedback to inform service improvement (Institute for Innovation and Improvement, 2013).

Studies of Patient Satisfaction

Only a small number of academic studies have explored patient satisfaction within non-forensic and forensic mental healthcare services, of which few have been conducted in the UK. However, the literature surrounding this topic is rapidly growing; many researchers have explored elements of patient expectations and satisfaction as core indicators of care. The concept of satisfaction and methods used to measure it vary within the literature (Soergaard, Nivison, Hansen & Oeiesvold, 2008). Qualitative methods, such as focus groups and interviews, often yield higher response rates within the literature, however disadvantages such as researcher bias, lack of statistical reliability and validity at a greater cost limits the extent to which these methods are used (Shirley, Josephson & Saunders, 2016). Quantitative methods are more common; however, surveys consist of variously worded questions and use multiple response formats such as simple yes-no formats, to multipoint satisfaction scales (Likert scale). The chosen method often depends upon the purpose for which the research is required (Konerding, 2016). The use of a global measure in comparison to multiple distinct domains often make it difficult to form comparisons between the findings within the literature (Shirley et al., 2016). Additionally, within mental healthcare settings

methodological problems may be derived from research samples with low response rates and stringent exclusion criteria, this may under-represent the evaluations of less compliant patients (Paludetto, Camuccio, Cutrone, Cocchio & Baldo, 2015).

The literature upon patient satisfaction within mental healthcare services support earlier findings relating to the 'therapeutic relationship' with staff reflecting positive patient satisfaction with medical care (Cleary & McNeil, 1988), alongside the 'institution' as reflecting negative patient satisfaction, particularly for in-patient mental healthcare services (Goodwin, Holmes, Newnes & Waltho, 1999). Patients within mental healthcare services have been found to be most dissatisfied with areas of information, restriction, compulsory care and the ward environment within an inpatient population in Finland (Kuosmanen, Hatonen, Jyrkinen, Katajisto & Valimaki, 2006). These qualities are thought to enforce punitive institutional controls (Hinsbury & Baker, 2004). Furthermore, a cross-sectional study conducted in India revealed that interpersonal relationships reflect more positive references to the patient-professional relationship (Holikatti et al., 2012). However, this study examined only the outpatient population within mental healthcare and therefore cannot be generalised to secure inpatient settings. Additionally, a systematic review of qualitative evidence revealed collaborative and inclusive care, positive relationships, and safe and therapeutic hospital environments as superordinate themes of positive reports within UK inpatient mental healthcare services (Wood & Alsawy, 2016). These findings highlight the importance of patient-staff relationships which may be at risk of becoming neglected within the institutional protocols which guide practice within mental healthcare services. These findings may however be influenced by the research agenda within satisfaction studies, prioritising interest in staff communication as a specific dimension of mental healthcare (Coffey, 2006).

The differences and similarities within the international data highlight that patient satisfaction with mental healthcare involves a complex relationship between clinical, personal and socio-cultural characteristics. However, the therapeutic relationship between patient and staff can be associated with higher levels of treatment satisfaction across both secure and non-secure mental healthcare services (Smith et al., 2014). The instruments used within these studies generally have good reliability and validity; however, due to their design by health research academics, they may not capture all the aspects of mental healthcare important to the patients within these services.

Limitations of Satisfaction Studies

Within satisfaction research, participants are required to give informed consent; This is likely to lead to sampling bias. The exclusion criteria within these studies often neglect those considered too fragile to give consent and those affected by a severe intellectual disability, who are not given the opportunity to participate (Kuosmanen et al., 2006). This is likely to reduce the internal validity of the patient views that were considered representative of the service within satisfaction research. Furthermore, satisfaction studies often neglect to consider the impact of more informative aspects of the patient environment upon perceived satisfaction, of which over-crowding is a prime example to predict more negative feedback scores (Young et al., 2000). Research participants are often recruited via self-selection sampling through adverts displayed within the service. This sampling method limits the reliability and generalizability; response bias within this sampling method may significantly impact the results of the satisfaction survey (Mazor, Clauser, Field, Yood & Gurwitz, 2002); in particular it might overestimate the level of satisfaction by the virtue of including those that are most satisfied with the service. Additionally, satisfaction research often neglects to explore the forensic population within mental healthcare services. The literature surrounding

forensic patient satisfaction often uses satisfaction as a measure of a specific phenomenon such as a programme or intervention, rather than an overall service evaluation (Brodey, Claypoole, Motto, Arias & Goss, 2000; Nesset, Rossberg, Almvik & Friis, 2009).

The Impact and Use of Patient Feedback

The NHS have begun using patient feedback to test the performance of their services; collecting rigorous systematic data from patients is assumed to give accurate measurements of the service which guides how improvements can be made (Picker Institute, 2009). Patient feedback research is limited due to its specificity that the data is collected by the service provider directly, to inform service improvement. This section aims to review the use and effectiveness of patient feedback in healthcare services, as opposed to more general satisfaction research.

Although UK government policy emphasizes the transformative capacity of patient feedback, this was not empirically supported by the studies that examined the impact of patient feedback upon the general practice organization or at the practitioner level, revealed within a literature review (Baldie, 2017). Staff beliefs about the validity and usefulness of feedback tools influence their efforts to engage in improvement strategies as a result of patient feedback. However, the literature review examined general practice environments thereby limiting the generalisability of the results of the review to forensic and non-forensic mental healthcare services (Ryan, 2013). Hospital based analysis shows support for these findings; the impact of patient feedback upon hospital quality improvement revealed that staff perceptions of the quality and type of data collected influenced staff willingness to listen to patient feedback and use it to inform their practice (Barr et al., 2006). These practice issues can be very influential in how patient feedback is used by the service provider and implemented within the service.

The extent of the literature exploring patient feedback within the NHS focuses upon how the data is used to improve service provision. The literature examining the findings of patient feedback data is limited. However, in an examination of positive and negative comments within patient's online feedback of NHS services, 228,113 patient comments were analysed (Brookes & Baker, 2017). Content analysis revealed that overall, NHS services reflected positive comments more often than negative. Treatment, communication, interpersonal skills and system/organisation were identified as the four key themes of positive comments. These findings highlight aspects of the 'interpersonal relationship' between staff and patient as salient within patient feedback comments of NHS services. The data was related to a wide range of areas within healthcare service provision, comments relating to the specific service provision were not compared in the analysis. This limits the extent to which the findings may be generalized to patient feedback within mental healthcare.

Furthermore, the literature exploring forensic patient feedback is extremely limited, often lacks methodological rigour (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2016) and tends to focus upon feedback with regard to a specific treatment intervention (Meehan, McIntosh & Bergen, 2006). Bamford and Benton (2015) gathered feedback from forensic patients within the community. Positive comments reflected the service supporting the patient's 'everyday life' alongside the therapeutic relationship with service staff. The restrictiveness of the service environment and its impact upon the patient's 'everyday life' is likely to have a significant influence upon service user feedback amongst forensic populations (Goodwin et al., 1999). However, these findings cannot be generalized to forensic inpatient services.

Methodological Concerns of Data Collection

Evans, Edwards, Evans, Elwyn and Elwyn (2007) conducted a systematic review of the suitability of instruments and methods of collecting and analysing patient feedback. Six instruments were reported to meet the inclusion criteria for evaluation at both the organizational and individual level. However, the instruments evaluated had varying methods of implementation and differing application to both the organization/service and individual level evaluation. This led to difficulty in interpreting and comparing findings (Evans et al., 2007). Additionally, the review did not examine reports in non-English language sources which limited the extent to which international practices were considered.

Various measurements and methodological approaches have been applied to obtain meaningful patient insight into NHS services. However, the triangulation of quantitative and qualitative data is limited within the literature. Triangulation is likely to support the attainment of the 'full-picture' regarding the patient view of NHS services (Sherri, 2014). Furthermore, the inclusion of qualitative feedback to give explanation to ratings on survey designs is likely to enhance staff understanding and attention paid to patient feedback (Baldie et al., 2017). The context in which feedback is collected must also make both practical and purposeful sense. Patient feedback studies within forensic mental healthcare services often lack a systematic and critical evaluation (Hopkins, Loeb & Fick, 2009), which represents the multiple perspectives of service users (Coffey, 2006).

Aims of present study

This service evaluation aims to analyse the patient feedback data; to extend and refine the limited previous literature in examining patient feedback within forensic and non-forensic mental healthcare services; within Nottinghamshire Healthcare NHS Foundation Trust. The following hypotheses were tested:

H1: Service users in non-forensic services will rate the care they have received more positively than those in forensic services.

H2: Service users residing in lower levels of secure care will engage more frequently in giving feedback of the service they have received than those in higher levels of security.

H3: Service users within lower levels of secure care will rate the service they have received more positively than those within higher levels of secure care.

H4: Coded comments that demonstrate 'interpersonal relationships' will reflect positive comments and 'institutional practice' will reflect negative comments across both forensic and non-forensic services.

Method

Study Design

A mixed quantitative and qualitative approach was adopted to explore the patient feedback data. The mixed method approach supports quantitative findings with extended examples from the qualitative data to ensure that relevant theory may be generated from the data and supported with patient feedback comments.

Data Sample

Data has been collected by Nottinghamshire Healthcare NHS Foundation Trust volunteers on a 6-monthly basis within the secure forensic settings. The patients are made aware of the feedback process by members of the staff team and are encouraged to engage with the volunteers on a voluntary basis. Within the community forensics directorate and the non-

forensic services, the feedback was collected regularly by staff who were encouraged to distribute the survey when possible.

The sample represents patients who have engaged in the Service User Care Experience (SUCE) form collected within Nottinghamshire Healthcare NHS Foundation Trust (see appendix 1). Feedback from both forensic and non-forensic patients who were receiving care for a mental health problem, male and female, over the age of 18, was collected.

Data Collection

The SUCE form (see appendix 1) was developed locally for use in the Trust, however some questions are consistent nationally such as 'How likely are you to recommend this service to friends and family if they needed similar care or treatment?'

The form consists of seven items/questions rated on a 6/5-point Likert scale (see Table one below). Additionally, the SUCE form also invites open ended comments from the respondents via the free text boxes 'What could we do better?' and 'What did we do well?' displayed below question one (see appendix 1). Further free text comments were prompted by the statement 'Please tell us why you gave this response?' under the remaining six questions. The SUCE form collects additional information about the service user/carer: gender, ethnic group, disability, religion/belief, sexual orientation, age, relationship status and pregnancy information. However, this additional information has not been made available due to confidentiality considerations.

Table 1: SUCE Form Question Layout

Question	Likert Scale Format					
How likely are you to recommend this	Extremely likely	Likely	Neither likely	Unlikely	Extremely unlikely	Don't know

service to friends and family if they needed similar care or treatment?			nor unlikely			
How good was the service you received?	Excellent	Good	Fair	Poor	Very poor	
How good were our services at:						
Listening to you?						
Communicating with you?	Excellent	Good	Fair	Poor	Very poor	
Showing you respect?	Excellent	Good	Fair	Poor	Very poor	
Involving you in decisions about your care or treatment?	Excellent	Good	Fair	Poor	Very poor	
Making a positive difference to your health and wellbeing?	Excellent	Good	Fair	Poor	Very poor	

Procedure

The following services from the Forensic Service Division were included: Community Forensics, Wells Road (Low Secure Service), Arnold Lodge (Medium Secure Service),

Wathwood (Medium Secure Service), and Rampton Hospital (High Secure Service). A total sample of 111 patients responded from these services (see Table two).

The sample of non-forensic services was collected from the Adult Mental Health and Substance Misuse directorates from the Local Partnerships Division of the Trust (see Table two). All participants were receiving treatment for a mental health disorder at the point of participation.

The data examined is based upon the SUCE form collection between 01/01/2017-30/06/2017. Forensic volunteers attend the forensic services once every 6 months to collect patient feedback. Therefore, a 6-month time scale has been used to ensure that each comment reflects the views of a different patient within the forensic services.

Table 2: Descriptives of the Patient Group

Forensic Directorates	**Number of Beds**	**Number of patients who participated**	**Services provided by the Directorate**
Community Forensics	N/A	12	Patients discharged from prison and secure units
Wells Road	92	10	Men and Women with a Mental Disorder and Men with a Learning Disability.
Arnold Lodge	102	13	Male Mental Illness, Male Personality

			Disorder and Women's Services.
Wathwood	76	15	Male Mental Disorder
Rampton	340	61	Male: Mental Health Service, Learning Disability Service, Deaf Service, Personality Disorder and Women's Service
Non-Forensic Directorates			
Adult Mental Health	Mix of inpatient and outpatient population.	643	Men and women diagnosed with a Mental Disorder receiving treatment within a non-forensic service
Substance Misuse	Mix of inpatient and outpatient population.	152	Men and women diagnosed with a Mental Disorder alongside Substance Misuse issues receiving treatment within a non-forensic service.

The investigator met regularly with executive members of the Trust's Involvement and Experience Team to discuss the study progress. Additionally, throughout the study process,

the investigator volunteered within the Trust to collect the patient feedback via the SUCE form collection. The investigator observed patient meetings within the high secure forensic service within which the SUCE form collection was discussed with a panel of patients. These experiences enabled the investigator to familiarise herself with the process of data collection.

Ethical approval

The investigator requested ethical approval from the Research and Innovation Team within Nottinghamshire Healthcare NHS Foundation Trust who conducted a review; the project met the criteria for a Service Evaluation (See appendix 2). External Ethical Approval was not required due to the data being made available to the public online via the Trust website. Additionally, the investigator received approval from the Division of Psychiatry and Psychology (DPAP) Faculty of Medicine and Health Sciences Research Ethics Committee (See appendix 3).

Quantitative Analysis

The data was transferred from Excel into IBM SPSS Statistical Software: The investigator assigned categorical labels to the data as presented in the SUCE forms (see appendix 1). The investigator removed all columns that were not relevant to the study hypothesis such as 'team', 'date', 'time' etc. The following columns were created by the researcher for analysis:

> *Feedback Score:* Overall Likert scale responses were dichotomized into a categorical variable Positive or Negative/Neutral feedback for each patient. A score of four or more positive selections across all 7 questions determined positive feedback. Additionally, a score of 4 or more negative/neutral selections across all 7 questions determined negative/neutral feedback. 'Extremely Likely', 'Likely', 'Excellent' and 'Good' were determined to be positive selections. 'Neither Likely nor Unlikely',

'Unlikely', 'Extremely Unlikely', 'Fair', 'Poor' and 'Very Poor' determined negative/neutral feedback.

Ward Response Rate: The ward response rates for the forensic patient data was calculated from the Trust website. The data was transferred into categorical variables: 25% and under, 26%-50%, 51-75% and 76% and over.

Security level: The data for the secure forensic population was categorised by level of security; Low Secure and Community Forensics, Medium Secure and High Secure services.

A Chi-Square test of independence (distribution free tool) was calculated to compare the feedback given by patients within forensic and non-forensic mental-healthcare services. The Chi-Square test for association was conducted as the dependent variable was made up of categorical data - feedback: positive/ negative or neutral. Additionally, the data meets the assumptions to conduct the Chi-Square test; the independent variable was made up of two categorical, independent groups: forensic patients and non-forensic patients.

Furthermore, the Chi-Square test was used to compare patient feedback by level of security for which the independent variable was made up of three independent categorical groups (Low Secure and Community Forensics, Medium Secure and High Secure mental healthcare services). The investigator had explored further binomial logistic regression to explore these results, however, the assumptions were not met; the model did not fit the data, consequently binomial logistic regression was deemed unsuitable.

Additionally, the Chi-Square test was conducted to determine the difference between response rates of low secure and community forensics, medium secure and high secure services; meeting the assumption for independent groups and categorical data. However, the

assumption for expected frequencies was violated as 50% (6 cells) had expected counts of less than five (see Table three below). Therefore, the Likelihood ratio statistic was used to interpret the results.

Table 3: Chi-Square Tests

	Value	**Df**	**Asymptotic Significance (2-sided)**
Pearson Chi-Square	21.917[a]	6	0.001
Likelihood Ratio	21.752	6	0.001
Linear-by-Linear Association	2.813	1	0.93
N of Valid Cases	99		

a. 6 cells (50.0%) have expected count less than 5. The minimum expected count is .91.

Qualitative Analysis

Qualitative data was analysed using a directed approach to content analysis (Hsieh and Shannon, 2005). The full body of patient feedback from forensic services data was extracted (111 comments), additionally, a random sample of 111 patient feedback comments were extracted from the non-forensic data, due to investigator time constraints, using Microsoft Excel. The data was separated into two groups: 'Best' grouping reported all anonymous free-text answers to the survey question 'What did we do well?' and 'Improve' grouping reported all anonymous free-text answers to the survey question 'What could we do better?' (see appendix 5). The free text comments to the remaining six questions were not made available by the Trust. The data was read repeatedly to derive codes, highlighting exact word/s from the text to illuminate key descriptions or concepts (See appendix 5). Labels for the codes

emerged that were reflective of more than one key thought, these labels laid the foundations for the coding scheme. The codes were distributed into categories and themes with regard to their relationship with each other (see appendix 4).

The categories identified within content analysis allowed the researcher to represent the explicit perspectives of the service users in order to understand and support quantitative findings (Hsieh & Shannon, 2005). Conventional content analysis was performed due to the limited existing theory and research surrounding patient feedback. This allowed for a richer understanding of the key concepts of the data compared to quantitative methodologies alone.

Results

Hypothesis Testing:

H1: Service users in non-forensic services will rate the care they have received more positively than those in forensic services.

A significant difference was found ($x^2(1)= 60.11$, $p<.001$) between the feedback given by patients within forensic mental healthcare services and non-forensic mental healthcare services. In accord with our prediction, service users in non-forensic services rated the service that they had received more positively (93.7%) than those within forensic services (71.2%). Furthermore, significant differences were found between forensic patients and non-forensic patients on every single question of the SUCE form (See Table four below). In sum, patients in non-forensic services returned more positive ratings on all the items in comparison to their non-forensic counterparts.

Table 4: Patient Feedback Percentages

		Extremely Likely	Likely	Neither Likely Nor Unlikely	Unlikely	Extremely Unlikely	Chi-Square Equation
Q1: Promoter	Forensic	15.7%	10.8%	4.9%	37.3%	31.4%	($x^2(4)$= 82.60, p<.001)
	Non-Forensic	3.6%	1.6%	2.7%	22.6%	69.5%	
		Very Poor	Poor	Fair	Good	Excellent	
Q2: Service	Forensic	0.9%	8.3%	18.3%	40.4%	32.1%	($x^2(4)$= 97.82, p<.001)
	Non-Forensic	2.2%	1.0%	4.1%	21.2%	71.6%	
Q3: Listening	Forensic	2.8%	6.4%	22.9%	37.6%	30.3%	($x^2(4)$= 105.10, p<.001)
	Non-Forensic	2.7%	1.1%	3.8%	22.2%	70.2%	
Q4: Communication	Forensic	3.6%	6.3%	15.3%	52.3%	22.5%	($x^2(4)$= 90.34, p<.001)
	Non-Forensic	2.4%	1.1%	5.3%	23.8%	67.3%	
Q5: Respect	Forensic	1.9%	10.2%	16.7%	35.2%	36.1%	($x^2(4)$= 114.53, p<.001)
	NonForensic	2.2%	0.6%	3.8%	17.4%	76.0%	
Q6: Involvement with Care	Forensic	4.5%	9.1%	15.5%	39.1%	31.8%	($x^2(4)$= 47.02, p<.001)
	Non-Forensic	2.6%	2.0%	6.7%	27.4%	61.4%	
Q7: Positive	Forensic	2.7%	10.8%	18.9%	42.3%	25.2%	

	Non-Forensic	3.3%	0.7%	7.1%	25.4%	63.5%	($x^2(4)$= 100.31, p<.001)

H2: Service users within lower levels of secure care will engage more frequently in giving feedback of the service they have received than those in higher levels of security.

The likelihood ratio revealed a significant difference (LR(6)= 21.75, p=.001) between ward response with service user feedback between security level (low secure and community forensics, medium secure and high secure)(see Table five below). Contrary to our prediction, service users within lower levels of secure care engaged less frequently (10.1%) than those within medium secure care (28.3%) and high secure services (61.6%).

Table 5: Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	21.917[a]	6	0.001
Likelihood Ratio	21.752	6	0.001
Linear-by-Linear Association	2.813	1	0.93
N of Valid Cases	99		

a. 6 cells (50.0%) have expected count less than 5. The minimum expected count is .91.

H3: Service users within lower levels of secure care will rate the service they have received more positively than those within higher levels of security

In contrast to our prediction, a non-significant difference was found ($x^2(2)= 3.520$, $p>.05$) between the feedback given by patients within Low Secure and Community Forensics, Medium Secure and High Secure mental healthcare services (see Table six below for percentages).

Table 6: Percentages of Feedback within the Security Level

Security	Negative/Neutral Feedback	Positive Feedback
Low Secure and Community Forensics	18.2%	81.8%
Medium Secure	36.1%	63.9%
High Secure	21.4%	78.6%

H4: Coded comments that demonstrate 'interpersonal relationships' will reflect positive comments and 'institutional practice' will reflect negative comments across both forensic and non-forensic services.

From the examination of the qualitative data, the hypothesis 'coded comments' that demonstrate 'institutional practice' will reflect negative comments and 'interpersonal relationships' will reflect positive comments' can be accepted for forensic patients. Forensic patients commented the most positively about staff support (15.9%) and staff listening to patients (12.19%), whereas negative comments were most frequently related to the lack of

staffing on the wards (17.76%) (see Table Seven below). The hypothesis was not confirmed for non-forensic patients; patients commented more frequently on the atmosphere of the service (11.34%), caring staff (9.72%) and service information (9.72%) positively. However, the highest frequency of negative comments within non-forensic patient comments were related to the access to services (16%), a characteristic of the 'institutional' setting (see Table eight below).

Table 7: Table of Percentages for Forensic Patients

'What did we do well'				***'What could we do better'***			
Theme	***Code***	***Number of comments***	***%***	***Theme***	***Code***	***Number of Comments***	***%***
Staff	*Supportive Staff*	30	15.9	***Staff***	*Supportive Staff*	4	2.96
	Being Listened To	23	12.19		*Being Listened To*	6	4.44
	Commun-ication	16	8.48		*Commu-nication*	5	3.7
	Respect	18	9.54		*Staffing Quality*	7	5.18
					Power Divide	5	3.7
					Bullying	4	2.96
Service	*Amenities*	7	3.71	***Service***	*Amenities*	9	6.66

	Service Process	3	1.59		*Access to Services*	2	1.48
	Service Under-standing	7	3.71		*Treatment*	6	4.44
	Treatment	13	6.89				
Environment	*Feeling Safe*	8	4.24	***Organisational Demands***	*More Staff*	24	17.76
	Care	15	7.95		*Seclusion Practices*	3	2.22
	Activities	7	3.71		*More Available Therapy*	9	6.66
Personal Development	*Future & Hope*	6	3.18	***Quality Of Life***	*Patient Need*	9	6.66
	Service Under-standing	4	2.12		*Respect/ Dignity*	8	6.92
Additional				***Additional***			
NA		30	15.9	***NA***		28	20.72
'Everything'		1	0.53	***'Nothing'***		7	5.18
Total		188		***Total***		136	

Table 8: Table of Percentages for Non-Forensic Patients

'What did we do well'	***'What could we do better'***

Theme	***Code***	***Number of comments***	***%***	***Theme***	***Code***	***Number of Comments***	***%***
Staff	*Supportive Staff*	9	7.29	***Staff***	*Being Listened To*	6	5.52
	Being Listened To	5	4.05		*Communication*	8	7.36
	Communication	5	4.05		*Consistency*	2	1.84
	Great Staff	5	4.05				
	Caring Staff	12	9.72				
Service	*Amenities*	5	4.05	***Service***	*Amenities*	9	8.28
	Access to Services	6	4.86		*Service Process*	9	8.28
	Supporting Future	6	4.86		*Access to Services*	16	14.72
	Informative	12	9.72				
	Organisation	10	8.1				
Environment	*Atmosphere*	14	11.34				
	Feeling Safe	5	4.05				
Additional				***Additional***			
NA		19	15.39	***NA***		43	39.56
'Everything'		11	8.91	***'Nothing'***		16	14.72
Total		124		***Total***		109	

Content analysis

Analysis of the free-text comments left by patients within forensic and non-forensic services support previous quantitative findings. Key themes have been identified throughout the free-text data within both forensic and non-forensic populations. Five themes have been found to be consistent throughout both populations alongside 3 additional themes identified within the forensic population only (See table eight and nine above for the themes and codes identified). Factors relating to Staff, Service and Ward Environment have been identified within both population comments. Additionally, Organisational Demands, Quality of Life and Personal Development themes have been identified within the Forensic population only. The codes identified within these themes highlight some similarities and differences between the two populations. The differences between forensic and non-forensic comments have been explored below. (Please see appendix 4 for the full analysis and representations of the themes and codes).

Both populations commented positively about the interpersonal relationships between patient and staff, specifically, communication and support. However, forensic patients were more likely to highlight negative characteristics of 'staffing quality', 'patient-staff power divide' and 'bullying' within forensic services. Patients felt that staff did not understand their needs fully and that they felt subordinate to staff.

> 'Employ more band 3 and people that know about forensics'

> 'I don't feel included staff/patient divide. Because when moved from Emerald no discussion as to why move was happening'

Furthermore, non-forensic patients were more likely to comment upon 'caring staff' and 'supporting staff' as aiding their recovery, often making an extra effort to make the patient feel comfortable.

> 'The care I was given was 100%. Nothing was ever too much trouble'

> 'Everything - all staff have been brilliant'

Both patient populations commented positively regarding the 'service' theme as supporting their needs. Patient comments referred to service 'amenities' and 'access to services' as positive aspects of the service.

> 'Better meals and able to have mobile phone' (Non-Forensic)

> 'Food is nice. Can have a shower when I want. Given money to spend in the shop. The shop is good. Sufficient clothing has been supplied' (Forensic)

Forensic patients were more likely to comment upon the 'service understanding' of their mental illness and treatment procedures positively. Meeting patient needs was highly valued and the services ability to address this was prioritised.

> 'Help very well with managing and understanding my illness and ensuring there is always someone to talk to'

> 'I feel the service has and is making a positive difference to my health and well-being'

Non-forensic patients were more likely to comment positively about the services characteristics such as 'supporting future', 'information' given by the service and service 'organisation'. Patients felt that the service encouraged personal skills and was prepared to deliver the service.

> 'It helped build my confidence'

‘Recovery team have provided essential education & have been approachable with any question arising’

Both populations valued the service ‘atmosphere’ and ‘feeling safe’ as an important aspect of the service environment which guided positive comments.

‘Great environment - professional and friendly’ (Non-Forensic)

‘It's like a home, not like being in a hospital. It's friendly with a homely feel to it’ (Forensic)

Additionally, forensic patients discussed that it was important to feel ‘cared for’ within the environment. Patient access to available ‘activities’ was regarded to aid their recovery and promote positive comments about the service environment.

‘I get all the care and support genuine’

‘We have a timetable of activities and therapies’

Additional Themes within the Forensic Population

Forensic patients commented regularly on three additional themes that were not identified within non-forensic patients which may give some insight into the patient view of the secure setting.

Personal development was highlighted as a positive theme of the service, such as aiding ‘future hope’ and increasing ‘patient understanding’ of themselves and their mental illness.

‘Look after people make them well giving people hope and a brighter future than the past’

‘Help very well with managing and understanding my illness and ensuring there is always someone to talk to’

The institutional setting guided negative evaluations of the service. Patient comments regarding the organisational demands highlighted ‘staffing numbers’, ‘seclusion practices’ and the ‘availability of therapy’ as being of detriment to the patient recovery process.

> ‘Dignity in seclusion via shower facilities including ways to help dry body or deal with periods’

> ‘More staff would provide a more concise activity facilities, but that's a major issue across the board’

Additionally, patients commented upon the quality of life within these settings, highlighting ‘respect and dignity’ as being neglected within the confines of institutional control. The patient quality of life was perceived as negative due to the distance from family and the service not understanding the ‘patient need’.

> ‘Dignity - once when I was unwell I stripped down naked and then held me in seclusion when I was naked I think it was wrong’

> ‘Some staff in the hospital are sometimes insensitive and unaware of patients medical/social needs’

Discussion

Summary of findings

From the analysis of service user feedback, forensic patients were more likely to give negative feedback of the mental healthcare service than non-forensic patients. A significant difference was found between patient involvement (as indexed by the response rate) and the level of security: high secure services had a higher overall response rate than lower secure services (community forensics, low and medium). Further analysis into forensic patient

feedback revealed no significant differences in feedback across the level of security (community forensics and low, medium and high).

Investigation into patient comments gave further insight into the differences between forensic and non-forensic patients regarding their service experience. For example, both forensic and non-forensic patients commented upon the interpersonal relationships with staff which reflected positive feedback. However, forensic patients were more likely to be dissatisfied with the staffing quality and power differential between patients and professionals. Additionally, the institutional practice of the service determined more negative comments within the forensic population, such as organisational demands and the quality of life.

Characteristics of the Patient Population

Characteristic differences between the patient population within forensic and non-forensic mental-healthcare services may provide some insight into the differences found between patient feedback. The majority of the forensic patient population within the study were receiving treatment within a secure setting (89%). Patients within secure forensic settings are detained under the Mental Health Act due to their risk and the experiencing of an acutely disturbed phase of a serious mental disorder, usually with complex co-morbidities (The NHS Confederation, 2012). Symptom severity was examined as a predictor of patient satisfaction amongst a sample of patients suffering from mental health issues. The severity of symptoms, comorbidities and prescribed drugs were found to predict reduced patient satisfaction (Kohler, Unger, Hoffmann, Steinacher & Fydrich, 2015). Additionally, higher levels of symptom severity can be associated with lower patient ratings of ‘quality of life’ within forensic mental healthcare inpatient settings (Priebe et al., 2011).

The ‘Quality Of Life’ theme identified within the forensic patient population highlights the importance of patient need alongside respect and dignity, which reflected negative comments about mental healthcare services. Additionally, overall dissatisfaction across the patient life span has been associated with lower satisfaction regarding healthcare services (Cleary & McNeil, 1988). The quality of life of forensic patients has been reported to be lower than the general population. For example, childhood trauma is more prevalent within forensic populations; 69% have suffered physical abuse, 69% emotional abuse, 47% sexual abuse and 41% neglect (Macinnes, Macpherson, Austin & Schwannauer, 2016). Patients diagnosed with mental ill health within forensic services are more likely to have experienced a traumatic childhood, adulthood or both. These characteristics are likely to increase the patient need within mental healthcare services and present as a barrier to recovery which may consequently encourage negative feedback.

Characteristics of mental ill health have been significantly associated with reduced patient involvement with satisfaction and feedback surveys (Peytremann-Bridevaux et al., 2006), specifically features of schizophrenia, like thought disorder have been associated with neurocognitive deficits that may influence the capacity to make decisions (Gayet-Ageron, Agoritsas, Schiesari, Kolly & Pernerger, 2011). Characteristics such as cognitive impairment across both forensic and non-forensic patient populations may be likely to discourage involvement due to apprehension about reading/writing (Jacomb, Jorm, Korten, Christensen & Henderson, 2002). Additionally, the severity of mental illness may discourage patient availability to complete patient feedback surveys (Laitila, Nummelin, Kortteisto & Pitkanen, 2018).

An investigation into the patient view regarding involvement across a variety of mental healthcare services revealed that patient involvement was encouraged by the care system; patient-centred care and treatment alongside a good therapeutic patient-professional

alliance (Laitila et al, 2018). These findings may give some insight into the low response rate across secure forensic services within the present study (99/610 patients responded). The low patient response rate, alongside forensic patient reports of poor staffing quality and staff bullying within the forensic setting, may have discouraged patient involvement with giving feedback. It is important to consider non-responders within service evaluation projects; research findings often favour the agenda of the researcher, whilst failing to account for the views of non-responders, who are likely to be the most dissatisfied with the service (Coffey, 2006).

Characteristics of the Forensic Environment

Forensic patients' negative comments about service staff highlight the importance of balancing the power divide within forensic settings. Furthermore, patients reported that they felt they were being bullied by the staff. These findings support the literature recognizing that balancing the power dynamic within services that are restrictive and controlling can be a complex process (Völlm et al., 2017). There are many procedures within secure forensic settings that are deemed necessary to maintain security within a therapeutic environment. However, these security procedures may give rise to a cultural ethos of control and surveillance. Rask and Hallberg (2000) found that within a Swedish sample of mental healthcare nurses apprehension was reported regarding their job responsibility within the secure forensic environment. The nurses were unable to clearly differentiate their role as a therapeutic agent from custodian. This cultural paradigm within forensic mental healthcare services can negatively impact the delivery of care (Mason, 2002); establishing the balance between security and therapy is likely to influence patient perspectives of their interpersonal relationship with clinical staff.

Within the secure forensic environment, patient aggression is highly prevalent (Daffern & Howells, 2002). Over-crowding within secure forensic services has been identified as a predictor of aggressive behaviour among patients. However, enlargement of the physical space did not reduce incidents of aggression (Nijman & Rector, 1999). Reduced patient privacy was in fact predicted to increase aggressive acts. This is important to consider within environments where surveillance is critical to ensure patient safety. As a consequence, staff are required to carefully manage their practice in response to these risks which often encompass professional isolation, identity and issues of the patient-staff power interplay (Mason, 2002). Within these environments it is likely to be much more difficult for staff to maintain the same level of perceived care as is evident within non-forensic services. Often the use of restrictive practices such as seclusion, restraint and sedation, are perceived as the staff employing power over the patient. These practices are necessary; however, may negatively impact patient perspectives about service staff's therapeutic responsibility within the service.

Staff Burnout

Existing evidence suggests that there may be a negative association between staff burnout and patient satisfaction. This may explain our findings of differential ratings for positive feedback across forensic and non-forensic mental healthcare services. Whitehead and Mason (2006) revealed a significant difference between the environments of forensic and non-forensic services that is likely to negatively impact staff burnout. These differences were in relation to higher levels of assault, threat of assault, self-injury, threat of self-injury and verbal abuse in forensic than non- forensic services. However, the generalizability of this study is restricted due to the small number of participants who engaged at each of the sites (Mair & Whitten, 2000). Forensic mental healthcare nurses are more at risk of developing

occupational stress and burnout than those working in non-forensic services. This is likely related to the severe and enduring mental health needs of forensic patients (Dickinson & Wright, 2008). Additionally, patient assaultive and aggressive tendencies within secure forensic services significantly impact the hospital environment, consequently impairing the functioning of staff to deliver an appropriate service (Kelly, Subica, Fulginiti, Brekke & Novaco, 2015).

The 'image' of the psychiatric hospital and reputation perceived by the general public, medical students, health professionals and the media within forensic services may lead to negative stereotypes about both staff and patients (Angermeyer, Van-Der-Auwera, Carta & Schomerus, 2017). Although in an examination of the differences in attitudes held by staff within secure forensic mental healthcare services, no significant difference in attitudes towards patients within low and medium secure services was found (Lammie, Harrison, Macmahon & Knifton, 2010).

Practice Issues

The findings of the present study contribute to knowledge within mental healthcare, teaching and future research. Forensic mental health practice must reflect strong values and standards of both personal and ethical frameworks alongside balancing the need to manage patient risk; all contributing to the culture of forensic mental health practice (Vinestock, 1996). This is embodied in official policy which gives a guide to relational security, promoting safe relationships for staff and patients in forensic settings (Department of Health and Social Care, 2010).

As discussed earlier, the balance of power within forensic settings may have some influence upon the accuracy with which patient feedback may be captured. The authentic voice of the patient is likely to be compromised by staff surveillance when giving feedback,

alongside patients feeling pressured to engage/dis-engage with volunteers to win the approval of others within the ward (Völlm et al., 2017). The investigator observed the feedback collection methods within Nottinghamshire Healthcare NHS Trust and noted that the presence of staff required within the secure forensic services did have some influence upon patient engagement. In some instances, patient's asked if they could complete the feedback away from staff surveillance. The Trust's use of volunteers within forensic services compared to non-forensic services, highlight important differences between the forensic and non-forensic population; forensic services are more likely to report negative feedback and engage less with service staff when giving feedback.

Staff should be trained to be aware of these practical issues and take actions to reduce their consequence (Coffey, 2006). For example, prior to volunteer arrival, the patients should be informed by a designated staff member that all the information they give will be confidential. This is likely to increase involvement as the patients have more of an idea of what the feedback is about and who they will be disclosing it to (i.e. volunteers and not staff). Additionally, the role of the designated staff member may be to encourage patients to express their views freely and without fear of consequences. Furthermore, it is important that volunteers do not ask leading questions when prompting free-text comments so that the patient response is influenced as little as possible by the presence of the volunteer (Ritchie, Lewis, Nicholls & Ormston, 2013). Patient feedback helps to inform action plans for each ward; communicating the process and progress of the action plan will keep patients informed and interested with feedback and future involvement (Picker Institute, 2009).

Forensic patients often include challenging, high risk or extremely vulnerable people whose behaviour may present as a risk to both themselves or to others (Spiers, Harney & Chilvers, 2005). Capturing the patient perspective in these settings involves overcoming many practical problems of access, capacity to give consent, risk of coercion and

appropriately trained staff/volunteers to work in these challenging settings. An investigation of the patient view regarding involvement across a variety of mental healthcare services, revealed that patient involvement is encouraged by the care system, patient-centred care and a good therapeutic alliance between the survey collector and patient (Laitila et a., 2018). These findings support Nottingham Healthcare NHS Foundation Trust's use of volunteers as survey collectors, who are interested in encouraging the authentic patient voice, due to their own experiences as patients within the service.

Limitations and Future Research

The investigator explored patient feedback using the data collected by Nottinghamshire Healthcare NHS Foundation Trust. The SUCE form (see appendix 1) encouraged both quantitative and qualitative feedback. However, Trust data recording neglects the free-text comments associated with the last six Likert Scale questions, reducing the availability to analyse the qualitative data. For a more informative analysis of patient feedback, future research should consider employing focus groups to examine current findings, while exploring the patient view of practice issues which may present as a barrier to feedback within forensic settings. Focus group interviews encourage the collection of a rich source of information that may better extract the authentic patient voice (McLafferty, 2004).

However, practice issues must be considered with all data collection methods within the secure setting. The present study distributed the feedback survey via volunteers within the forensic setting. Volunteers have a role within the Trust which may therefore influence the way that the patients respond to their presence. However, the motivation for volunteering for the majority of the volunteers, stem from their own experiences as a patient within mental healthcare services. These experiences are likely to drive volunteers to encourage truthful and meaningful feedback from the patient group so that the mental healthcare service can be

improved. Additionally, survey distribution via the volunteer group rather than the investigator, limits the extent to which the data collection can be influenced by the investigator, thereby reducing issues of researcher bias (Coffey, 2006).

The findings illuminate that what is important to patients within forensic and non-forensic services may vary, although general similarities can be found. Forensic populations may require the design of a survey to address their unique need in a more individualistic format. Grouping forensic and non-forensic populations under the same 'mental health' group is likely to increase the risk of neglecting important feedback that may inform the practice within a specific service setting. Additionally, future research should focus upon exploring appropriate data collection methods and survey tools that have been validated within the literature and facilitated within different settings and NHS Trusts. This may encourage more of a national patient feedback examination of consistent methodology. The inconsistency of methods and results between studies within the literature makes it difficult to compare findings, such as the process of collection and the way in which surveys have been presented (Evans et al., 2007). The design and implementation of a universal feedback survey, specific to the patient population (forensic and non-forensic) within mental healthcare services, would allow for the transferability and generalisability of findings to promote knowledge sharing within the NHS, and service improvement nationally.

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Appendices

Appendix 1: Service User Care Experience (SUCE) Form.

Your Feedback

We would like to ask you some questions about the services you have received to help us to improve them.

Please note: some questions may not apply to you. If this is the case then please ignore these questions.

I am a: ☐ service user/patient

☐ carer/relative/friend

Please circle the appropriate answer in the following questions:

1. How likely are you to recommend this service to friends and family if they needed similar care or treatment?

Extremely likely | Likely | Neither likely nor unlikely | Unlikely | Extemely unlikely | Don't know

What could we do better?

What did we do well?

2. How good was the service you received?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

How good were our services at:

3. Listening to you?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

4. Communicating with you?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

5. Showing you respect?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

6. Involving you in decisions about your care or treatment?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

7. Making a positive difference to your health and wellbeing?

Excellent Good Fair Poor Very Poor

Please tell us why you gave this response

☐ Please tick this box if you DO NOT wish your comments to be made public

How else can you let us know what you think?
You can:

- post your stories online via feedback.nottinghamshirehealthcare.nhs.uk or patientopinion.org.uk
- contact the Involvement Team on 0115 993 4567 or 0115 956 0845

Disability:
Do you have a disability or a long-term health condition which affects your day to day activities?

☐ Yes ☐ No ☐ Do not wish to say

Religion/Belief:

☐ Christian ☐ Buddhist ☐ Hindu ☐ Jewish
☐ Muslim ☐ Sikh ☐ Other ☐ No religion
☐ Do not wish to say

Sexual Orientation:

☐ Heterosexual/Straight ☐ Gay man
☐ Lesbian/Gay woman ☐ Bisexual
☐ Do not wish to say

Age (ranges):

☐ Under 12 ☐ 12-17 ☐ 18-25 ☐ 26-39
☐ 40-64 ☐ 65-79 ☐ 80+ ☐ Do not wish to say

What is your relationship status?

☐ Single ☐ Civil partnership ☐ Widowed
☐ Married ☐ Separated ☐ Other
☐ Co-habiting ☐ Divorced ☐ Do not wish to say

Are you pregnant at this time?

☐ Yes ☐ No ☐ Do not wish to say

Have you had a baby within the last 26 weeks?

☐ Yes ☐ No ☐ Do not wish to say

Thank you for completing this survey.

We would really like some more information to help us to provide good services to all the people we care for. You do not have to complete this part but it would be great if you could.

Please tick the appropriate boxes below:

Gender:

☐ Male ☐ Female ☐ Other

Ethnic Group:

White
☐ British
☐ Irish
☐ Other (please specify)

Black or Black British
☐ Caribbean
☐ African
☐ Other Black (please specify)

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Other Asian (please specify)

Dual Heritage
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other Mixed (please specify)

Chinese
☐

Gypsy/Roma/Traveller
☐

Other Ethnic Group
☐ (please specify)

Do not wish to say
☐

Please turn over...

Appendix 2: Research and Innovation Team Service Evaluation Support Letter.

positive ☑

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: Randlenquiries@nottshc.nhs.uk

Date of letter: 19/12/2017

Trixie Mottershead
Division of Psychiatry and Applied Psychology
University of Nottingham

Dear Trixie

Study title: Service Evaluation of Patient Feedback within Nottinghamshire Healthcare NHS Foundation Trust.

Nottinghamshire Healthcare NHS Foundation Trust Research and Innovation team have reviewed the documentation associated with the project listed above. I can confirm that the project is classified as a Service Evaluation. The project will be formally approved following receipt of University Ethical Approval.

Yours Sincerely

Lindsey Peggs
Research & Development Support Officer

Appendix 3: Division of Psychiatry and Psychology (DPAP) Ethical Approval

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

22nd February 2018

MsTrixie Mottershead
MSc Forensic and Criminological Psychology Student
c/o Professor Birgit Vollm
Chair in Forensic Psychiatry/Hon Consultant Forensic Psychiatrist
Forensic Mental Health, Division of Psychiatry and Applied Psychology
Room B18 Institute of Mental Health Building
University of Nottingham
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Ms Mottershead

Ethics Reference No: 237-1802 **– please always quote**	
Study Title: A Service Evaluation of Nottinghamshire Healthcare NHS Foundation Trust	
Chief Investigator/Supervisors: Professor Birgit Vollm, Forensic Mental Health, Division of Psychiatry and Applied Psychology, Dr Najat Khalifa, Associate Professor and Forensic Psychiatrist, Institute of Mental Health/Nottinghamshire Health Care NHS Trust	
Lead Investigators/student: Trixie Mottershead, MSc Forensic and Criminological Psychology Student, School of Medicine	
Other Key Investigators:	
Type of Study: Service Evaluation, Anonymised secondary database analysis	
Proposed Start Date: 01/03/2018	**Proposed End Date:** 01/08/2018 5 mths

The Committee considered this straightforward application at its meeting on 16 February 2018 and the following documents were received:

- FMHS/DPAP REC Application form and supporting documents version dated 20.12.2017
- Letter from Research and Development Nottinghamshire Healthcare NHS Foundation Trust dated 19/12/2017.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 4: Content Analysis Codes, Categories and Themes.

Staff Theme:

This category is based upon staff-patient interpersonal relationships and communication as reported by the patient. The relationship between the codes within this theme has been built upon the patient interaction with members of staff. To begin with codes that were found to be consistent within both populations of patients have been explored. Following the initial similarities, codes that identify differences between the patient populations are explored.

Similarities Between Forensic and Non-Forensic Patient Feedback

'Supportive Staff' Code- Patient comments identified service staff as supportive and helpful within both patient populations. Additionally, forensic patients also reported that service staff could be more supportive in areas of crisis management.

Non-Forensic 'Best'

'Quick response to crisis. Nurses and doctor helped all the family understand the illness not just my daughter. Made us closer as a family'

Forensic 'Best'

'Support, advice. Always someone available even through night'

Forensic 'Improve'

'When staff become stressed they are not so good at being supportive'

'Being Listened To' Code- Patients within both populations commented on both service staff's ability to listen to the patient and respond appropriately as well as their inefficiency to listen to the patient.

Non-Forensic 'Best'

'Listening to your concerns'

Non-Forensic 'Improve'

'**** healthcare weren't helpful at all in as they didn't listen or understood and they assumed things I didn't say'

Forensic 'Best'

'Listened to my problems and didn't judge'

Forensic 'Improve'

'I am always able to express my opinion, but it is rarely listened to'

'Communication' Code- Patients commented upon service staff's ability to explain and relay information. It was also important for patients to have staff answer questions.

Non-Forensic 'Best'

'Very helpful staff who put me at ease and answered all questions as and when asked. Good Job'

Non-Forensic 'Improve'

'I was discharged without being told why'

Forensic 'Best'

'Support, advice. Always someone available even through night. Information passed on and explained. Good rapport. Definitely. Physical check up regularly. All information passed on.

Forensic 'Improve

'could be more accurate in taking evidence and relay back to ensure accurate'

Differences Between Forensic and Non-Forensic Patient Feedback

Codes Identified within Non-Forensic Patients Only

'Great Staff' Code- Patients often complemented the service's staff without giving further explanation

'Everything - all staff have been brilliant'

'Caring Staff' Code- Patients reported staff to be caring and attentive, often making an extra effort to make the patient comfortable.

'The care I was given was 100%. Nothing was ever too much trouble'

'Consistency' Code- Patients commented upon the inconsistency of staff as being an area that needs to be improved within the service.

'every time I had a appointment I seen a different doctor'

Codes Identified within Forensic Patients Only

'Staffing Quality' Code- Patient's gave negative comments in relation to the quality of staff, often feeling that staff were not attentive or understood their needs fully.

'Employ more band 3 and people that know about forensics'

'Power Divide' Code- Patients commented upon the power divide between patient and staff; patients being subordinate to the power of staff.

'I don't feel included staff/patient divide. Because when moved from Emerald no discussion as to why move was happening'

'Bullying' Code- Patients commented upon being the victim of bullying by members of staff, feeling that staff ignored their needs.

‘Help me. Treated unfairly. The staff prefer to bully me. Never ask me if I’m OK. I've been bullied by the staff. I don't get a choice or a voice’

‘Respect’ Code- Patient commented upon members of staff being respectful and understanding which was held at high value to the patient feedback.

‘All our day care staff show respect even when a patient is struggling’

Service Theme:

This theme relates to the ‘service’ as a system supplying the public need for healthcare as separate from patient relationships with staff.

Similarities Between Forensic and Non-Forensic Patient Feedback

‘Amenities’ Code- Patients commented regularly on the amenities of the service. Food/Drink was both complemented and criticised by patients. The facilities within the service, hygiene and shopping access was generally well regarded by patients.

Non-Forensic ‘Best’

‘Good food. Good having a TV’

Non-Forensic ‘Improve’

‘Better meals and able to have mobile phone’

Forensic ‘Best’

‘Food is nice. Can have a shower when I want. Given money to spend in the shop. The shop is good. Sufficient clothing has been supplied’

Forensic ‘Improve’

‘Say things will change then they don't.. Don't always get fed or drinks given’

‘Service Process’ Code- Patients often commented on the institutional processes of the service such as waiting times, multi-agency working and referral processes. Non-forensic patients criticised the service process whereas forensic patients generally regarded the service process as being a good contributor to the overall service.

Non-Forensic ‘Improve’

‘The therapists were great, it's the process that are awful.??? ineffective, referred to wrong services in crisis moments’

Forensic ‘Best’

‘signposted well to after services + information’

'Access to Services' Code- Patients commented upon the practical access to services, such as waiting times, treatment sessions, involvement, building accessibility and frequency of activities. Forensic patients were more dissatisfied with service accessibility than non-forensic patients.

Non-Forensic 'Best'

'Venues are easy to find and attend'

Forensic 'Improve'

'More off ward activities'

Non- Forensic 'Improve'

'More services so I could see inclusion team more often'

Differences Between Forensic and Non-Forensic Patient Feedback

Codes Identified within Non-Forensic Patients Only

'Supporting Future' Code- Patients found that in addition to the support that was received from staff regarding recovery, additional service support encouraged personal development such as patient confidence.

'It helped build my confidence'

'Information' Code- Patients regarded the service's sharing of information and teaching patient-led understanding of mental health positively.

'Recovery team have provided essential education & have been approachable with any question arising'

'Organisation' Code- The organisation of the service within the institutional context was commented upon; patients viewed the service as well structured and prepared to deliver the services.

'I was pleased that although I saw different people, each one was up to date with my notes before seeing me'

Codes Identified within Forensic Patients Only

'Service Understanding' Code- Patients positively perceived the service to understand their need and address this appropriately.

'Help very well with managing and understanding my illness and ensuring there is always someone to talk to'

'Treatment' Code- Patients reported mixed comments in relation to their treatment; medication, therapy and recovery progress.

'Best' Category

'I feel the service has and is making a positive difference to my health and well-being'

'Improve' Category

'Not enough psychological treatments/therapies'

Environment Theme:

This category relates to the environment in which the service is being delivered, as reported by patients.

Similarities Between Forensic and Non-Forensic Patient Feedback

'Atmosphere' Code- Patients commented positively about the atmosphere of the hospital, being made to feel comfortable in their environment.

Non-Forensic	Forensic
'Great environment - professional and friendly'	'It's like a home, not like being in a hospital. It's friendly with a homely feel to it'

'Feeling Safe' Code- Represents patient comments about the environment promoting respect and dignity in which the patient feels safe within the service.

Non-Forensic	Forensic
'Gave more respect confidence to speak'	'Keep the ward safe, help patients with their problems'

Differences Between Forensic and Non-Forensic Patient Feedback

Codes Identified within Forensic Patient Feedback Only

'Care' Code- Patients often commented on feeling that they were being cared for by the service.

> 'I get all the care and support genuine'

'Activities' Code- Patient commented positively about feeling that the activities provided by the service promoted their recovery.

> 'We have a timetable of activities and therapies'

Forensic Only Themes and Codes

The researcher identified three additional themes within the forensic population of comments that were absent within the non-forensic data.

Organisational Demands Theme

Patient comments that were related to the institutional practice of the service were categorised into codes that were made up of organisational demands. These codes were all identified within the 'improve' category of patient comments.

'More Available Staff' Code- Patients often felt that there were not enough available staff to cater for patient needs, restricting the amount that the patient could do due to low staffing.

> 'More staff would provide a more concise activity facilities, but that's a major issue across the board'

'Seclusion Practices' Code- Patient did not comment positively with regard to the present seclusion practices often feeling that they could not maintain their dignity within the environment they were secluded in.

> 'Dignity in seclusion via shower facilities including ways to help dry body or deal with periods'

'More Available Therapy' Code- Patients additionally felt that they did not have enough access to therapies and that the waiting times for therapy was too long.

> 'Not enough psychological treatments/therapies'

Quality of Life Theme

Patient comments that illuminated the quality of life of the patient were identified within the 'improve' category of comments. These codes could be determined by the patient desire to live a 'happy' life within restricted environments.

'Meeting Patient Need' Code- Within secure services often the patient perceives that their need is not being met. Patients comments related to being near their family, medical/social needs and service understanding of their index offence.

> 'Some staff in the hospital are sometimes insensitive and unaware of patients medical/social needs'

'Respect/Dignity' Code- The nature of secure services requires a degree of surveillance over the patients within the service. Patient comments have highlighted issues with regard to maintaining respect and dignity within these environments.

> 'Dignity - once when I was unwell I stripped down naked and then held me in seclusion when I was naked I think it was wrong'

Personal Development Theme

Alongside treatment progress, support with personal development and future planning is important within the 'best' category of patient comments. Understanding oneself and holding hope for the future was valued by patients.

'Future and Hope' Code- Patient comments highlighted the service and staff's ability to give hope for the future and setting achievable goals.

> 'Look after people make them well giving people hope and a brighter future than the past'

'Patient Understanding' Code- Patients have highlighted the importance of improving their own ability to understand themselves and their mental illness.

> 'Help very well with managing and understanding my illness and ensuring there is always someone to talk to'

Appendix 5: Coded Raw Data

What did we do well? Forensic Codes

Just being there as support. Felt not alone, someone to talk to impartial, not being judged. Someone there all time, not alone. Joanne rang, just in general, really good follow up from staff. Kept me informed. Felt had someone there who understood.
Good service, very understanding.
Every was good, there for you listen, help you and advice you where to go and where things are. Let me speak. there for me no rushing take my turn to speak each other. Explain everything well. Very polite to me took their time. Showing what I need to do and get myself right in long run.
Helping the service user with everyday tasks, support, and informed with support key worker. Every time I am visiting the hospital for any reason the staff are very nice and helpful and medication. Listening: - good because the staff and myself are busy people and been in the system. Every time I visit staff are keen to help. I am happy because some people do care (previous hospital appt). Monthly visits from social worker and CPA meetings medication. shopping time out, activities, gym, integrating (nature in mind)
Listened to me, good advice, given support. Listened to my problems and didn't judge.
I have been given some genuinely useful insights from the psychologists report. The workers her are, attentive and many of them have given ongoing attention to my case. I generally have the impression of friendliness here and concern. Dialogue has been genuine and meaningful. I feel treated as an equal. I was regularly informed that appointments are optional and flexible. In the circumstances I think coming her was a very good idea, to help me understand my situation.
As a mother and carer, I received one of the best explanations from staff, and I visited my son and I had the best service possible. I complain because nothing evolves and we are in a 21st Century and still following 20th Century's policies. 1983 Mental Health Act has to be reviewed and changed to our scientific point of view with this VOICES matter. We are in 2017 we have to make a difference we have a cure for everything and everyone.
Very good service. Very compassionate, extremely helpful, honest + signposted well to after services + information. Listened well and helped without judgement. Treated very well as a person and not as number statute. Very good at signposting and helping with choices + what can aid me. Felt better for speaking to ??? Someone listened and did their best to help.
NA
Everything. Get breakfast, watch TV, day care. Like the nurses but don't always listen.
I like and trust ****. ***** looks after me. College ladies help.
Look after patients. Treat you with respect. Good food. Treated well supportive staff. They ask me what medication I want to be on. Staff look after you quite well.

Groups. Playing pin-ball games. Social nights. Food is good. We have a timetable of activities and therapies. I go to the forum.
Look after me. Help me to take my medication. Make sure I'm safe. My nursing team look after me.
Help me. Listen to me. Give me med's when I need them. Really good.
Support, advice. Always someone available even through night. Information passed on and explained. Good rapport. Definitely. Physical check up regularly. All information passed on.
Support when needed, staff go out of there way to help. Staff always available. Respect goes both ways. Regular ward rounds. Named Nurse sessions. Physical health state at when needed, given support.
Caring for me.
Helps patients physical and mental health. Helps patients understand mental illness via psychology, off ward activities.
NA
Keep the ward safe, help patients with their problems. Give patients the correct medication. Looking after patients/visitors at visits. Very good.
Some good staff. Sometimes. No comment.
Keep us all feeling safe. Meals are always delivered on time & hot. Physical & mental well-being well cared for. Plenty of people willing to listen. There's a lot of things that get done here that would get neglected on the outside.
Look after me and make me better. I was really poorly when I came here and no I am coming back to my normal self.
Food is nice. Can have a shower when I want. Given money to spend in the shop. The shop is good. Sufficient clothing has been supplied.
Taking everything into consideration they do very well. I don't consider myself to be mentally ill. They treat us as equals.
Keep me safe. Support me when i feel ill. When i hear voices on and off ward, the staff are there to support me and show me care. They try their best for us. Named nurse is there for me all the time. My clinical team listen to me a lot and take it on board. They give me hope for the future. The support from staff both on and off ward are helping.
Activities, off ward treatment.
NA

NA
Support with medical problems.
Listen to me and help with my treatment. Some staff can sign - some not.
Catering for patients needs. Ensuring safe environment. They can override your input at any moment so our input is not really appreciated.
NA
NA
Nothing. No. No. No. No. No. No
You provide a lot of support for the patients in your care.
NA
Support from PT'S and staff.
NA
NA
Listen, understand. Never had any problems. I feel that people do care.
As stated in day to day life it is fairly good. General day to day is really good. Same as above. All our day care staff show respect even when a patient is struggling they allow us to vent appropriately and don't always judge the things first and support us through. Most of the time the patient is informed after the MDT discussed and decided. I think general day care services are good as they enable me to focus my mind and energies away from the traumas of therapy.
NA
NA
NA
Look after people make them well giving people hope and a brighter future than the past. 2 to 1 talking to staff and their is always someone to talk too. Even when on constant watches and taking care daily the staff give you respect. Instant care on all services.
NA
ok. n/a
Treatment, activities, safe environment.

Some times good but some times ****. You never know about all your care. Some staff show you respect others are *****. Sometimes good but sometimes ****. Can't get proper dressings for my arm and can't see meds centre.
NA
NA
I feel the service has and is making a positive difference to my health and well-being.
You treat mental health seriously and treat us with respect. I've been treat good since I've been on Cheviot Ward. Staff explain everything you need to know. Because I was treated with respect when I came here and since arriving. I was previously here for 5 years and never had no problems, I've only been back here for 2 weeks on the PD side. Because i was given a full screening when i came.
Work with patients that can sometimes be very hard to work with. Also the next day after an incident the staff treat it as a new day and a new start. On good days I know the staff do the best they can. If one asks for help we are offered it and staff show patients respect. As long as the staff are available we get the help and are thrown we are considered by the communications. I'm always kept informed. Have helped understand myself.
Almost all services and the view then can improve further. Experts involved with all parts. Taking time support with listening & reply. told of change before keeping informed. Dignity, patience, space. I am talked to asked for thought, feeling and time. Efficient responsible fitting.
Staff (most) given the opportunity can be very supportive.
Look after us, listen, meet our needs. My ward is brilliant and the staff are great. Because they staff my needs. Because I can talk to the nurses.
NA
Use look after us really well.
Good at listening, make a good effort at looking after me when ill, supportive when dealing with family.. Overall, fairly good.. We have advocacy, named nurse sessions and community meetings.. Sometimes just a bit slow at communicating messages across to us.. It depends on what staff are on.. Good.. It has been better than previous places.
Prepare people for leaving well in advance. Food nice. Rooms and en suite nice..
We have a laugh and staff help me to distract myself when Im feeling unwell they never give up on me they hold hope for me when I lose it myself.
Take care of us.
Look after patients well. When staffing levels adequate support and activities happen. Support you and have a laugh.. When in seclusion felt like was listened to enabling me to return to ward environment.

Nothing.. Never enough staff to staff the ward so we as patients loose out on services.
Listen and protect us well. They believe in what I said so I have not told a lie. And they've said I have not told a lie.
The hospital are good at finding out our goals in life plus helping us to work towards it, in small gradual manageable steps..
Look after me well. Cook good meals. I like giving love.
Understand my illness and listening to staff.
Doing the best. Not bad. It is not bad. Mainly about my move
Support
NA
Looking after people. I can approach staff. Work together. Show respect get respect. Staff are good to support me.
NA
General support. Always have time for 1:1. Team leader is excellent.
NA
Care for us. Listen. Guide us. Help with medication. Help me get back into community as soon as you can. Good undestanding. Staff always listen to patients, whether good or bad.. Staff communicate well with me and other patients. Staff show me respect. I get all the care and support genuine
Listened, Advice, follow up. Appropriate humor helps. Respect is what it is to another human. Plan together for best results. Positive difference:- not sure if work does that only the recipient makes change.
Staff are brilliant at their jobs, fantastic level of service.
***** he was very calm, he cared, understood, never rushed & listened to me very well. He made me feel calm. The service I was given was great! the staff are very polite, kind Y make you feel welcome. My health practitioner listened to me very well. Couldn't ask for better. I received letters for my appointment date weeks before. The communication I received was good. Didn't speak/act differently towards me due to my illness. Very respectful. Listened to my needs. I was told what therapy would be best. ***** involved me, explained it very well & asked me. Giving me an opportunity to refer to Notts Recovery college. This will make a massive difference. I had excellent service, not a bad word to say.
1:1 sessions and support. Treatment is good. Some staff listen more than others. Because there are a lot of ways for staff to communicate with patients. Because they are fair and good mannered. I have always been spoken to about all aspects of my care. Good because some nurses have positive 1:1 sessions with you. It would be excellent if all nurses were the same.

NA
Staff are there for you. As I've had one to ones and they have helped me. It's what I feel.
I have been in various hospitals since age 18yrs. I am now nearing 45yrs and consider Arnold Lodge to offer the best care out of all of them. I take supported baby steps and am making good progress. It has offered me hope, self esteem and confidence through their ongoing support and care. My needs are respected as far as is possible and time spent with me is on a regular basis. Please see number 3. I am in regular contact with all disciplines and I am told at all stages of my care what is happening with me. When ever I need to talk the staff are always willing to listen and I am usually allowed to talk 1:1 privately. All aspects of my care are talked through with me and my opinions respected. They support me in taking baby steps towards progress without fear of instant discharge.
You have to work well and maintain groups and keep stability, which get support. Staff want a duty of care. Gym staff are always asking how your feeling. As before always well spoken. Gym staff ask if you want to use the gym, even if its not your selected slotted time. Explaining things. gym staff are always on the ward to ask if you want to use the gym.
1:1's are good when needed. I think things are shaping up. Different in staff. Consistency. Better than others, some staff are. That's the way I feel about this. Just the way it is.
NA
NA
It's like a home, not like being in a hospital. It's friendly with a homely feel to it. I came from a low secure and it was very different, difficult to live there.
Ironically sometimes my family and friends say can I book in for a couple of weeks. There's no opportunity to talk to someone when you like about therapy groups to aid your well being - O.T groups - including library and cooking - listen to what the patient wants in their care. The service I receive is good in the extent that Im kept up to date on my care and im included in this process. The team which over sees my care have regular updates with me, especially when I might need 1-1's. I have talks with my named nurse and other members of the nursing team and my RMO. At times when I have been unwell and have needed more input they have shown me dignity and care. You are kept up to date - through your care plans. Talks with your etam C.P.A 1 mini and 1 full. Way is they are good at listening as well as ensuring our safety, this is both when we are well or not so well.
NA
They know we're here and talk to me. Yes, they are at all times. My treatment is usually good and they give me my information every day. They are there at all times.
Doctors are good. Staff always help. Nurses are good and healthcare assistants too.. .. Because the staff always come out to talk to you when i need them.. They always let us know whats going on.. They treat us all individually.. Very good.. Because the staff are good.
NA

NA
NA
NA
NA
NA
Everything.
Help very well with managing and understanding my illness and ensuring there is always someone to talk to.
Help from C.B.T staff talk one to one. Support from staff is very good.
Install values to make a better life for myself. Goal Setting
Provide patients with the input they require psychologically. Staff will often make time for patients if struggling. Staff are pleasant enough and make themselves clear, but are also generally very patronising. I am always able to express my opinion, but it is rarely listened to. When I came to Wathwood I was struggling with numerous personal issues - the support from psychology an nursing staff are helping me lead a happy, manageable life.
NA
Very good but not perfect.
Everything is best. Everything I am happy with here are: respect from staff - support - leave - all the meeting like community meeting or ward round - low price phone for me for another country - service - shopping - cleaning service - food games - always staffs are ready to help and this give me feeling safe - sport - good plan for our free time - medication. Is not any problem. They are very kind - big thank you from me.. My team and other in hospital always have time for me and listening to me and helping me.. Because I feel very happy. Everyone respect to me and very kind and friendly. My feeling and my opinion is very important for them. I feel very good now. I am very happy about my medication. Everything is best
Get us all on leaves. 1:1'S. Very good got me well again but need to get well patients out and ill ones in. Always someone here to listen to me. Good most of the time sometimes you get the odd sarcastic member of staff. Good at involving me in decisions. It's alright just keep you too long.

What Could We Do Better- Forensic Codes

No - didn't know about service previously.
More groups.
Nothing really
Just keep listening to the patient or service user e.g. reviews. Less time waiting at appointments.
Doesn't think there anymore improvement.
Sometimes I feel the service is a bit like a mirror, asking me how I feel and then reflecting my answers back.
Seclusion revews: Why haven't they changed since 1983? Why do patients/prisoners, hearing voices that means victims of terrorism, have to be punished because no one not even the State, for example Action fraud because of identity thefts or Scotland Yard because of terrorism, they can't stop them " the voices" how can the patients? How can you leave them for 5 days under a bright light like they are in a sun bed, in those we only can be 1/2 hour a day, because of skin cancers. Breathing the same oxygen for 5 or 6 days, there is no window or take him for fresh air? Have for example rubber headphones with their music on not to hear so much or so near the voices. Dimmer lights and an Emergency Talking Therapist after 1 or 2 hours being in seclusion because it's better for them than changing the Medicine. They need to be cared for and understood, not punished, entertain them instead.
NA
More staff - need another 4 staff. Especially at weekends.
Sort out the bullying.
Nothing.
NA
Wedges are cold. I want to get out of Rampton so I can be near my sisters.
More staff for more activities.
More activities at weekend.
More regular staff on wards.
Staffing levels.
More fitness, gynasium ECT
More off ward activities.

NA
More staff needed on the ward.
Resolutions? Some crap staff.
Pint of lager. Tease and torment you. Ok. Depends who you want to talk to. They tell you what they want you to do.
Employ more staff. Bring back free weights at the gym.
More activities, more gym.
I need to be reassured there are no cameras in my room. Telephone problems have not been sorted out.
No a lot.
More activities on the ward. A broken shower has still not been repaired after about 3 months. In the evenings 7.30 - 8.00pm we are given a piece of fruit. I would like a small pack of biscuits to see me through the evening.
Staff to show us respect. Staff like to ignore patients. Staff can't treat us with respect. A lot more could be done to help us all individually.
Considering the disability from which I stopped restrictions in participation mean there is insufficient activity. As a patient it feels like i am living the life of a cabbage and many patients have voiced the same opinion. Some staff in the hospital are sometimes insensitive and unaware of patients medical/social needs.
NA
More understanding of index offence and reason for this.
More support when something is wrong.
Listen to patients more. Address staff shortages. Arrange more activities/vocational packages.
When we say we gonna do something do it! Move staff. Gets me off ward to meet people.
NA
Nothing.
By not taking members of staff off the ward to cover other wards which affects all the patients & staff on my ward.
NA
Stop moving staff.
NA

NA
More staff.
More staff would provide a more concise activity facilities, but that's a major issue across the board. This is dependent on what and whom. Psychology etc is BAD as they are too fixed on their own views. Sometimes breaks down when various areas/depts are involved. Rarely does the patient get asked or have input.
NA
NA
Food-care- the way you treat patients the way staff treat patients.
Get more staff.
NA
Get more staff and stop spending money on things that dont need fixing and use it to employ more staff and raise pay for them.
Better staff attitude towards patients sometimes. - React better to conflict on wards. - Place less judgments on situations and go on facts.
Get more staff and help people move on.
Get gym on regular.
Where do I start. Hate Rampton. Poor marking is modern matron. I've been in Rampton 12 years and its always been ****.
NA
Less short staff issues so activities don't get cancelled.
Have more staff to carry out activities. We have a shortage of staff that can sometimes lead to a breakdown in prompt responses.
Keep the perspective of care - share & look and be kind to one another.
More staff.
Nothing.
NA
NA
Get more staff. When staff become stressed they are not so good at being supportive. Offer more activities, groups, therapies.
Visits with family & friends should be easier to book. Visitor should phone reception and they send out 3 letters to ward, visitor and patient. Then visitor should bring their letter to reception and they

wont be let in without it. Staff treat pts badly locking them in rooms 24/7 given no fresh air or exercise.. Ask for something and given something else.. Say things will change then they don't.. Don't always get fed or drinks given.. Care plans are just written for you. No input.. Not enough psychological treatments/therapies. Not enough gym.
Dignity - once when I was unwell I stripped down naked and then held me in seclusion when I was naked I think it was wrong.
More staff on Ruby.
More talkative to patients - quality not brief ones. More staff on wards. Food terrible and ward noisy at night. Medication gives me bowel problems.. I don't feel included staff/patient divide. Because when moved from Emerald no discussion as to why move was happening.. I was young when I came to this hospital. I was young and I found it sedentary and sat down for long periods of time and found very little to occupy my time.
Everything. Never enough staff to staff the ward so we as patients loose out on services.
Protect us and listen more carefully. Could respond quickly when something needs doing. Could be better
The hospital could give individual step by step progress plans to include what is needed before discharge from hospital also what went wrong e.g. what is preventing me from getting discharge and formulate a plan of action to overcome these problems and work towards a successful discharge planner with patient involvement through out all the stages of the plan. This service doesn't guarantee anything - it taken too long to progress - Then I experience too many set - backs in my care.. They listen, but are slow to respond.. They communicate well - but do not always solve the problems.. They do what they need to do thats all.. I attend every ward round. Plus I attend the patient forum to discuss ward problem and other hospital and patient problems.. Not enough feedback to the patient
N/A
Not too long in the hospital
Get me a place quicker
Allow E-cigs on the ward
NA
More staff on the ward
Help me. Treated unfairly. The staff prefer to bully me. Never ask me if i'm OK. I've been bullied by the staff. I don't get a choice or a voice.
Consistency in rules.
NA
Nothing

I the work thinks they could not do any more then it is OK? could be more accurate in taking evidence and relay back to ensure accurate.
Too much waiting time between services. Lack of funding has a direct impact on service users,
Nothing. I had excellent service, not a bad word to say.
Complaint services. Some staff listen more than others.
Hyperbole?. .. .. Suggesting I take said drug, my refusing said drug. Resulting in fourteen staff members partaking in my being held down as a team member injects my backside.. .
Be less reminded about rules. Give support, watch over us. Staff do there best to help. As some staff show less respect at times. Things get done without us there.
Dignity in seclusion via shower facilities including ways to help dry body or deal with periods.
less rules and more duty of care.
Employ more band 3 and people that know about forensics.
NA
Everything non clinical. Letting peers have a better independence. Ban all blanket bans. Move from the 1980's to the 21st Century. Clinical matters, i.e. PHC. It could be better on many levels. Sometimes you get the balance just right then you switch off. Some staff always treat you as equals others draw a line in the sand and see us as offenders. I have no comment to make. I have much decisions and they are currently being used. Because so much has changed in the way services are delivered since I came here.
More activities in the sensory room.
Improve structured day activities give out mini satisfaction surveys more often because this could be to identify.
NA
NA
Meals.
NA
Let me out quicker than within 6 months.
NA
NA
NA
NA

Nothing.
NA
NA
NA
Improve staffing levels. Train staff not to cover for each other. Less patronising. Overall, the service is poor because there is never any change, staffing levels are too low and the staff that are around lack the commitment to want to help. However, when patients request changes to be made they rarely are. Staff are pleasant enough and make themselves clear, but are also generally very patronising. I frequently hear staff talk about me in a unsettling manner and they put their own conversation before patient requests. I am always able to express my opinion, but it is rarely listened to. I am always able to express my opinion, but it is rarely listened too.
NA
I did see someone once about issues but she only did what she had to and no more could have been better.
For leave: 4 hours leave is enough for 1 or 2 patient for example to Parkgate or Rotherham or Doncaster but sometimes there is more than 2 patients and we need 6 hours leave please.
Have more staff on so were not waiting for things all the time because there always busy because there is never enough on. Sometimes you get the odd sarcastic member of staff. It's alright just keep you too long.

What did we do well? Non-Forensic Codes

All OK
All staff were fantastic including Recovery staff, couldn't pic on bad person out. Fantastic.
Appointment started on time. Staff were very welcoming and reassuring. Given plenty of time to talk.
Both the therapists I saw at ??? were great as was the wonderful receptionist ?? always treated everyone with such Respect/Dignity.
Care & a little craft.
Clean environment Nice people
Clear accurate presentations Good leaning methods Friendly tutors.
Contents of talk
Course well organised
Created a relaxed environment and excellent hand-outs.
Crisis plan has already been invaluable, and I feel like I should have had one sooner.
Crisis team were very helpful.
**** in the CRISIS team, also the CRISIS team. Amazing work they kept me alive. GP amazing listened, encouraged & cared. Sandra - brought me back to life. Thank you so much for being there and caring.
Employed ****** - who 'saw' what I really needed & helped me to access it.
Everything
Everything
Everything
Everything
Everything

Everything
Everything - all staff have been brilliant.
Everything - listening the services offered. Very please though out
Everything else
Everything else
Everything really e.g. watching TV. If I need I can go to staff member.
Everything staff wicked, everyone brilliant, try to help absolutely brilliant.
Everything was brilliant. The care I was given was 100%. Nothing was ever too much trouble. Service was excellent.
Everything! An inspiring, warm, welcoming, safe learning environment.
Everything! A wonderfully relaxed & welcoming learning environment.
Everything. Staff made me happy again & helped me stay calm. Staff had time to talk to me and cheer me up. staff respected me. Everyone was excellent. Thank you.
Excellent example of putting learned into practical outside of lesson.
Excellent service though, well done to you all.
Explained everything well throughout course also using handouts and use of techniques to use ourselves.
Family work. Quick response to crisis. Nurses and doctor helped all the family understand the illness not just my daughter. Made us closer as a family.
Feeling safe
Gave more respect confidence to speak
Gave out lots of knowledge by direct teaching & group discussion. Learnt a lot.
General care and attention is good.
Get to know the patient before they attend.

Giving support and making us very welcome.
Goin thro it
Good food. Good having a TV Got medication right.
Good service
Good tutors and resources.
Great Christmas and New year. Help me to stay positive.
Great environment - professional and friendly.
Have a lot of support and friendly.
Honestly I thought everything was perfect the way it was. Definitely would recommend the service.
I think it was **** who covers everything I needed to know and quickly.
I think you did everything well
I thought everything was well run and organised.
I was pleased that although I saw different people, each one was up to date with my notes before seeing me.
It helped build my confidence.
Just a very good service all round.
Kind friendly interesting
Likely
Looked after ten plus people, services users with distressing ???
Made be better.
Made me feel comfortable.
Made me feel very welcome and safe ??? at a pace that I could keep up.

Made me feel welcome and safe & part of the group.
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
Not alot at all.
Not much. **** is amazing, though.

Nothing - feed me food & brilliant drugs.
Peer tutors were very positive and interested in learning for all in group. Was very impressed again with attitude of all involved.
Pretty much everything
Professional, friendly and good at putting us at ease.
Provided good support
Providing help and support for social groups.
Really fun and interesting. Valuable ???? Educationist Sociable.
Recovery team have provided essential education & have been approachable with any question arising.
Relationships with all the nurses.
Some really caring staff. In particular CA's - ***** - all very friendly & seem genuinely interested in my well being. ?? *** (excellent 1:1 sessions)
Staff are polite, friendly and check you are ok.
Supportive, Inclusive environment. Once again fantastic.
Taken time so I could understand and I could understand more cause of questions I asked.
Taking time involving with the course ???? to the day activities.
Talk listened help Understand Always there when I or we need the nurses.
Taught well, gave great service
Teachers were friendly
The courses are well structured and planned. They offer a wide range of support to get the most from the lessons. Staff are friendly and polite. Venues are easy to find and attend.
The group sessions.
The visits were very warm and you explained everything I needed to know well.

They explained the course materials well.
Very friendly with patients and ??? is also very good.
Very helpful staff who put me at ease and answered all questions as and when asked. Good Job.
Very welcome & informative.
Very welcoming, explain things well, provide good service.
We spoke about everything to do with self confidence.
You did everything well
The food was nice, Curry!!
Kind and caring. Listening to your concerns.

What could we do better? Non-Forensic

Better disable access.
A bit more garden time
Did not receive expected phone call but knew meeting was late in the day.
The therapists were great, it's the process that are awful. ??? ineffective, referred to wrong services in crisis moments.
It needs a prayer room. A little more listening ear? Help people to want give up smoking not pushing them.
Email all class handouts to students Reducing doing discussions with neighbor.
Television and video
Accomodation
NA
Extend the course to 3 sessions as there is so much amazing advice to absorb.
There should be a better awareness within primary care + other main referrers to mental health services to avoid referral into crisis team when it's unnecessary - Very Disjointed!
Insight healthcare weren't helpful at all in as they didn't listen or understood and they assumed things I didn't say. The wait was long and I have been jumped from place to place.
Nothing
Sack Xxx self absorbed & not interested in what the patients want only what she wants. Horrible human being.
Allow more than 3 terms
No
Nothing
Nothing

Nothing
Nothing it is all good
Nothing - all staff have been brilliant.
Nothing very please though out.
Entertainment
Offer longer period for students to do course (longer than 1 full academic year)
Bedroom areas should be more clean. Toilet should be cleaner. Fresh airs in Bedroom.
**** off the ******s that just talk about **** etc etc
NA
Can't think of anything
NA
Nothing at all, everything was excellent.
NA
Sadly a taxi was sent for me 3 times and didn't arrive each time. It is such a big deal for me to prepare for an appointment and my emotions are all over the place when taxi doesn't arrive. Then to attend the appointment is too traumatic for me.
NA
NA
How quickly you are move through observation periods e.g. every 10 mins, every hour, Accompanied for 2 weeks. So was 2 weeks before I could leave ward unattended.
More support Audio support More space More respect
NA
NA

NA
NA
NA
don't lock people in. ??? time waiting however understand it takes time to process people & wait for professionals
Everything is fine.
Less crowded classrooms/more room
Better meals and able to have mobile phone.
Longer courses
Nothing everything is fine.
Everything went pretty well with my appointment
Nothing
Nothing needs to be better
NA
NA
More services so I could see inclusion team more often.
Can't say. Just a very good service all round.
NA
NA
Do more one to one to see the study/work go in.
NA
Nothing!
NA

Make them longer courses.
Hot chocolate.
Keep the same doctor.
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
NA
Not really
I was discharged without being told why and every time I had a appointment I seen a different doctor.

Xxxx could have more patient when talking to people. She assumes she knows all about a person simply because she's read a few papers. Stop assuming you know how people feel & why.
Listen to patients needs want. Act on your accuracy. Stop getting info wrong on patients.
Nothing really, perhaps offer a follow up session(s)
There was nothing you could of done better.
NA
NA
Provide more staff for people so they can get to know one and another.
Longer course!
Medication times need to be structured better e.g. everyone waits in the dining area until individually called.
Can we have hookers in the rooms please, thing get lost a lot mixing with clothes.
Trying to accommodate the need for physical health checks within a Mental Health ward. I needed my temperature taken first thing every morning to track ovulation and it took 3 weeks for it to be passed on to the relevant staff.
NA
NA
NA
Have more homework for focus better.
Nothing
May be the courses longer
NA
NA
NA

Not much, you were very good indeed.
No
Have short chat with patients more time ie I know that a lot of time is spent computer and order to full in..
More activities/diverse daily plan structure to relieve boredom.
NA
NA
Nothing as everything was great.
Nothing
More beds so people like me didn't need to be sent to a private hospital xxx knows how far away.
Get some morals.

Research Portfolio

Trixie Mottershead

5. Executive Summary

Word Count: 906 words

Executive Summary

The Service Evaluation aims to inform policy makers, service providers and members of staff who are looking to improve the quality and understanding of the service they provide within mental healthcare, from the patient perspective. The importance of patient feedback to guide practice is becoming increasingly important due to reductions in government funding, thereby encouraging healthcare providers to demonstrate the quality, efficiency and financial viability of the services they provide. Patient involvement and satisfaction of healthcare services has become central to government policy in health service provision. Patient feedback encompasses various aspects of the patient's views and opinions towards the care they receive. The literature upon patient feedback is limited due its specificity that the data is collected by the service provider directly, to inform service improvement; lacking a systematic and critical evaluation of patient feedback within mental healthcare services, which represent the multiple perspectives of the patient.

The Service Evaluation aims to extend and refine the limited previous literature in examining patient feedback within forensic and non-forensic mental healthcare services within Nottinghamshire Healthcare NHS Foundation Trust. The examination of the patient perspective within mental healthcare services encourages recommendations to mental healthcare practice and employment of patient feedback surveying. The following hypothesis will be explored:

H1: Service users in non-forensic services will rate the care they have received more positively than those in forensic services.

H2: Service users within lower levels of secure care will engage more frequently in giving feedback of the service they have received than those in higher levels of security.

H3: Service users within lower levels of secure care will rate the service they have received more positively than those within higher levels of security.

H4: Coded comments that demonstrate 'institutional practice' will reflect negative comments and 'interpersonal relationships' will reflect positive comments.

The data was collected by Nottinghamshire Healthcare NHS Foundation Trust volunteers on a 6-monthly basis within the secure forensic settings. The patients are made aware of the feedback process by members of the staff team and were encouraged to engage with the volunteers on a voluntary basis. Within the community forensics directorate and the non-forensic setting, the feedback was collected regularly by staff who were encouraged to distribute the survey when possible. All patients involved with the feedback were receiving care for a mental health problem, male/female over the age of 18. The feedback form consisted of both Likert-scale questions and free-text comment boxes. The form was developed locally by the Trust however some of the questions have been implemented on a national scale. The data was examined using a statistical software package (SPSS); Chi-square tests were performed on the data. Additionally, patient free-text comments were explored using conventional content analysis. The triangulation of quantitative and qualitative analysis aims to support the attainment of the

'full-picture' regarding the patient perspective within mental healthcare services.

From the analysis of service user feedback, forensic patients were more likely to give negative feedback of the mental healthcare service than non-forensic patients. A significant difference was found between patient involvement (as indexed by the response rate) and the level of security: high secure services had a higher overall response rate than lower secure services (community, low secure and medium secure). Further analysis into forensic patient feedback revealed no significant differences in feedback across the level of security (low secure and community forensics, medium secure and high secure).

Investigation into patient comments gave further insight into the differences between forensic and non-forensic patients regarding their service experience. For example, both forensic and non-forensic patients commented upon the interpersonal relationships with staff which reflected positive feedback. However, forensic patients were more likely to be dissatisfied with the staffing quality and power differential between patients and professionals. Additionally, the institutional practice of the service determined more negative comments within the forensic population, such as organisational demands and quality of life.

The findings of the Service Evaluation contribute to knowledge within mental healthcare. Specifically, in an examination of the findings, reference is made to the characteristics of the patient population, forensic patient environment and staff burnout as reflective of the differences between the

forensic and non-forensic patient findings. Recommendations to mental healthcare practice has been outlined in the following section.

The findings illuminate that what is important to patients within these services may vary. Forensic patients require important considerations about the way in which patient feedback is collected within the forensic environment such as staff surveillance and volunteer involvement.

> 'Staff should be trained to reduce the consequence of practical issues such as surveillance. For example, prior to volunteer's attendance on the wards the patients should be informed that their involvement and the information they give, will be confidential.'

> 'it is important that volunteers do not ask leading questions when prompting free-text comments so that the patient response is influenced as little as possible by the presence of the volunteer.'

Inconsistencies within the literature such as varying methods of implementation and differing application within healthcare services leads to difficulty in interpreting and comparing findings.

> 'Future research should focus upon exploring appropriate data collection methods and survey tools that have been validated within the literature and facilitated within different settings and NHS Trusts. This may encourage more of a national patient feedback examination of consistent methodology.'

> 'The development of a universal feedback survey, unique to forensic services within the NHS, would allow for the transferability and

generalisability of findings to promote knowledge sharing and service improvement nationally.’

Research Portfolio

Trixie Mottershead

6. PowerPoint Presentation Slides

Power Point Presentation Slides

A Mixed Methods Examination of Patient Feedback within Secure and Non-Secure Psychiatric Services- A Service Evaluation of Nottinghamshire Healthcare NHS Foundation Trust

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Aims of Research and Rationale

- Government policy in the UK has emphasised the importance of patient feedback within the National Health Service (NHS).
- The literature surrounding Patient feedback is limited, particularly when considering forensic patient feedback within mental healthcare services.
- This service evaluation aims to extend and refine the limited previous literature on patient feedback within forensic and non-forensic mental healthcare services; examining the role of the service security and patient involvement.
- Additionally, exploration of patient free-text comments aims to contribute to the 'full-picture' of patient feedback within mental healthcare services.

Method

- A mixed quantitative and qualitative approach was adopted to explore the patient feedback data.
- Chi-square tests were performed using the statistical software IBM SPSS to analyse the patient response to the Likert-scale items.
- Patient free-text comments were explored using conventional content analysis. These comments were made in response to the questions 'What did we do well?' and 'What can we do better?'
- The triangulation of quantitative and qualitative analysis aims to support the attainment of the 'full-picture' regarding the patient perspective within mental healthcare services.

Findings

- From the analysis of service user feedback, forensic patients were more likely to give negative feedback of the mental healthcare service than non-forensic patients.
- A significant difference was found between patient involvement (as indexed by the response rate) and the level of security: high secure services had a higher overall response rate than lower secure services (community, low and medium).
- No significant difference was found between security (low and community, medium and high) and patient feedback.
- Both forensic and non-forensic patients commented upon the interpersonal relationships with staff which reflected positive feedback. However, forensic patients were more likely to be dissatisfied with the staffing quality and power differential between patients and professionals. Additionally, the institutional practice of the service determined more negative comments within the forensic population, such as organisational demands and quality of life.

Implications and Recommendations

- The findings illuminate that what is important to patients within the secure and non-secure service varies. Practice issues within the forensic environment may impact involvement such as staff surveillance and volunteer involvement.
  - 'Staff should be trained to reduce the consequence of these issues'
  - 'It is important that volunteers are trained to avoid leading questions'
- The inconsistency of methods and results between studies within the literature makes it difficult to interpret and compare findings (Evans, Edwards, Evans, Elwyn & Elwyn, 2007).
  - Future research should focus upon exploring appropriate data collection methods and survey tools validated within the literature and facilitated within different settings and NHS Trusts.
  - The development of a universal feedback survey, specific to a particular service within the NHS, would allow for the transferability and generalisability of findings to promote knowledge sharing and service improvement nationally.

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Research Portfolio

Trixie Mottershead

7. Reflective Report

Word Count: 1973 words

Reflective Report

Conceptualisation

In September, I began volunteering within Nottinghamshire Healthcare NHS Foundation Trust collecting patient feedback within mental healthcare across a range of secure hospitals (Low, Medium and High). I was motivated to work with patients to improve mental healthcare services and support their recovery process. I wanted to focus my research upon this area to both prioritise my time; focusing my volunteering and research upon the same area whilst exploring an area of psychology that I am interested in. This decision certainly aided my time management between volunteer engagement and research exploration.

I approached the forensic lead within Nottingham Healthcare NHS Trust via email following my initial interview/meeting. Within this email (see appendix 1), I discussed that I would like to conduct a piece of research within the Trust alongside my volunteering. This was supported and an initial meeting with the Involvement Lead and Forensic Lead encouraged me to begin conceptualising what it is I wanted to explore. I learned from this meeting that my research would be of benefit to the Trust, specifically to explore service effectiveness whilst increasing recognition of the use of patient feedback within forensic services. My meetings with the Trust members highlighted that effective communication certainly promotes active engagement from all parties, a strength that should be maintained throughout the entirety of the research process. I discussed that I was thinking about conducting a service evaluation of the Experience, Involvement and Volunteering Team within Nottinghamshire Healthcare NHS Trust with my supervisor and my project proposal was granted.

29/09/2017- Initial meeting with supervisor to discuss ideas

05/10/2017- submit project outline

06/10/2017- First meeting with Nigel Groves and Paul Sanguinazzi to discuss research idea.

13/10/2017- Supervisors allocated

13/10/2017- Completed online course 'Informed Consent with Adults Lacking Capacity' and 'Introduction to Good Clinical Practice' as part of the National Institute for Health Research (see appendix 2 and 3).

Design

I initially had considered conducting focus group interviews with patients within secure services whilst using the Trust's data on patient feedback that had been collected and made available online. However, it was considered that patient interviewing would be too time-consuming due to ethical approval, emphasis was therefore placed upon the Trust's collected data. Initially I felt a little disappointed that I would not be able to interview patients to collect rich data. However, I explored the data available online and began considering how the secure and non-secure environment may have some influence upon patient feedback.

I began working upon the Proposal and Ethics Application to the university. I met with Nottinghamshire Healthcare Ethics committee representative to acquire Trust approval for the Service Evaluation prior to submitting to the university. However, this was a challenging process as the

Trust ethics committee would not grant approval until the university ethics had and vice versa. To overcome this, I spoke to the university ethics directly. It was agreed that the university would give ethical approval under the circumstance of NHS ethical approval. Through this process I was able to achieve ethical approval from both organisations. During this time, I read around the literature and developed my hypothesis.

Alongside developing my design, I volunteered within the service collecting feedback within the secure hospitals. This gave me a great insight into how the data was collected and aided analysis of how the process may influence the feedback that is given as well as patient involvement. I noticed that some of the volunteers were asking leading questions which may have influenced the authentic voice of the patient. Additionally, the timings of collection significantly influenced involvement, for example, patients often sleep in on a Friday morning which significantly reduces the amount of feedback collected at that time. I took notes following my volunteering observations so that I could feed my experience into how I develop and explore the data and analysis. In reflection I would have liked to incorporate interviews with the volunteers themselves about collecting feedback, their experience and knowledge surrounding the volunteer's role in the data collection process. This would have given me the opportunity to examine how the volunteer group may have some influence upon the reliability and validity of the data collection process.

16/10/2017- Meeting with Nigel Groves, Paul Sanguinazzi and Christopher Beeley regarding data available and Ethics Application.

20/10/2017- Meeting with Birgit Vollm and Najat Khalifa.

03/11/2017- Volunteers meeting, presented research plan to other volunteers.

04/11/2017- SUCE Form collection at Arnold Lodge.

14/11/2017- Meeting with Kayley Whyatt (Nottinghamshire Healthcare Ethics Committee representative) to discuss research and application process.

20/11/2017- AM- Meeting with Birgit Vollm and Najat Khalifa to discuss Proposal and Ethics Application.

20/11/2017- PM- Meeting with Paul and Chris to discuss Proposal and Ethics Application, to make sure everyone was happy with my proposal to move forward to submit.

24/11/2017- Passed Research Integrity and Ethics Test.

24/11/2017- Submitted draft of Projects Proposal and Ethics Application.

25/01/2018- Meeting with Birgit and Najat to sign ethics application and submit final Ethics Application and Project Proposal.

Data Collection

The data obtained from the Trust website was not clearly presented, the rows and columns were not labelled with explanatory information. I met with the Trust's Senior Data Analyst as he played a role in inputting the data from the feedback form onto the excel spreadsheet. We went through the data and I made notes of the column representations. I faced some challenges with the data such as the incorrect recording of child feedback within an all adult sample. I began to go through the data myself labelling the columns appropriately and getting rid of information that was not relevant to my study. Additionally, I added sections to the data; determining positive/ negative and neutral feedback

and the security level of the forensic data alongside patient involvement. Upon occasion the data was recorded incorrectly by the Trust (as discussed earlier), I notified the Senior Data Analyst within the Trust so that he could rectify the issue with the recorded information he held. This process was quite time consuming and on occasion became frustrating that the data had not been recorded consistently.

I would have liked to be involved with the process from start to finish; collecting the data with volunteers, inputting the data into excel before analysing it myself. However, this was not possible. From the point of collection, the data is fed into action plans within the trust; it takes some time for the data to be transferred onto an excel format and displayed online. Additionally, part of the process does require recording patient information that has been deemed confidential and is therefore not displayed online; working with this data would require more stringent Ethical Approval processes. However, the 'cleaning' and labelling of the data allowed for me to get to know the data very well which adds strength to my decisions regarding analysis. Additionally, my attendance at the patient meetings to review the feedback form collection and action plans enabled me to grasp an idea of the 'bigger picture'.

29/01/2018- Meeting with the Senior Data Analyst to discuss patient data (decoding the columns, highlighted issues with data recording (adult/child) and disjointed rows). Discussed potential to have information regarding age and gender but these details were not passed forward due to issues regarding confidentiality of the patient.

12/02/2018- Patient meeting in high secure learning disability and mental health wards, reviewing SUCE collection on the ground.

Data Analysis

During my meeting with my supervisors I discussed my proposed data analysis. It was agreed that the Chi-Square test should be conducted as the dependent variable was a dichotomised categorical variable: 'positive' and 'negative/neutral'. I was able to access reading for the process of the Chi Square and interpretation of the output. I enjoyed conducting this test and exploring further the significance of each of the survey questions which gave a meaningful insight into my hypothesis. I presented my findings to my supervisors who were happy with how my table looked, additionally it was useful to receive advise about condensing my results write-up. For the second part of the quantitative analysis I had conducted a Binary Logistic regression test on the dichotomised dependent variable (patient feedback). However due to a violation of assumptions I was not able to explore this test further and apply it to my data. However, I enjoyed reading about the test as it was not one I was familiar with. For part of this process I lacked confidence, feeling that I was conducting the tests incorrectly, however I utilised my supervisor feedback and discussed my outputs within our meetings.

For my analysis of patient comments, content analysis was recommended- I explored this further and decided to conduct conventional content analysis due to the lack of theory and research within patient feedback at this time. I coded the data and often corrected my coding upon reflection if I found a term that I felt would be more appropriate for all codes within that group. This process happened consistently throughout the analysis. Additionally, when my themes were formed I made comparisons between forensic and non-

forensic as well as positive and negative comments. Some of my coding encompassed the same concept but were coded differently. I amended these terms so that they were consistent throughout the data. I enjoyed this process and found the patient comments intriguing in giving an explanation to my previous quantitative findings. However, I was aware that I must remain reflexive and not let my previous findings bias my judgement of the coding scheme.

15/02/2018- Meeting with my supervisors to discuss quantitative data analysis due to the independent variable being a categorical variable- approaches to analysis were discussed.

10/03/2018- Beginning of Quant analysis (Chi Square).

19/02/2018- Patient feedback collection at high secure women's service within Rampton.

22/03/2018- Supervisor meeting- presented findings from quantitative analysis, happy with results that a significant difference was found.

24/04/2018- Supervisor meeting to discuss section two of quantitative analysis (further investigation into the forensic feedback). Binary Logistic Regression was discussed.

20/05/2018- Binary Logistic Regression was conducted on both Security and Patient Involvement. Due to the inappropriateness of the test to fit the data, a simple Chi-Square was conducted to interpret the findings.

11/06/2018- Beginning of Content analysis.

Write Up

I enjoyed writing up the findings of my data analysis and reflection upon previous literature. I have found that my research adds important comparisons to the literature upon patient feedback that have not been explored before. The write-up of my literature review began slowly from the conceptualisation of my project idea. I began drawing together research that looked at patient feedback and satisfaction. Initially these two concepts were merged together; I separated research by methodology such as quantitative and qualitative. However, guided by feedback from my supervisor, I learnt that these concepts must be separated due to the nature of the research. Previous literature encompassed studies that were guided by an independent researcher (satisfaction studies) vs service provider-led feedback collection. The differences between the two became very apparent throughout the write-up process.

I found that some of my challenge during the write up was my explanation of why I found particular research or concepts relevant to my explicit study. On occasion I have been so interested in the previous literature that I have included sections of work that are not entirely relevant. To overcome this challenge, I have been re-reading my work and asking myself the question 'how does this give insight or explanation to my study and findings?'. This has helped me to be critical about the research I explore within my paper.

20/05/2018- Submitted draft Literature Review.

22/05/2018- Received Draft Literature Review with comments.

24/05/2018- Supervisor meeting to discuss Literature Review.

19/06/2018- Bringing together the sections into one piece and finishing off all areas.

26/06/2018- Submitted Draft Research Paper.

10/07/2018- Final supervisor meeting to discuss draft feedback.

11/07/2018- Work begun on final adjustments.

02/08/2018- Portfolio completed in full and submitted.

Appendices

Appendix 1: Correspondence with External Organisation: Nigel Groves- Forensic Lead (Nottinghamshire Healthcare NHS Involvement and Experience Team).

Groves Nigel - Involvement & Experience Lead Forensic

Thu 28/09/2017, 19:21

Hello Trixie

This is indeed good news and the fact your supervisor works at Rampton is very helpful. I will be able to open doors relating to this work and I will be updating the Associate Director of Nursing (for all the Forensic Division) Dave Mason on our plans going Forward. Dave is a keen champion for involvement and to this end I have regular meetings with him. I will also seek some support from the General Manager of the Mental Health Directorate and National Learning Disability Directorate for support (Adele Bryan)

I will confirm the 6 th with Paul. If we could meet in the involvement Centre around 1.45pm, I can then take us down to Paul office

BW

Nigel Groves
Involvement & Experience Lead, Forensic Services
0115 969 1300 ex 14242
Mob: 07917232929
0800 052 1415 (Involvement, Experience & Volunteering Team)

From: Trixie Mottershead
Sent: Thursday, 28 September 2017 18:15
To: Groves Nigel - Involvement & Experience Lead Forensic
Subject: Re: Research in Involvement / involvement / Forensics

Good evening Nigel,

It is great to hear from you and I am so pleased that Paul Sanguinazzi is like you, very supportive about this proposal. it is great news and I am excited to hear his thoughts too!

The 6th of October works perfectly for me and the sooner we can have a chat about our ideas is better!

I am having a meeting with a potential supervisor tomorrow morning so that I can put my proposal to her about the potential of this research- she is a Forensic Psychiatrist currently working in Rampton. For me to be able to conduct the research I have to have the support from one of my supervisors and she has expressed interest in her research papers about patient involvement within Forensic settings. Following this chat I have to submit my

proposal by the 5th for the deadline, however I will get a pretty good idea from her tomorrow whether the University will back me with this research so it is all moving forward very well!

Thanks again for being so supportive and I look forward to meeting with yourself and Paul Sanguinazzi on the 6th to discuss this further!

Kind Regards,
Trixie Mottershead

Thu 28/09/2017, 12:31
You;
Sanguinazzi Paul (Paul.Sanguinazzi@nottshc.nhs.uk)

Dear Trixie,

I have met with Paul Sanguinazzi today (Head of Involvement)

As suspected Paul was very supportive and interested in the Research topic. To this end could we meet up with Paul please to see how this could develop. This might be the work around evaluating Involvement in Forensics but also could be something wider. Paul has some ideas about this.

Looking at free dates and times.

6th October 2pm. At the Nottingham Centre

Or,

13trh October between 9.30 and 11.30 or 2pm (the morning slot would be the best time and date for me) At the Nottingham Centre

Or 3rd November 11.30 at the Rosewood Involvement Centre

BW

Nigel Groves
Involvement and Experience Lead, Forensic Services

Nottinghamshire NHS Foundation Trust
0115 969 1300 ex 14242
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Changing Lives, Changing Services, Changing Culture
If you want to leave your feedback or share your story go to:
http://feedback.nottinghamshirehealthcare.nhs.uk/leave-feedback

https://twitter.com/InvolveT1

Involvement Blog:
https://involvementvolunteeringexperience.wordpress.com/about/

From: Trixie Mottershead [mailto:Trixie.Mottershead@outlook.com]
Sent: 25 September 2017 19:43
To: Groves Nigel - Involvement & Experience Lead Forensic
Subject: Re: New Volunteer (Trixie M)

Hello Nigel,

Thank you for getting back to me so promptly!

I could not have wished for a better reply that is great news! All of those suggestions sound great and topics I would love to get involved with by supporting with research!

I will be awaiting eagerly to hear back following a discussion with Paul Sanguinazzi- is there anything that you would like me to do to support this?

Kind Regards,

Trixie Mottershead

From: Groves Nigel - Involvement & Experience Lead Forensic <Nigel.Groves@nottshc.nhs.uk>
Sent: 25 September 2017 19:37:16
To: Trixie Mottershead
Subject: Re: New Volunteer (Trixie M)

Hi Trixie,

It is good to hear from you.

I will have a chat with the Head of Involvement and see if there is anything he would be interested in you doing relating to research. This might be around feedback and how Involvement can help bring about change. Also the value of involvement to the Trust and also personally for volunteers many of who are still service users.

How does that sound? Of course it will have to be decided by Paul Sanguinazzi (Head of Involvement) but it is possible I think for us to do some research into Involvement in the Forensic Division.

BW

Nigel Groves
Involvement & Experience Lead, Forensic Services
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0800 052 1415 (Involvement, Experience & Volunteering Team)

From: Trixie Mottershead
Sent: Monday, 25 September 2017 19:18
To: Groves Nigel - Involvement & Experience Lead Forensic
Subject: Re: New Volunteer (Trixie M)

Hello Nigel,

I hope you are well!

I have only just accessed your email as it disappeared into my junk folder. I will have chance on Wednesday to discuss with my tutors the availability of me beginning my safe guarding training next week.

In the mean time I was hoping to discuss with you the opportunity for potential research. As part of my Msc programme it is required that I conduct research in an area that I am passionate about. I was wondering whether there is anything within your project that you would like me to conduct research in or surrounding? This is really flexible at the minute and so I thought it would be great to potentially research something that may contribute to a difference in practice, specifically supporting your work.

This research will not be conducted until next year however the university is wanting project ideas to be submitted next week so that the students are beginning to think about ideas.

If you feel that there is not anything that you can particularly think about within your area that would be appropriate to conduct research this is absolutely fine and I will be thinking about other areas alongside this. I just felt that I could ask as it would be great to be able to tie in my work with you to my academic study. But if not directly through research that is absolutely fine as I will be picking up invaluable experience working alongside yourself.

I look forward to hearing from you.

Kind Regards,

Trixie Mottershead

From: Groves Nigel - Involvement & Experience Lead Forensic <Nigel.Groves@nottshc.nhs.uk>
Sent: 20 September 2017 13:49:38
To: Pope Sally - Volunteering Support Officer; 'Trixie Mottershead'
Cc: ZOMMERS Teresa - Volunteering & Befriending Services Administrator
Subject: RE: New Volunteer (Trixie M)

Dear Sally

I have just met with Trixie.

I have explained the process around the Forensic Side of things and the Forensic Group I run at both centres.

Trixie cannot make the Forensic meeting next Thursday at DMH but hopes to join us at Rosewood on the 26th October 1pm /3pm (meeting starts at 1.30 that day)

I am sure we can place Trixie in the Forensic Division and at Key meetings ect to help her with her university work and get some experience volunteering with us.

I will endeavour to make opportunities available like we do with the other volunteers and to this end an opportunity to showdown me/ Involvement.

This might be at Wells road once that is up and running, Rampton, Arnold Lodge, possible offender Health and community forensics.

I have explained about expenses and asked her to talk with you about that side of things. She will be working with us in Forensics with Patients so will need the DBS sorting which Trixie tells me you have the information needed for this.

I am sure as we move forward Trixie will become a great member of the Volunteer Involvement Team.

Once we get the DBS back I can get the ball rolling. So if you let me know please

BW

Nigel Groves

Involvement and Experience Lead, Forensic Services

Nottinghamshire NHS Foundation Trust

0115 969 1300 ex 14242

Mob: 07917232929

0800 052 1415 (Involvement, Experience & Voluteering Team)

Appendix 2: Certificate- Introduction to Good Clinical Practice eLearning (Primary Care)

NHS
National Institute for Health Research

CERTIFICATE of ACHIEVEMENT

This is to certify that

Trixie Mottershead

has completed the course

Introduction to Good Clinical Practice eLearning (Primary Care)

October 13, 2017

A practical guide to ethical and scientific quality standards in clinical research

Including EU Directives, Medicines for Human Use (Clinical Trials) Regulations & the Department of Health Research Governance Framework for Health & Social Care, as applied to the conduct of Clinical Trials & other studies conducted in the NHS

Modules completed:

Introduction to Research and the GCP standards
Preparing to deliver your study
Identifying and recruiting participants: eligibility and informed consent
Ongoing study delivery and data collection
Safety Reporting
Study closure

This course is worth 4 CPD credits

CPD

Delivering research to make patients, and the NHS, better

Appendix 3: Certificate- Informed Consent with Adults Lacking Capacity

NHS
National Institute for Health Research

CERTIFICATE of ACHIEVEMENT

This is to certify that

Trixie Mottershead

has completed the course

Informed Consent with Adults Lacking Capacity

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