

Perspectives on co-production in developing the Patient Safety Climate Tool

Scottish Patient Safety Programme for Mental Health (SPSP-MH)

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This project was undertaken as part of the Scottish Graduate School of Social Sciences internship programme in partnership with Healthcare Improvement Scotland.

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Summary

Background

The Patient Safety Climate Tool (PSCT) is a facilitated self-reported measure which assesses perceptions of environmental, relational, medical and personal safety. It provides a snapshot of what goes on in a specific ward at a specific time.

The original aim of this project was to understand the co-production process that took place during the development of the PSCT. However, while interviewing it became clear that they were also discussing the co-production process that took place during the delivery of the PSCT (for example, the piloting and the ongoing use). Therefore, the aim of the project was extended to include the delivery of the PSCT.

Key findings

All thirteen respondents had a very good understanding of the context and environment in which the development and delivery of the PSCT took place. There was also evidence to suggest that the correct conditions for co-production to work had been created, and that parity and genuine collaboration had been achieved. However, there was some evidence that more could be done to achieve co-production.

Recommendations

Building on the key findings of this report, the following recommendations have been developed to support co-production of future projects within mental health care.

- There was no conscious decision to use a co-production approach. However, there is evidence that co-production took place, to a degree, throughout the development and delivery of the PSCT and appears to have been integral in the success of the PSCT. Therefore, it would be recommended that a formalised co-production approach is used in future to build awareness of the benefits of co-production.
- The support of the Third Sector and Independent Sector Engagement Lead should be sought should any issues arise in future co-production projects. This will help to ensure that wider co-production capacity, confidence and capability is built into improvement approaches and programme planning.
- Decisions about what needs to be developed should be formally shared with service users.
- It is recommended that a mental health co-production framework, such as the National Survivor User Network's *4PI National Involvement Standards*¹⁴, is used in the development and delivery of any future co-production projects.

- It is important to obtain the views of those who have experience of being a service user. It is, therefore, recommended that a wider range of individuals are consulted in the development of any future versions of the PSCT.
- Given the success of the PSCT, it is recommended that other versions are considered and developed for carers, older people, people with learning disabilities and the Child and Adolescent and Mental Health Service.
- To ensure equality, each NHS board needs to have a formal process to ensure all service users who complete the PSCT receive feedback. The delivery of such feedback could be done in an informal manner.

Conclusions

Despite the development of the PSCT not incorporating a formalised co-production approach, it is evident that many of the key features of co-production were present during the development and delivery process. This is encouraging for both service users and professionals.

1. Introduction

This report presents the key findings from a series of interviews with Healthcare Improvement Scotland and third sector professionals involved in the design, development and delivery of the Scottish Patient Safety Programme's Mental Health Patient Safety Climate Tool (PSCT). The aim of these interviews was to assess the co-production process that took place in the development and delivery of the PSCT.

The purpose of this report is to share learning from a co-production process taking place in a mental health context by reporting on the experiences of those who were at the centre of the PSCT development. The report was completed by a PhD student who was undertaking a three-month internship at Healthcare Improvement Scotland, funded by the Scottish Graduate School of Social Science.

2. Background

The Patient Safety Climate Tool

The Scottish Patient Safety Programme (SPSP) is an internationally recognised patient safety initiative. It is embedded within Healthcare Improvement Scotland's Improvement Hub which supports health and social care services in providing effective care. The mental health strand of the SPSP (referred to as the SPSP-MH) is based upon a harm reduction approach. Its ethos is to ensure that staff and service users not only are safe but *feel* safe when receiving care. Since the SPSP-MH was launched in 2012, reductions in patient self-harm, physical violence and restraint have been documented in many of the inpatient mental health wards involved in the programme¹.

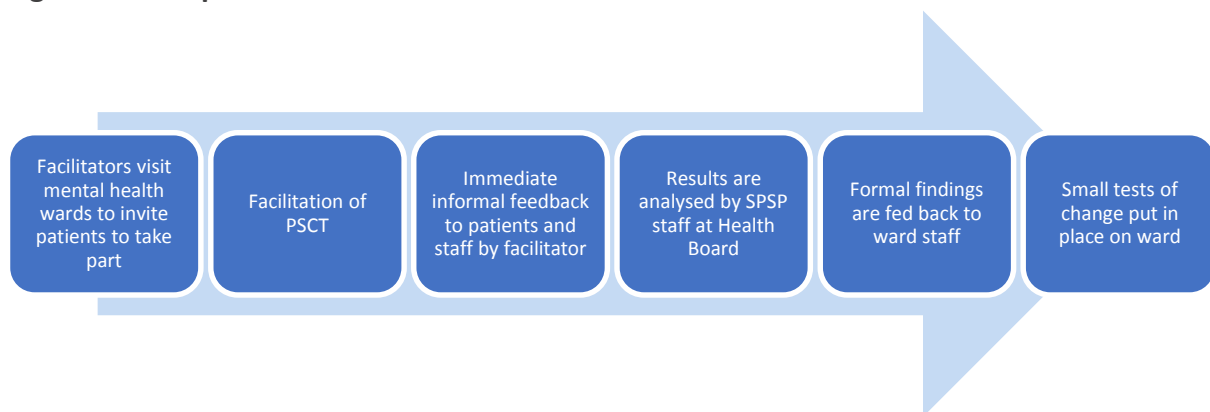
To achieve an increase in patient safety, the SPSP-MH team supports frontline staff to test and gather real-time data and reliably implement interventions. Such work is predominantly supported using the PSCT. The PSCT (Appendix A) is a self-reported measure (although participants are usually supported by a facilitator to complete it), which assesses perceptions of environmental, relational, medical and personal safety. It provides a snapshot of what goes on in a specific ward at a specific time. Therefore, it can be influenced by multiple factors such as time of day, weather and whether an incident has recently taken place.

The PSCT is considered integral to the improvements that have been demonstrated in mental health patient safety¹. The PSCT was also endorsed by the Mental Welfare Commission for Scotland who highlighted safety concerns in wards at night and how these can be addressed, in part, by the ongoing use of the PSCT².

Figure 1 demonstrates the different stages of the PSCT process. The first stage involves facilitators, who are typically staff from mental health organisations and sometimes clinical

governance staff from the NHS board (but are always individuals who are independent from the ward staff) visiting the inpatient ward at a pre-arranged time. All service users who are on the ward that day are invited to take part. Service users who wish to take part would visit a quiet room with the facilitator who guides them through answering the PSCT questions (Appendix A) in a conversational way. A scribe is also in the room to record what the service user says. The facilitator then provides informal feedback to the service users such as what will happen to the information they have provided and what it is hoped it will achieve. If necessary, the facilitator will inform staff of any urgent changes that need to take place immediately to ensure patient safety. The data from all the interviews are then collated by the SPSP staff within the NHS board and fed back to the ward in the form of a report. The findings are then discussed by staff and small tests of change are put in place using the Plan, Do, Study, Act ethos of the model for improvement³.

Figure 1: PSCT process



Ten NHS boards began to use the PSCT when it was launched in 2013 and seven currently use the PSCT on their inpatient mental health wards as shown in Table 1 on the next page.

Table 1: NHS boards' use of the PSCT

NHS board	Used PSCT at launch (2013)	Currently using the PSCT (2017 evaluation)
NHS Ayrshire & Arran	Yes	No
NHS Borders	Yes	Yes
NHS Dumfries & Galloway	Yes (Pilot site)	No
NHS Fife	Yes	Yes
NHS Forth Valley	Yes	Yes
NHS Grampian	Yes	Yes
NHS Greater Glasgow and Clyde	Yes (Pilot site)	Yes
NHS Highland	Adapted version	
NHS Lanarkshire	Yes	Yes
NHS Lothian	Yes	No
NHS Orkney	No (no inpatient wards)	
NHS Shetland	No (no inpatient wards)	
NHS Tayside	Yes	Yes
NHS Western Isles	Adapted version	
The State Hospital	Adapted version	
Total	10 NHS boards	7 NHS boards

Over 700 PSCTs have been completed nationally. There is also a high level of international interest, with various countries, including Denmark and New Zealand, expressing an interest to adapt the PSCT and develop their own versions.

There are differing reasons why some of the NHS boards do not use the PSCT. NHS Highland developed its own version as the PSCT was not deemed appropriate for their mental health patient population. The State Hospital also uses an adapted version to meet the needs of the high security population they serve, whilst NHS Western Isles uses its own localised version. NHS Orkney and NHS Shetland have no inpatient wards, so the PSCT is simply not relevant for them to use.

Presently, the tool is being revised in terms of format and content. It is also being adapted so that it can be used in a variety of clinical settings, including learning disabilities and for service users with cognitive impairments.

The development of the PSCT

There were four distinct sets of individuals who worked in partnership and contributed towards the development and delivery of the PSCT:

- Healthcare Improvement Scotland – SPSP-MH team and Patient Partnership Involvement (PPI) staff members

- members of third sector organisations, including Mental Health Network Greater Glasgow, Voices of Experience (VoX), and Users and Carers Involvement Dumfries
- service users supported by the third sector organisations mentioned above, and
- staff members from two NHS boards involved in piloting the PSCT – NHS Dumfries & Galloway and NHS Greater Glasgow and Clyde.

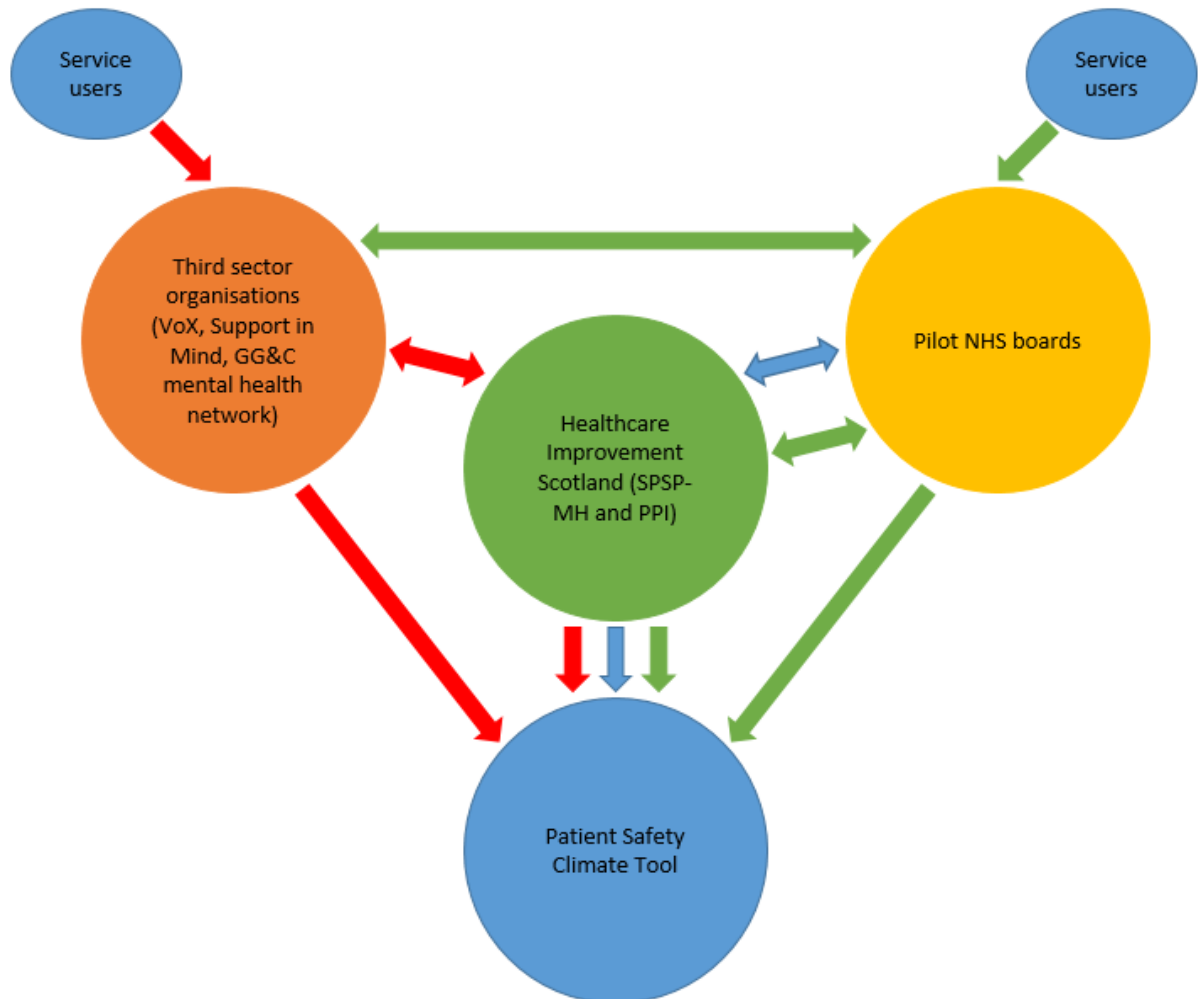
Healthcare Improvement Scotland staff played a multi-faceted role in that they supported the design of the PSCT with the authors group which managed the content of the PSCT. The delivery group was responsible for how the tool was tested and/or used. The action group led on the operational elements, such as the look, feel, format and development of the guidance.

The third sector organisation staff were involved in designing the questionnaire, being part of the authors group and supporting the action group by facilitating use of the questionnaire in the pilot NHS board sites. Service users or members of third sector organisations were recruited (by the third sector organisations) to take part in local events in which they fed back their thoughts on the suitability of the PSCT.

The staff from the two pilot NHS boards (NHS Dumfries & Galloway and NHS Greater Glasgow and Clyde) contributed to the action group through testing the PSCT with service users in inpatient mental health wards. The relationships between these four sets of individuals are displayed in Figure 2 on the next page.

Figure 2: The relationships between those involved in the development and delivery of the PSCT

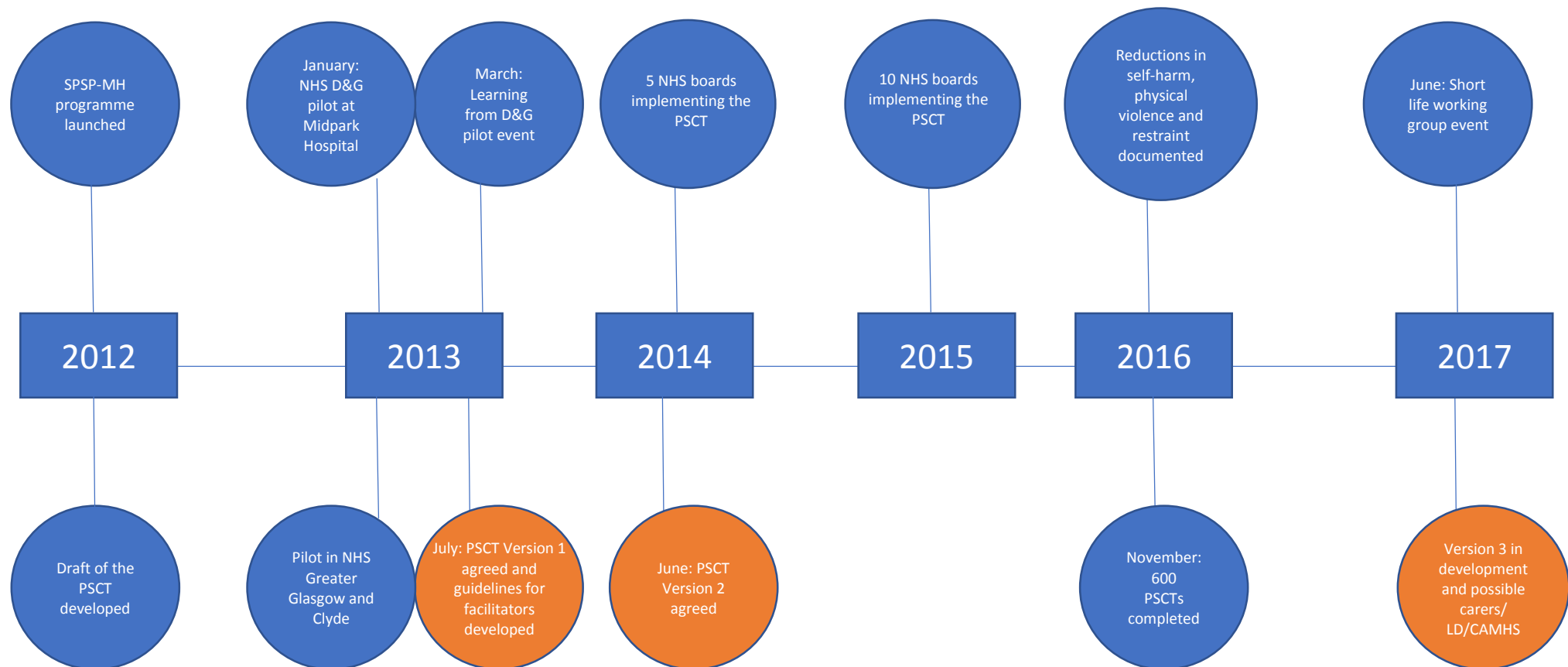
Key to arrows: red = author group, blue = delivery group, green = action group



To give an overview of the development of the PSCT, a timeline of the key events that took place from its inception in 2012 until the present time (2017) is provided in Figure 3. Shortly after the launch of the SPSP-MH programme in 2012, a draft of the PSCT was developed by the authors group. NHS Dumfries & Galloway undertook the first pilot in 2013, followed by NHS Greater Glasgow and Clyde. The first version of the PSCT was launched in 2013 along with guidance for the facilitators. In 2014, following feedback from the pilot NHS boards, version 2 was developed and five NHS boards were implementing the PSCT. By 2015, 10 NHS boards had begun using the tool and by 2016, over 600 PSCTs had been completed and reductions in self-harm, physical violence and restraint were reported¹.

Version 3 is currently in development and discussions are taking place about the possibility of a carers, older people, people with learning disabilities and the Child and Adolescent and Mental Health Service versions.

Figure 3: 2012-2017 timeline of the development of the PSCT



Co-production

It was evident that a wide range of individuals contributed to the development of the PSCT. There was no conscious use of a co-production approach. However, it appears that there was the potential for co-production, or at the very least a level of co-production, to have occurred during the development of the PSCT. There are various definitions of co-production in health care, including six key principles that must occur within the development process for true co-production to take place⁴. These are:

- recognise people as assets (enabling service users and professionals to be viewed as equal partners)
- build on people's existing capabilities (recognising people's capabilities)
- mutuality and reciprocity (mutual responsibilities and expectations)
- engaging peer support networks (to transfer knowledge)
- break down barriers (between the traditional role of professional provider and patient recipient), and
- facilitating rather than delivering (the role of public services becoming facilitator of service opposed to deliverer of service).

It is inevitable that the degree to which these principles occurs varies depending on many different factors and the context. There is recognition of this as demonstrated by the basic, intermediate and transformational levels of co-production referred to in the literature⁵. For basic co-production to occur, individuals must participate in public services. Intermediate co-production acknowledges individuals' skills and supports their contributions but only with the delivery of the service. Transformational co-production occurs when the traditional power and control changes so that individuals using services participate in the design, commission and delivery of the service.

Co-production in a mental health setting

Analysis of the small body of existing evidence suggests that there are promising results to support the use of co-production in a mental health setting⁶. Studies demonstrated the impact of co-production in terms of: well-being related outcomes (for example, improved physical and mental health), enhancing social networks and inclusion, tackling stigma, improving skills and employability and the preventative aspect which relates to the provision of support. Despite the focus on enhancing well-being, few used a dedicated well-being framework in which to assess the potential impact of co-production on such outcomes. However, a clear theoretical link between well-being and co-production via self-determination theory (SDT)⁷ appears to exist.

Self-determination theory suggests that three components: competence, autonomy and relatedness are integral in influencing the degree to which an individual's behaviour is self-

motivated and self-determined (without the influence of external factors). It is suggested that the six key principles of co-production can be categorised in terms of these three components^{4, 6}:

- **competence** is based upon recognising people as assets and building on their capabilities
- **autonomy** is related to blurring distinctions between traditional roles and public services being facilitated, not delivered, and
- **relatedness** is explained as mutuality and reciprocity between professionals and service users and engaging peer support networks to exchange knowledge.

Several challenges of co-production in a mental health setting have been identified, including resistance to change, restrictive administrative procedure and professional practice, avoidance of challenge, confrontation and emotional expression, and the demand to conform to institutional rules, roles and cultural norms⁸. To help overcome these challenges, the National Development Team for Inclusion (NDTI) developed a guide that can be used when working on a co-productive project. The *Practical Guide: Progressing Transformative Co-production in Mental Health*⁹ encourages the consideration of three key steps in achieving transformative co-production in mental health. These are:

- Step 1 – Setting the scene: Understanding the context and the environment in which co-production is going to take place
- Step 2 – Coming together: Creating the right conditions for co-production to work
- Step 3 – Working together: Achieving parity and genuine collaboration

3. Methods

The original aim of this project was to understand the co-production process that took place during the development of the PSCT. However, while interviewing the professionals, it became clear that they were also discussing the co-production process that took place during the delivery of the PSCT (for example, the piloting and the ongoing use). Therefore, the aim of the project was extended to include the delivery of the PSCT.

Design

This was an assessment, using one-to-one, semi-structured interviews to investigate the two aims described above.

Respondents

Potential respondents were identified by the SPSP-MH team as being individuals who played a role in the original development of the PSCT. All except for one potential respondent agreed to take part when approached. Respondents came from three distinct groups of professionals, employed by the following organisations at the time the PSCT was developed:

- three were employees from third sector mental health organisations
- five were employees of Healthcare Improvement Scotland, and
- five were health professionals employed by the two NHS boards where the PSCT was piloted (NHS Dumfries & Galloway and NHS Greater Glasgow and Clyde).

Three respondents alluded to having lived mental health care experience as a mental health patient and/or service user. However, due to the time and access constraints of the researcher's internship, no respondents who were purely involved from a service user or patient perspective were interviewed. All respondents who took part gave written consent (Appendix B).

Materials

Interviews were audio recorded and the researcher based the questions on an interview schedule (Appendix C) informed by the NDTI's practical guide⁹. A list of the key principles that according to Nesta⁴ must occur for true co-production to take place were visible during the interview to ensure that respondents were reminded of the definition of co-production.

Interview and assessment procedure

Information about the study was provided verbally and in written format using the information and consent form (Appendix B). The interviews were undertaken by a PhD researcher from the University of Stirling over a four-week period (June-July 2017). Eleven interviews took place in person but, due to time constraints, two interviews were carried out by telephone. The researcher listened back to the audio recordings and made detailed notes and transcribed the data which was deemed relevant for the purposes of the assessment. The notes and transcribed data were then sent to the respondents for approval and changes were made if required. The researcher then used the notes and transcribed the data collected. This was used as evidence to assess the degree to which the practice lessons outlined in the NDTI's practical guide⁹ had taken place during the development and delivery of the PSCT.

Research governance

Following consultation with the research governance team, the project was deemed to be a service evaluation project and registered on the Healthcare Improvement Scotland research register. Research governance principles, such as ensuring the anonymity of those taking part and safe storage of the data collected, were considered by the researcher and adhered to throughout the project.

4. Key findings

4.1 Step 1 – Setting the scene: Understanding the context and environment in which the development and delivery of the PSCT took place

The NDTI's practical guide⁹ recommends that for co-production to occur it is necessary to understand the wider context of the mental health system, cultural forces and the broader environment. During the interviews, respondents discussed various aspects of the context and environment in which the development and delivery of the PSCT took place. The evidence is presented below under the following themes:

- power, hierarchy and authority
- institutional systems and resistance, and
- leadership commitment and senior support.

4.1.1 Power, hierarchy and authority

Respondents discussed the lack of power that exists for service users in a mental health care environment. There was a clear emphasis on how mental health care differs from the care of physical long-term conditions in that there is a legal requirement that individuals experiencing severe levels of poor mental health can be detained for treatment. The implications of how this is in total contrast to co-production were evident from interviewee statements such as the following:

'There are certain ways in which the culture is imposed and we take choices and control away from people: "You are taking the medication because the Dr said so".'

'Because we detain people, that's the extremes of not involving people in their care, you're taking away their decisions about everything, you cannot decide this, you will stay here, and you will take this medication.'

'Are you really talking about co-production with somebody who is so disturbed they are really quite psychotic and they end up in a different position with you because you're the person who is detaining them and you've taken away somebody's liberties so that is something you've done in a position of power and you've taken away their power and autonomy and that has implications however well you do that so co-production has a kinda funny sitting.'

'I think the end result has to be meaningful to everybody, not just the scientists... and it has to have some value. I suppose that's the reciprocity. The service users, the people that take part in actually filling it in and devising it have to get some benefit from it and that's always the problem with, I think, with reciprocity with a mental health population.'

There was also discussion of the power imbalance that exists between service-users and staff and the resulting authority that staff have:

'It's not one culture on a ward, it's two cultures interacting. It's the staff and it's the service users and it's the interaction of that. One culture has power, wears uniforms and has freedom and autonomy and is paid to be there, has society backing them up, and has professional registration the other one is not given credibility, it's a controlling environment.'

However, there were several statements made that suggested that the mental health environment in which the PSCT was developed and delivered was changing so that the ethos was more in keeping with a co-production approach:

'Initially we talked about safer restraint, then we talked about reducing restraint and now we're talking about using least restrictive practice so a lot of the culture has been about saying "we'd love it if there was no restraints ever" unfortunately as a very, very last resort it should be done but that's a last resort and a lot of that has been about culture so staff are going into an event and are thinking de-escalation rather than thinking "maybe we need to restrain".'

'It's just what we do, it was about patient involvement, it's part of our culture.'

4.1.2 Institutional systems and resistance

There was some discussion of the bureaucracy of the NHS and the potential resistance of staff in asking mental health service users for feedback on their care:

'I think people, even in mental health services, are still sceptical asking people with mental health problems for two reasons: 1) they are too unwell to be valid, they are invalid in the true sense of the word and 2) the only ones that are going to speak to you are the ones that have got an axe to grind... and they're not truly representative.'

However, the mental health organisations and NHS staff involved in the development and delivery of the PSCT were willing to go against the norms of mental health care⁸ by taking a novel approach which was not supported by scientific evidence. By doing so, they provided an opportunity in which to go against the norms of the NHS:

'The NHS is a very top-down, audit heavy culture and so to innovate and develop something you have to probably fight the prevailing culture and so the SPSP gave the staff permission to do that.'

4.1.3 Leadership commitment and senior support

For co-production to occur, leadership must embody personal and professional commitment. There was an appreciation of this as demonstrated by the following statement:

‘When you go into an acute setting there are higher rates of detention, more restrictions put on people, treatment orders. If the ethos is there, then the parity comes back quicker. If the ethos isn’t there, if it’s a control and command ethos then co-production goes out the window and it doesn’t take much to break that if the leadership isn’t there to support it.’

There appeared to be a great deal of support from senior clinicians (psychiatrists) as evidenced by the number who agreed to be interviewed for this report and spoke highly of the PSCT. Leadership support is also demonstrated by the fact that seven (of a possible 12) NHS boards use the PSCT.

4.2 Step 2 – Coming together: Creating the right conditions for co-production to work

The NDTI’s practical guide⁹ recommends that a “setting up” stage is required in which the practicalities of bringing different people together to work are considered in achieving equality and parity between all those involved. The ultimate purpose of this is to prevent those taking part conforming to institutional rules, roles and cultural norms⁹. During the interviews, the respondents discussed various aspects of the conditions that the development and delivery of the PSCT had taken place in. The evidence is presented below under the following themes:

- time preparation, planning and clarity of purpose
- common and shared values, aims and language
- ground rules for group working
- navigating roles and boundaries
- process and participation facilitation
- payment and welfare benefits, and
- sharing the defining and decision-making.

4.2.1 Time, preparation, planning and clarity of purpose

The NDTI’s practical guide⁹ suggests it is necessary to spend time planning what it is that needs co-produced and why to ensure that everyone involved has a clear understanding of what change is being attempted. Involving the people with the “*correct skills, experience, values and attitudes*” is considered an essential part of this process⁹. Figure 2 demonstrates the wide range of individuals who were involved from the third sector, the NHS and Healthcare Improvement Scotland. Figure 3 highlights the planning that continues to take place as the PSCT evolves. The data gathered from the interviews suggested that there was an appreciation of the importance of this:

‘...just because it’s right to involve service users and families doesn’t mean we just do it without thinking about how we do it, and so somebody had actually taken the time to think about how we do it and most of those people had lived experience.’

When it came to the delivery of the PSCT, it was evident that there was an appreciation of the importance of preparing service users, family and staff. This was done by displaying posters on the wards and providing briefs for staff and service users so they were aware of what was going on. Staff involved with the delivery of the PSCT also discussed the PSCT with service users, family and staff in the week or fortnight before the PSCT sessions took place. Overall, there was a clear build-up to the delivery of the PSCT and service users were given time to consider making up their mind about whether they wanted to take part which helped to break down barriers between staff and service users.

‘We hadn’t gone into so much detailed planning when we first tested it so the things we put in place in terms of safety and support were based on feedback we’d got the first time around when they said: “What is it I’m going to?” and “Is that it now?” and just that awareness that we’ve come in and asked all these questions and they’ve gone back to their ward and we just had a sense that didn’t feel right.’

4.2.2 Common and shared values, aims and language

It was apparent that there was a shared value in which to produce a piece of work from which the evidence base came from service user experience rather than focusing on developing a valid and reliable research tool, although this took some time to achieve as illustrated in Section 4.3.8. The overall aim was to give service users a “voice” to express how safe they felt:

‘Very basically what we wanted to do was to give service users a voice, to give them some sort of way of expressing how safe they felt and what they saw the issues are because what we found quite often was sometimes it was really simple things that the staff never thought of or just never knew was an issue and could be changed very quickly.’

‘Thankfully our ethos wasn’t to find the perfect tool and spend years and years perfecting something as you would do in a scientific process but go with what you’ve got and see what it feels like.’

It is also recommended that a shared definition or understanding of what co-production is and how it differs from what occurred previously is necessary amongst those involved in projects such as this one. However, as previously stated there was no conscious decision to use a co-production approach. Despite this, the professionals involved in the development of the SPSP were clear that it was taking a different approach in which service users and/or service users were regarded as equal partners:

‘I don’t think there are many true examples of co-production, I think the way the PSCT was developed....although I don’t think we thought of it as co-production at the time but I think it really was, it was an idea that came from service users and I think they were there as equal partners, their capabilities and strengths and experiences were very much at the forefront.’

4.2.3 Ground rules for group working

It is suggested that ground rules are established to provide a supportive and negotiated environment in which difficulties can be overcome by the whole group. Given that many of those involved came from organisations which have their own standards and guidelines, such as those used by Voices of Experience (VoX)¹⁰, there are clearly rules which may have influenced the co-production process. However, examining these in detail is outwith the scope of this project. The only formal ground rule detected was a decision taken by the authors group that no changes were to take place without their approval, to ensure fidelity of the tool.

4.2.4 Navigating roles and boundaries

The navigation of roles and boundaries requires a move away from a traditional professional-patient dynamic so that the collaboration makes optimal use of the different types of skills and expertise that professionals and service users bring to a co-production project. Given the dual role that several individuals played in being a professional and former patient and/or service user, and the strong working relationships demonstrated between the various groups of individuals involved in the development and delivery of the PSCT, a blurring of boundaries appeared to be evident.

4.2.5 Process and participant facilitation

If it appears that co-production may be difficult to achieve then it is recommended that external facilitators can be brought on board to assist. Healthcare Improvement Scotland has a member of staff who specialises in co-production. However, at the time of the development and delivery of the PSCT, this individual’s role did not exist. It is recommended in Section 5 that this individual is consulted during the future development and delivery of the PSCT.

4.2.6 Payment and welfare benefits

Service user feedback was sought on early drafts of the PSCT at local events. It was generally agreed that the set-up of third sector organisations involved supported service user input by paying travel expenses on the day of the event. They then invoiced Healthcare Improvement Scotland who covered the costs incurred. The VOX guidelines¹⁰ were frequently referred to during the interviews as being followed when paying service users expenses, which includes mention of the potential impact of service user involvement on welfare benefits.

4.2.7 Sharing the defining and decision-making

It is suggested that decisions about what needs to change must be made equally with service users and carers at the beginning of the development process. In terms of the development of the PSCT, it appeared that service users were involved from an early stage.

'I really like the fact that service users and their families were very much involved in the development of the PSCT from the beginning.'

However, it was less clear as to who had been involved in the decision about what needed to be developed or changed as a lot of the early decision-making about the type of intervention being developed appeared to be based on anecdotal conversations between Healthcare Improvement Scotland and third sector organisations.

'Without being critical, when we got the tool there was a sense that this was not to be altered (laughs). So in the truest sense, if it was a co-production, it was a co-production before I ever got anywhere near it and subsequently we tried to tweak it but there was always a resistance to multiple changes and because we were keen to go ahead with this, we didn't, I don't remember getting too upset about that. Some of my colleagues were asking "What's the point of asking us to do this if our feedback isn't going to be enacted on, it's not going to lead to any change".'

The delivery of the PSCT ensures that service users can contribute to changes that take place in the ward. However, they are not actively involved in sharing the decision-making about what should change as although informal feedback is given to them by the facilitators, no formal feedback is presented or discussion takes place. This was cited as sometimes being due to quick service user turnover in the wards.

'The tie between the questionnaires and the action on the wards doesn't seem to be there.'

4.3 Step 3 – Working together: achieving parity and genuine collaboration

The final stage that the NDTI's practical guide⁹ focuses on is the achievement of parity and genuine collaboration. This is an important part of co-production within mental health care as there is evidence to suggest that avoidance of difficulties, conflicts and emotional expression may damage the process⁹. During the interviews, the respondents discussed how the service users and professionals had worked together in relation to the development and delivery of the PSCT. The evidence is presented below under the following themes:

- trust, honesty, communication and transparency
- reviewing, learning and making mistakes
- equality, assets and experience
- practical, flexible frameworks
- emotional and psychological support and facilitation

- staff support and perspectives
- service user and/or carer support and perspectives, and
- addressing challenge and tensions.

4.3.1 Trust, honesty, communication and transparency

For successful co-production to occur, realistic and clear objectives were necessary in defining what is and is not possible in the development and delivery of the PSCT. An acknowledgment of tensions was apparent about the validity of the tool and there was a recognition of what was possible within a non-research environment:

‘There will always be tension between what you can do in a pure research context and what you can do in real life.’

There appeared to be a high level of trust based on third sector professionals’ descriptions of working with Healthcare Improvement Scotland as a collaborative effort, in which they were recognised as equal partners:

‘Healthcare Improvement Scotland is very good at taking partnership working through in that way, we never feel, as we do sometimes that we’re asked for input and then that is taken away and used. With Healthcare Improvement Scotland there is always an acknowledgement that things have taken place in partnership and we have played an important role in them.’

The role of the facilitator was perceived to be crucial in ensuring that service users could feel they could be honest when completing the PSCT, therefore limiting the potential for biased responses:

‘It’s just as valid to ask about the experience when they are experiencing it. I think you get more honesty.’

‘The information we got back from people using our services was that they were more likely to give honest answers to service users and carers than to staff collecting the data because there may be an anxiety of saying no I don’t feel safe here, you’re not likely to say that if it’s a member of staff whereas if it’s a former patient they may well feel more confident in doing that.’

4.3.2 Reviewing, learning and making mistakes

The respondents made several reflective statements throughout the course of the interviews which suggested there was a willingness to take risks, make mistakes and learn from them. Overall, these comments appeared to have a general theme around recognising that the PSCT, although not scientifically valid, was novel in that it asked service users how they felt about the mental health ward environment and how they were treated by staff,

using questions which were developed by people with lived experience, with the ultimate aim of putting changes in place to make service users feel safer:

‘There will always be tension between what you can do in a pure research context and what you can do in real life and when it comes to it, the ultimate aim is to improve the safety on a ward or the sense of safety within the ward so I get the service user’s agenda would be: “Why are we using this? It’s not so we can get a score and do another score and demonstrate how wonderful we are or otherwise, it’s so we can get some rich data information that we can act upon”.’

There was also discussion of how the authors group had perhaps underestimated the degree of work required to spread the PSCT nationally as they had not foreseen the possibility of resistance from NHS boards. For example:

‘I think we probably underestimated the amount of work that would need to be done to spread it nationally. I think we naively thought if we do it two or three times then everyone else would say – “Oh it looks brilliant, can we do it?” whereas we found every time we moved into a new area we were having to go and sell it again and gradually overtime that did become easier because there was a kind of awareness nationally and through the learning sessions and the literature that was produced that it was going on in other areas and that it was seen as a good thing. I think what resistance there was gradually reduced rather than I think we thought it might have dissipated quite quickly after we had done the first couple.’

4.3.3 Equality, assets and experience

Recognition that skills, assets and experience are equal, regardless of whether an individual is a service user or a professional is a key element of successful co-production. According to the NDTI’s practical guide⁹ the input of individuals is not necessarily limited to their primary role. For instance, professionals can be influenced by their personal experiences. This was evidenced during the development and delivery of the PSCT by the dual role that some of the professionals had due to also being former service users and/or service users:

‘You had ownership of it and the people who were taking part could see.... this is a question I’d like to be asked after an incident and I’ve made it up, here it is, it’s going into the questionnaire.’

During the delivery of the PSCT, service users’ contributions were recognised through practicalities such as ensuring specific appointment times were given and letters and thank you cards were sent recognising their input.

4.3.4 Practical, flexible frameworks

It was previously stated the development and delivery of the PSCT was not consciously based on a co-production approach. Therefore, it is not to be expected that a co-production

framework was used during either the development or delivery process. However, within Healthcare Improvement Scotland several Public Partnership standards are adhered to including the Scottish Community Development Standards for Community Engagement¹¹ and the Scottish Health Council's Participation Standards¹². Healthcare Improvement Scotland also has an Involvement Strategy¹³. Therefore, it is expected that this documentation influenced the development and delivery of the PSCT.

4.3.5 Emotional and psychological support and facilitation

The change in power and authority means the emotional and psychological impact of co-production can be profound. To counter this, it is necessary to provide effective emotional and psychological support and facilitation for all involved. For example, during the piloting of the PSCT, it became apparent that a service user needed more support in dealing with issues that were outwith the focus of the SPSP-MH remit:

'They went through the PSCT and then wanted to talk about a whole lot of different stuff because they had someone listening and hearing what they were saying so there was a bit about that structure and how the meeting would be; always being very clear beforehand with the patient about what it would be and what it would feel like and if they needed to talk further then this would be what was available.'

There was also recognition that by not addressing potential patient safety issues through the delivery of the PSCT, there was the potential to cause further trauma:

'Not asking is traumatising, not involving is traumatising. Asking, discussing, allowing, facilitating... I don't think I'd ever say that in its own right is traumatising because if you're already traumatised, you're traumatised.'

4.3.6 Staff support and perspectives

Consideration of the support professionals may require in managing the risks associated in stepping out of their typical role is another important component in a successful co-production process. There was a general sense that some NHS staff on the wards had felt anxious about the introduction of the PSCT as they viewed it as a method by which service users rated the care they received. However, there was discussion of how this diminished over time through the facilitators building up positive relationships with ward staff and providing them with positive feedback to demonstrate that one of the main objectives of the tool was to highlight good practice so that it could be replicated:

'I think there probably were a number of staff who would be a bit anxious about it because would the outcome of the survey be a reflection on their care or you know things like that. There was a natural anxiety - was it some kind of scrutiny or some kind of inspection tool to see how well they were doing their job? but that's usually the case with things like this but I think once we went through the initial phase those kind of anxieties damped down a wee bit.'

'I remember at one of the learning sessions, one of the nurses saying staff had been a bit uncertain about this whole process but actually when they looked at it actually service users thought they did a good job most of the time, so they saw that as a bit of validation of the programme.'

'We learned to involve staff more, give them more control, as in all involvement work you have to listen to staff, as well as the patient as well as the managerial people involved in doing it, joint events are good for that but you have to encourage that.'

One respondent also felt that, compared to other health professionals, mental health professionals have a relatively high amount of autonomy:

'Mental health staff work within a culture where they feel they have a great deal of autonomy, and don't feel a need to seek permission to test change with a level of patient involvement always given consideration.'

Regarding support for the facilitators, it was not widely discussed in the interviews. However, Healthcare Improvement Scotland produced facilitator guidance (Appendix D) and the SPSP-MH team continues to actively support facilitators with training and events such as short life working groups aimed at updating the tool and guidance. In addition, several of the facilitators are well known to the SPSP-MH team and appear to have an excellent working relationship with them.

4.3.7 Service user and/or carer support and perspectives

It is necessary to ensure that service users are adequately supported in their co-production role as often they have experienced instances where they have not had their views or perspective recognised fully⁹. Facilitator guidance was produced by the SPSP-MH team (Appendix D) which provided specific information about how service users should be supported when taking part in the PSCT. There was a clear emphasis on ensuring any patient who wished to complete a PSCT should be given the opportunity to do so. Service users were also reminded of their right to withdraw at any point.

'Our approach has always been to say that anyone who wants to take part should be given that opportunity, if you are giving everyone the opportunity that's a signal in itself that you want all views and if people just want to come in and say one thing and go away again that's fine as well.'

'We are quite often asking people to re-live and talk about things that were fairly traumatic and doing it in a closed, confidential environment and doing it in a supportive way that says "actually if you don't want to talk about this anymore, that's fine".'

There was discussion of whether service user input was truly captured during the development phase as most of the individuals with lived experience who played a key part in developing the PSCT also had a professional role. Obtaining significant input from

individuals who have experience of being acutely unwell and who do not have a high degree of involvement in a third sector organisation was acknowledged as a barrier to undertaking a co-production approach in a mental health care setting:

‘How do you get service users who would have lived experience of this kind of ward, you could have the usual suspects of people who maybe have more minor mental health disorders but how do you really get into the people who have experience of being detained, of being in a ward like that, it’s really hard.’

4.3.8 Addressing challenge and tensions

Due to the evolving nature of relationships within a co-production context, addressing challenges and tensions is a key aspect of co-production. Several examples were given of problems which arose. A frequently mentioned issue, during the development phase, was concern from NHS nursing staff that the PSCT was, in some way, an assessment of the care they provided and therefore some negativity was being directed towards the use of the tool. This appeared to be managed through working collaboratively with staff to ensure they were aware of the aims of the PSCT and providing them with examples of the positive feedback which was collected:

‘Those people who didn’t take the time and effort to have a look at what the tool actually said were assuming this was some method of appraising their performance as nurses.’

‘The commonest comment from nurses was around the lines of “we didn’t expect them to be that complimentary.” They expected everybody to complain.’

Also, ensuring a good working relationship between the wards and the facilitators appeared to be important in overcoming this challenge:

‘We give the wards a great deal of control, that’s one thing we’ve learnt, the wards are working environments and they don’t like it when external people come in and start making demands....so we’ve learned from that, you have to work with wards in a kind of partnership way and give them that degree of control.’

The other main issue mentioned was the resistance by some professionals about the use of a non-scientific validated measure although this issue had been resolved by the time the PSCT was being delivered, as mentioned in Section 4.2.2 it was an apparent problem during the development process:

‘We got challenged on a lot was what’s the scientific validity of this tool? There were some thick skins developed around about there is no scientific validity to this.’

To overcome this issue, clear objectives were set out about the purpose of the PSCT:

‘We got into a bit of a stand at one point because there were individuals in the steering group who very much wanted a validated tool and it was research based and we had a bit of

a challenge at the beginning about this is about the model for improvement, this is about looking at what we can do, it's not about a research project, this is about how people feel in our services, we think we know how they feel but actually how do they feel, what's important to them, what matters to them.'

5. Conclusions and recommendations

Table 2 provides an overall summary of the degree to which each of the requirements within the three stages were judged as taking place.

Step 1 – Setting the scene: Understanding the context and the environment in which co-production is going to take place

Overall, the data from the interviews suggested that in terms of understanding the context and environment in which the development and delivery of the PSCT occurred, the individuals interviewed were clearly aware of the prevailing top-down culture within mental health care and the power imbalance that exists between those providing and receiving care. There appeared to be a willingness to go against the institutional norms and overcome resistance. This was supported by senior staff providing leadership commitment and support. Therefore, there was a good understanding of the context and environment in which the development and delivery of the PSCT took place.

Step 2 – Coming together: Creating the right conditions for co-production to work

As for creating the correct conditions for co-production to work, the evidence gathered from the interviews suggests that there was a great deal of preparation and planning that went into both the development and delivery of the PSCT. There was clearly a shared value of ensuring the patient voice was heard, with the common aim of making service users feel safer, although this appeared to take time. A lot of the issues, such as ground rules and payment of welfare benefits, were effectively managed due to the guidelines and standards set by the third sector organisations involved. Navigating roles and boundaries was evident from the strong working relationships demonstrated and the dual role that several of the key individuals played in developing and delivering the PSCT.

Thinking about what could have been done to make the process more consistent with a transformational co-production approach, process and participation facilitation could perhaps be helped in the future by identifying an individual who can assist should any issues arise in the development stage of a project. Sharing the defining and decision-making could be built upon by including a wider range of service users and staff at an earlier stage in the development process. Providing formal feedback for service users who participate in the delivery of the PSCT would also contribute to this.

Step 3 – Working together: Achieving parity and genuine collaboration

Finally, thinking about achieving parity and genuine collaboration, the data collected suggests that there was a high level of trust, honesty, communication and transparency. Reviewing, learning and making mistakes was demonstrated through the various reflective statements made. Equality, assets and experience of all those involved appeared to be valued. There also appeared to be a high level of emotional and psychological support and facilitation available as shown by the additional support provided to those who required it. Staff support and perspectives were clearly considered as evidenced by the continued support offered by the SPSP-MH to professionals involved in the delivery of the PSCT. In terms of addressing challenge and tensions, it appears that the main issues encountered, including the concern by some NHS staff about their performance being appraised and a resistance by some professionals to a non-validated tool being developed, were overcome by reminding individuals, who expressed concern, of the primary aim of the PSCT: to give service users a “voice” to express how safe they felt. However, there is the possibility of bias in the interview sample meaning that only those who felt positively towards the PSCT were interviewed.

Thinking about what could have been done to make the process more consistent with a transformational co-production approach, it would have been useful if a framework had been used which was specific to mental health co-production such as the National Survivor User Network’s *4PI National Involvement Standards*¹⁴. Service user and/or carer perspectives could have perhaps been obtained from a wider range of individuals as it appears a significant amount of this type of input came from individuals who also had a professional role.

Building on the key findings of this report, the following recommendations have been developed to support co-production of future projects within mental health care.

Key recommendations:

- There was no conscious decision to use a co-production approach. However, there is evidence that co-production took place, to a degree, throughout the development and delivery of the PSCT. It appears to have been integral in the success of the PSCT. Therefore, it would be recommended that a formalised co-production approach is used in future to build awareness of the benefits of co-production (4.2.2).
- The support of the Third Sector and Independent Sector Engagement Lead should be sought should any issues arise in future co-production projects. This will help to ensure that wider co-production capacity, confidence and capability is built into improvement approaches and programme planning (4.2.5).
- It is necessary to formally share decisions with service users in regard to what it is that is required to be developed (4.2.7).
- It is recommended that a mental health co-production framework, such as the National Survivor User Network’s *4PI National Involvement Standards*¹⁴ is used in the development and delivery of any future co-production projects (4.3.4).

- The importance of obtaining the views those who have experience of being purely a service user. It is therefore recommended that a wider range of individuals are consulted in the development of any future versions of the PSCT (4.3.7).
- Given the success of the PSCT ^{1,2}. It is recommended that a carers, Child Adolescent and Mental Health Service, older people and, learning disabilities versions are considered.
- To ensure equality, each NHS board needs to have a formal process to ensure all service users who complete the PSCT receive feedback. The delivery of such feedback could be done in an informal manner (4.2.7).

It is recognised that this report is limited for several reasons. Nobody who was involved as purely a patient or service user was interviewed. If this work is to be developed further, it is recommended that this group of individuals is included. The report is also attempting to assess co-production when no conscious decision was made to use such an approach. Finally, the PhD researcher solely made decisions about whether criteria had been fulfilled which introduces the potential for bias. Therefore, although research methods were used to collect data, it was not analysed in a fully robust, evidence-based manner.

In conclusion, despite the development of the PSCT not incorporating a formalised co-production approach, it is evident that many of the key features of co-production were present during the development and delivery process. This is encouraging for both service users and professionals.

Table 2: Summary table

		Evidence to support development	Evidence to support in the delivery	Recommendations
Step 1 – Setting the scene	Power, hierarchy and authority	✓	✓	
	Institutional systems and resistance	✓	✓	
	Leadership commitment and senior support	✓	✓	
Step 2 – Coming together	Time, preparation, planning and clarity of purpose	✓	✓	
	Common and shared values, aims and language	?	✓	There was no conscious decision to use a co-production approach. However, there is evidence that co-production took place, to a degree, throughout the development and delivery of the PSCT. It appears to have been integral in the success of the PSCT. Therefore, it would be recommended that a formalised co-production approach is used in future to build awareness of the benefits of co-production (4.2.2) (Development).
	Ground rules for group working	✓	✓	
	Navigating roles and boundaries	✓	✓	
	Process and participant facilitation	?	✓	The support of the Third Sector and Independent Sector Engagement Lead should be sought should any issues arise in future co-production projects. This will help to ensure that wider co-production capacity, confidence and capability is built into

		Evidence to support development	Evidence to support in the delivery	Recommendations
				improvement approaches and programme planning (4.2.5) (Development).
	Payment and welfare benefit	✓	✓	
	Sharing the defining and decision-making	?	?	It is necessary to formally share decisions with service users in regard to what it is that is that is required to be developed (4.2.7) (Development). To ensure equality, each NHS board needs to have a formal process to ensure all service users who complete the PSCT receive feedback. The delivery of such feedback could be done in an informal manner (4.2.7) (Delivery).
Step 3 – Working together	Trust, honesty, communication and transparency	✓	✓	
	Reviewing, learning and making mistakes	✓	✓	
	Equality, assets and experience	✓	✓	
	Practical, flexible frameworks	?	?	It is recommended that a mental health co-production framework, such as the National Survivor User Network's 4PI National Involvement Standards ¹⁴ is used in the development and delivery of any future projects (4.3.4) (Development and delivery).
	Emotional and psychological support and facilitation	✓	✓	

		Evidence to support development	Evidence to support in the delivery	Recommendations
	Staff support and perspectives	✓	✓	
	Service user and/or carer support and perspectives	?	✓	The importance of obtaining the views those who have experience of being purely a service user. It is therefore recommended that a wider range of individuals are consulted in the development of any future versions of the PSCT (4.3.7) (Development).
	Addressing challenges and tensions	✓	✓	

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Appendix A – Patient Safety Climate Tool



patient safety
climate tool

Date		Time		Name of ward	
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How long have you been an inpatient in this ward?			
<i>Less than 1 week</i>	<i>Between 1 week and 1 month</i>	<i>More than 1 month</i>	<i>Would rather not say</i>

How old are you?					
<i>Under 18</i>	<i>18-24</i>	<i>25-44</i>	<i>45-64</i>	<i>65+</i>	<i>Would rather not say</i>

Are you detained under the Mental Health Act?		
<i>Yes</i>	<i>No</i>	<i>Would rather not say</i>

Gender?		
<i>Male</i>	<i>Female</i>	<i>Would rather not say</i>

Is this your first admission?		
<i>Yes</i>	<i>No</i>	<i>Would rather not say</i>

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
01	I feel safe in the day time.						
	Comments						
02	I feel safe at night time.						
	Comments						
03	I feel safe in the shared areas of the ward.						
	Comments						

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
04	I feel safe when staff are not obviously visible. For example, handover times or meal times.						
	Comments						
05	I feel the ward is a safe one to visit - including carers, friends, family and children.						
	Comments						
06	The mixture of male and female patients in this unit/ward feels safe.						
	Comments						
07	I feel safe even when there are difficult events on the ward involving other patients.						
	Comments						
08	I feel confident that staff deal safely with difficult events on the ward.						
	Comments						

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
09	I think there are enough staff to manage difficult events on the ward.						
	Comments						
10	Staff help me to make sense of difficult events on the ward after they have happened.						
	Comments						
11	If I had to be restrained or witnessed somebody else being restrained I feel this would be done safely.						
	Comments						
12	I was involved in making decisions about my medication and included in any reviews.						
	Comments						
13	I feel I have received enough information about why I take my medication and also about the side effects it may cause.						
	Comments						
14	Staff support me if they see me becoming upset.						
	Comments						

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
15	I feel safe to express any concerns I have regarding safety.						
	Comments						
16	If I have concerns about my safety, I would know who to go to.						
	Comments						
17	When I expressed concerns I felt staff provided appropriate support.						
	Comments						
18	I feel staff consider my safety and involve me when planning my care.						
	Comments						
19	Can you let us know anything you think would improve the safety of this ward.						
20	What do you do to keep yourself safe?						

On behalf of the Scottish Patient Safety Programme for Mental Health, thank you for all your help.

additional information (to be provided by the facilitator or volunteer)

Your name and	
----------------------	--

Approximate time taken by the patient to complete the questionnaire? (Please tick the relevant box)	Less than 10 minutes	<input type="checkbox"/>
	10–30 minutes	<input type="checkbox"/>
	More than 30 minutes	<input type="checkbox"/>
	Kept to complete later	<input type="checkbox"/>
	Not able to complete	<input type="checkbox"/>

How much help did the patient need to complete the questionnaire? (Please tick the relevant box)	Self completed	<input type="checkbox"/>
	Brief guidance and self completed	<input type="checkbox"/>
	Guidance during half of the questionnaire	<input type="checkbox"/>
	Guidance throughout	<input type="checkbox"/>

Acknowledgements

We would like to thank all those who have worked with us to produce the Scottish Patient Safety Programme for Mental Health Patient Safety Climate Tool.

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Appendix B – Information and consent form



Staff perspectives on the process of co-production in developing the Scottish Patient Safety Mental Health (SPSP-MH) climate tool

My name is Julie McLellan and I am a PhD researcher undertaking an internship with Healthcare Improvement Scotland. I am interested in talking to staff members (NHS and third sector) who were involved in the development in the patient safety climate tool.

Interviews are being undertaken as part of a service evaluation which aims to understand how “Co-production”- defined as a “relationship where professionals and citizens share power to design, plan and deliver support together” (Slay and Penny, 2014) was achieved in the development of the patient safety climate tool. To report the findings effectively it would be useful to audio record the interviews.

The findings will be presented in an internal Healthcare Improvement Scotland report. The findings may also be published externally, for example at relevant health care conferences and events.

If you are happy to proceed then please complete this form by ticking the boxes and signing below:

1-I confirm that I have read the information above for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	<input type="checkbox"/>
2-I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason	<input type="checkbox"/>
3-I agree to audio recording and the use of anonymised quotes in research reports and publications.	<input type="checkbox"/>
4 - I agree to being interviewed as part of this service evaluation project	<input type="checkbox"/>

Name _____
Signature _____
Job Title _____
Date _____

Appendix C – Interview schedule

Co-production definition: professionals and service users share power to design, plan and deliver support together, recognising that both partners have vital contributions to make. It occurs in critical middle ground, where combining strengths and resources of people and communities and professional skills and knowledge takes place (point out the laminated sheet with the principles on it).

Background

Before we begin, can you tell me how you view co-production?

As you know I'm interested in talking to you about the co-production process that took place in developing the patient safety climate tool so to start off can you tell me a little about who initiated/or led on the development of the patient safety climate tool?

What were the desired outcomes for the service users and the service systems?

Who decided upon the outcomes?

Was there a shared understanding and agreement among the service users, frontline staff, health care improvement Scotland staff and clinicians of the issue being tackled? (were staff and service users able to express their stories and use lived experience?)

Why a co-production approach was utilised

What was envisaged would be achieved by using a co-production approach?

How much did you feel you needed to use a co-production approach?

What it was like to use a co-production approach

What were the main barriers and challenges experienced and how were they overcome?

How easy was it to maintain a co-production approach?

What would have happened if you hadn't used a co-production approach?

The process of using a co-production approach

Were the necessary resources available to those expected to undertake co-production?/ How were other practical issues such as access (information, timing of sessions, location and choice of venues for meetings), payment as recognition of value for time and expenses (with regard to welfare benefits) and facilitation of meetings considered?

Do social influences facilitate or hinder co-production? (prompts: peers, managers, other professional groups, service users, relatives)

To what extent do emotional factors facilitate or hinder co-production? (trauma recall)

Was there an explicit recognition of the knowledge, expertise, assets, strengths and contribution of everyone involved?

Tracking progress

How was progress tracked in regards to:

- a) Achieving the desired outcome for service users and the service system*
- b) The co-production approach itself*

Reflecting

What was learnt and by whom? What would you do differently next time?

Thanks for answering my questions. Do you have any questions?

I will listen back to our discussion and make some notes. Would you be happy for me to send these to you to confirm that I've understood everything you've said and to clarify the points raised in our discussion?

Appendix D – Facilitator guidance



Patient Safety Climate Tool

The Scottish Patient Safety Programme is co-ordinated by Healthcare Improvement Scotland

Patient Safety Climate Tool

The questions have been developed by mental health service users and carers, and the SPSP Mental Health Teams across NHS Boards have supported the implementation and delivery of the Patient Safety Climate Tool (PSCT). The tool is designed to enquire about environmental, relational, medical and personal safety and the layout of the tool is designed in such a way that there is a flow through the questions. This has come about after a number of tests of change and analysis of responses to these tests.

Generating knowledge, cultivating learning among those delivering and in receipt of care, and using knowledge to improve safety are core values of the Scottish Patient Safety Programme (SPSP), and they are values that align with the importance of using this climate tool.

We use the term “tool” to mean a standard set of items given to participants to assess different aspects of a ward or unit’s safety climate. There are many issues to consider in order to produce survey data that is trustworthy and useful. This includes the mixture and analysis of qualitative and quantitative data. Additional research is planned to refine this tool as a best practice survey instrument.

It is important to note that the tool provides a snapshot at a given point in time and does not take into account and indeed is not required to, where individual patients may be in relation to their recovery. What is key is that unless it is clinically inadvisable, every patient is given the opportunity to participate.

The tool is made up of 20 questions: 18 questions that ask for a score with supporting narrative and two further open questions that ask what safety improvements could be made and what the individual does to keep themselves safe.

In terms of frequency we recommend that the PSCT be completed at least once a year by all wards participating in the SPSP-Mental Health or more often as required. The view of the PSCT steering group is that the tool should not be used at a set point in the clinical process such as admission or discharge; rather it is designed for use with a mixed group of patients at a point in time, as this potentially provides more varied responses.

It is immediate and provides responses based on feelings and issues that are important to the patient while on the ward or unit, not on reflections given some time later.

What is the value of the Patient Safety Climate Tool?

'The patient safety climate tool will give patients the chance to express their feelings and concerns about their safety while on a ward. This information will then allow services to make any improvements needed, resulting in a better patient experience of hospital care.'

Gordon Johnstone, Director of VOX

Enabling patients to share the way they feel about their experiences forms a powerful message that will help staff working in wards and units to:

- Have a greater understanding of the complexity of the patients' experience
- Reflect on practice
- Aim to minimise the possibilities of re-traumatisation
- Develop a service that is more responsive to the experiences of those who receive the service
- Provides concrete real ideas for improvement

The tool has been in existence since 2012 and through pilot sites, tests of change and direct feedback from NHS Boards and facilitators the following has been suggested:

- The climate tool can provide information about patient perceptions, knowledge and attitudes relevant to safety.
- The climate tool can provide information about safety issues in a particular clinical area (Acute, ICU, Forensic, and Rehabilitation etc), enabling wards and units to tailor and/or develop interventions and improvements.
- Using the climate tool can demonstrate a commitment to listening to patient safety issues and build trust with patients, staff, carers and others.

Why is it facilitated?

It is strongly recommended that completion of the tool is supported by an external facilitator. Within the tool there are a number of potentially challenging questions and statements and facilitation will provide support to the individual in completion of the tool and where appropriate, encourage discussion and record the subsequent narrative. We recognise that this will vary in different areas, but **it is essential that the facilitation is carried out by those who are not directly employed or involved as core members of a ward or unit team.**

The use of an external model of facilitation is considered to be best practice and where possible an advocacy organisation or third sector organisation should be approached to carry out the facilitation role and many NHS Boards have already used this model. If there is any doubt regarding the facilitation please contact the SPSP-MH Coordinating team for advice.

Key points for facilitators:

- There should be 2 facilitators.
- One facilitator should take the role as note taker and the other asking the questions. These roles should be explained to the patient completing the tool at the beginning.
- The tool and an introductory statement as to why the tool is being used should be introduced to the patient with a copy made available throughout.
- When introducing the tool indicate that it's okay to not give responses, if necessary request to end the session early and ask for questions to be reworded for ease of understanding. **If the patient wishes to stop or you feel it is not appropriate to continue then there is no requirement to complete it.**
- Explain the 5 point rating scale rating and where required repeat this.
- Ensure that the brief demographic questions, the information about how long each tool took to complete, and how much assistance was required are completed.
- Feedback has suggested that the current version of the tool should take no longer than 15-20 minutes to complete, often shorter.
- If a patient is taking a long time to complete the tool (more than 25 minutes) the facilitator should seek guidance from the named contact staff member.
- If the patient does not want help (facilitation) to complete the tool, they should be allowed to do so. Please ensure that the completed tool is returned either to the facilitator or sent to the agreed address in the envelope provided.
- The PSCT responses are **anonymous** and it is essential to remind patients of this and that all information shared is used for continually improving the safety and quality of care.
- Question number six is not applicable in single sex units/wards.

Key points for the ward/unit:

Feedback has suggested that where preparatory work has been carried out by the ward staff prior to the administration the PSCT, there is a greatly increased qualitative response. Self completed questionnaires tend to be ticked with minimal comment whereas discussing it with a briefed patient enables facilitators and wards/units to get much more from the tool.

- The ward should allocate a designated member of staff to support facilitators and patients through the process.
- This member of staff should act as contact person and introduce the facilitators to the patient and vice versa.
- Ensure that advertisements are displayed in relevant places approximately a week in advance to inform patients and staff that the climate tool is being undertaken, when, where and who to speak to for more information.
- Ensure there is a quiet, private room to for the tool to be completed in.

What happens with the feedback?

The results from all the completed tools should be entered into the PSCT data entry sheet provided. The direct patient feedback should be analysed locally and key themes identified shared and actions for improvements set in place. It is hoped that the feedback from the PSCT will inform some of the discussion in Patient Safety Leadership Walkrounds. Examples of themes from completed PSCT's have included the requirement for more information about medication and possible side effects and positive comments about staff and their ability to deconstruct and help explain and support to interpret difficult situations.

As stated the ownership and use of the information is primarily for the ward/unit and NHS Board. At a national level the SPSP-Mental Health Co-ordinating Team will request twice annually the following information from each Board:

- Number of and type of wards/units completing PSCT
- Total number of PSCT's completed
- Total number of action plans and examples of themes
- Who is supporting the facilitation of the PSCT?
- How is the learning from the climate tools fed back?

The rationale for collecting information is to aid the development of the tool and also to identify key themes and issues where learning and sharing may support and accelerate improvements.

Version control and amendments:

No changes can or will be made to the PSCT without consultation with and agreement from the Service User and Carers organisation representatives who created the tool and the SPSP-Mental Health Leadership and Culture Workstream Development Group. The PSCT was last reviewed in June 2014 and will be reviewed again in January 2015.

Definitions:

- Staff – Staff includes all members of the multi professional team.
- Difficult Event – A difficult event is defined as anything that makes the individual feel unsafe whatever the given situation. Examples of this could be excessive noise through to witnessing or actually being restrained.
- Shared areas – examples of these are dining rooms and communal seating areas.
- Unit/Ward – these are interchangeable and are used to describe the inpatient area.
- Not obviously visible – staff are present, are in the vicinity but not immediately in sight.

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