The Secure Quality Involvement (SeQuIn) Tool: benchmarking coproduction in secure services

Journal:	*Journal of Forensic Practice*
Manuscript ID	JFP-01-2022-0001.R2
Manuscript Type:	Research Paper
Keywords:	Coproduction, Benchmarking, Forensic mental health, service improvement, Quality assurance, Participatory methods

MANUSCRIPT DETAILS

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ABSTRACT:

Secure mental health services in one UK region have acted within a network to develop a range of involvement practices. A new quality benchmarking tool has been created to appraise the implementation of involvement practices and this paper reports upon a qualitative evaluation of this development.

Staff and service users involved in the co-production of the benchmarking tool were engaged in a series of focus groups and participatory inquiry approaches enacted in the course of scheduled network meetings. Data thus collected was subject to thematic analys

Four distinct themes were identified which we have titled: Taking time, taking care; The value not the label; An instrument of the network; and, All people working together. These are discussed in relation to recent theorising of coproduction.

Effectively, our study represents a case study of developments within one region. As such, the findings may have limited transferability to other contexts.

Staff and service users can work together effectively to the benefit of each other and overall forensic services. The benchmarking tool provides a readymade mechanism to appraise quality improvements.

Despite a prevailing culture of competition in wider healthcare policy, cooperation leads to enhanced quality.

The benchmarking tool is a unique development of a longstanding involvement network, demonstrating the positive implications for enacting co-production within secure services.

The Secure Quality Involvement (SeQuIn) Tool: a study of the development and implementation of a benchmarking approach to coproduction in secure services

Abstract

Purpose

Secure mental health services in one UK region have acted within a network to develop a range of involvement practices. A new quality benchmarking tool has been created to appraise the implementation of involvement practices and this paper reports upon a qualitative evaluation of this development.

Design/methodology/approach

Staff and service users involved in the co-production of the benchmarking tool were engaged in a series of focus groups and participatory inquiry approaches enacted in the course of scheduled network meetings. Data thus collected was subject to thematic analysis.

Findings

Four distinct themes were identified which we have titled: *Taking time, taking care; The value not the label; An instrument of the network;* and, *All people working together*. These are discussed in relation to recent theorising of coproduction.

Research limitations/implications

Effectively, our study represents a case study of developments within one region. As such, the findings may have limited transferability to other contexts.

Practical implications

Staff and service users can work together effectively to the benefit of each other and overall forensic services. The benchmarking tool provides a readymade mechanism to appraise quality improvements.

Social implications

Despite a prevailing culture of competition in wider healthcare policy, cooperation leads to enhanced quality.

Originality/value

The benchmarking tool is a unique development of a longstanding involvement network, demonstrating the positive implications for enacting co-production within secure services.

Keywords

Coproduction; benchmarking; forensic mental health; service improvement; quality assurance

Plain Language Summary

This paper reports upon a service evaluation of the development and implementation of a new Secure Quality Involvement Tool for benchmarking practices which promote participation and shared decision making within secure mental health services. Patients and staff from secure services across the UK Yorkshire and Humber region developed the benchmarking tool together during several pre-arranged meetings. Their use and experience of the tool was then discussed at the same networked meetings and through focus groups to gain insight into experiences developing the tool.

Four distinct themes were identified which we have titled: Taking time, taking care; The value not the label; An instrument of the network; and, All people working together. These are considered in the context of acting cooperatively and creatively.

We conclude staff and patients can work together effectively the benefit of each other and secure services. The benchmarking tool provides a readymade way to appraise quality improvements.

Introduction

This paper describes the development of a co-produced benchmarking tool designed to promote participation and shared decision making within secure mental health services before presenting findings from a qualitative, participatory evaluation. Specifically, the first part of this manuscript is concerned with outlining the background and development of this novel tool, created in the Yorkshire and Humber region of the North of England as part of wider systems of inclusive and cooperative practice. The second part provides a qualitative analysis of the perspectives of staff and service users to evaluate the efficacy of the benchmarking tool.

Staff and service users within the secure estate of this region have worked together over several years to develop a range of new and creative practices for the planning and delivery of different aspects of secure care (Author, 2017). The new The Secure Quality Involvement (SeQuIn)[1] benchmarking tool enables staff and service users to view the care and treatment delivered against a set of agreed standards for good practice. It is also a means for appraising the uptake of these involvement practices in the various secure units across the region.

The SeQuin tool was developed by a regional 'Involvement Network' to gauge the success of involvement practices at service level. In this context 'involvement' refers to processes of cooperation where all stakeholders, including service users, staff and commissioners, worked in creative processes of co-production (Lambert and Carr, 2018). The tool allows for relevant standards to be rated using a common scoring mechanism for 12 discrete areas of practice as follows:

- Involvement
- Recovery Pathway
- Recovery College
- Reducing Restrictive Practices
- CPA Standards
- Friends, Family and Carers
- MDT Standards
- Dining Experience and Healthy Weight
- Meaningful Activity
- Shared Risk Assessment
- Recruitment and Selection
- Technology

Each section is rated against 10 bespoke questions (see Figure 1 for examples). The tool is designed to be implemented in a co-productive fashion, with staff and service users using it to jointly audit services for the quality of involvement practices. For example, a member of staff and a service user from a specific unit might meet to reflect on practices in a particular domain of the tool, talk to other staff and services users, review documentation and note evidence of innovations or shortcomings. Together they will arrive at a rating for each question and from there an overall rating for the area of

[1] A full copy of the tool can be found here https://www.yorkshireandhumberinvolvementnetwork.nhs.uk/wp-content/uploads/2021/03/SeQuIn-Tool-Instructions-2.pdf

practice. Sharing the outcomes of these reviews across the network is intended to inspire collective enhancements of quality through mutual identification of best practice.

Background: Democratising mental health care

The development and appraisal of involvement practices are characteristic of a broader policy and practice turn towards more democratic relations of mental health care. Over the years, progressive reform of mental health services has focused on how users of services can have a voice regarding their care or speak collectively about how services are organised (Carr, 2016). This has included increasing degrees of involvement, albeit occasionally tokenistic, within policy-making forums. Hence, notions of user involvement have been consistently promoted within policy, practice, research and practitioner education domains for some time now in both the general health and social care context and particularly in relation to mental health care (Beresford, 2005; Crawford and Brown, 2019; Felton and Stickley, 2004; Hodge, 2005; McKeown et al., 2022; Tait and Lester, 2005).

In a nutshell, such initiatives are concerned with the constructive and productive involvement of people who use services, and/or family carers, in the strategic shaping of services or in organising the care practices that take place within services. At the level of individuals, care planning and delivery is also, crucially, meant to be co-constructed between staff and service user, where the service user voice ought to be prioritised, or at the very least, properly listened to and taken account of. In mental health care, a recent prioritisation of service user involvement has typically been framed by a conceptualisation of therapeutic alliance or relationship (McAndrew *et al*., 2014) or referred to as shared decision-making (Drake *et al*., 2010). Service user involvement for more strategic or organisational ends can be organised at all levels within healthcare systems and is usually transacted by inviting representatively diverse groups of individuals to forums or meetings specially convened for such purposes (Tait and Lester, 2005). Arguably, the better processes for involvement utilise creatively democratised approaches to facilitating the expression of service user voice. This emphasises deliberative rather than simplistically instrumental communication (Hodge, 2009). There is a role for independent mental health advocacy within such processes, especially if individuals face barriers to involvement or are relatively incapable of meaningfully taking part (Newbigging *et al*., 2015).

Standard approaches to user involvement have often been found lacking and there is an ever-present danger of co-option or a too ready dismissal of critical or dissident standpoints (Author ref, Forbes and Sashidharan, 1997; Pilgrim, 2005). Even where involvement practices have been found to be healthily present across organisations, certain areas of practice may be neglected. Involvement in risk management, for example, is often lacking in direct involvement of service users (Coffey *et al*., 2017; Markham, 2018, 2020). Furthermore, even where involvement practices or independent advocacy are more fully supported, the process by which people get to be involved may be a means to positive relational outcomes but not necessarily deliver service users' immediate wishes (Author refs).

Paralleling mental health services' interest in involvement and shared decision making, broader activism and theorising in communities has centred on a concept of co-production. This in turn has fed back into health and social care contexts and mental health services particularly (see Fisher, 2016). Co-production principles thus define a new set of cooperative relationships between professionals and service users, policymakers, and citizens, with desired outcomes achieved in a process of democratised co-creation. The concept has its origins in community development work in the US going back several decades (Cahn, 2000; Ostrom et al., 1973) in the ecology sector and latterly in health and social care. The New Economics Foundation define coproduction as 'a relationship where professionals and citizens share power to design, plan and deliver support together, recognising that both partners have vital contributions to make to improve quality of life for people and communities (Boyle and Harris, 2009). On this basis, co-production becomes a means of 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours' and 'where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change' (Boyle and Harris, 2009 p11).

Involvement practices can also be recognised within secure services, though these have not always been defined as service user involvement or coproduction. So, for example, Livingston and colleagues (2012) evaluated processes of person-centred care within the Canadian forensic mental health context and remarked upon the capacity of services to support characteristics of person-centeredness but that efforts to expand this should take account of staff's anxieties over safety. Further attention to involvement practices within secure care settings has unarguably been associated with the emergence of a recovery paradigm (Author ref; Alred and Drennan, 2010; Chandley and Rouski, 2014; Chandley *et al*., 2014; Corlett and Miles, 2010; Drennan *et al*., 2014;

Dunn, 2014). Indeed, an influential national involvement network funded by NHS England (NHSE) and delivered by Rethink, which was established because of the success of the Yorkshire and Humber network, has styled itself as the secure care 'Recovery and Outcomes' network (Author ref; McCann *et al*., 2018). This national network also supports a successful annual conference and is currently working on research into involvement practices.

The Yorkshire and Humber Context

The Yorkshire and Humber region has 15 secure units in total (5 medium secure, 10 low secure) spanning NHS and independent providers. These services have been organised into the Yorkshire and Humber Involvement Network, from 2007, following a regional involvement strategy (Yorkshire Secure Commissioning Team, 2010). The network exists to promote and support innovatory practices that in current parlance are best described as co-production, but to begin with pre-dated adoption of this term in UK health services. These initiatives have involved staff and service users working together in network meetings and at unit level to co-create new ways of working that cover areas of practice ranging from dining experiences to risk management. Supported by two involvement leads who visit and work within the constituent units to embed and encourage relevant service developments, a range of new activities have been established. It is these domains of practice which are the basis of the benchmarking tool.

The work of the Yorkshire and Humber Network was evaluated in an earlier study, which noted that the spaces where involvement practices are conducted can be influential on the experiences and outcomes of such involvement (Author ref). Central network meetings are held in an open, non-secure community setting in Wakefield, with participants travelling from the various secure units, but other activities, including development work undertaken between meetings must take place within the secure environments where network members reside or work. Commissioners attend these central meetings, easing communication about commissioning priorities and how these can be influenced by the group. Such interaction strengthens legitimacy of the proceedings.

A critical issue with both the regional Yorkshire and national networks is a sometime contrast between the high quality experiences of engagement and imaginative ways of working evident in the network meetings and a more constrained set of involvement practices able to be achieved in the challenging context of the host secure units and individual wards (Author ref). Similar observations have been made in other research in secure settings highlighting how service users' agency and

relationships are influenced by a life-space that can limit opportunities for recovery and be disconnected from both their past and imminent future (Reavey *et al*., 2019).

Latterly, concerned with a need to evaluate and keep track of the sustainability of developments in involvement practices, participants within the network established themselves into a working group to produce a benchmarking tool for this purpose. Additionally, NHS England identified a need to demonstrate how involvement impacts on the quality of services. The benchmarking tool was developed through a series of workshops, regional and service level meetings and discussions at a wide variety of forums with service users, staff and commissioners, and tested/piloted/refined over a number of years. It brings together several areas of activity previously focused on by CQUINs as well as a few areas identified by everyone as key in terms of involvement. Indeed, the Sequin title is a play on words with CQUIN. Initially the tool was a way for services to measure themselves in isolation, however it has now evolved an online site whereby all the services in the Network can benchmark themselves against each other and use this to improve and share best practice.

In the development phase, iterative meetings of service users and staff addressed and refined the different elements of the tool. Separate groups were allocated different sections of the tool to reflect upon, discuss and offer suggestions for revision and improvement. People were asked to imagine using the tool in practice, for instance how they might ask colleagues or peers particular questions, whether all relevant information was covered, or whether the wording of the tool was accessible and comprehensible. Specific questions included:

- Do all the standards make sense?
- Is the language clear and understandable?
- Is there any repetition? Do any of the standards repeat themselves or seem to be saying the same thing?
- Is there anything relevant that is missing?
- Are there too many standards? If you think so, which ones would you leave out? Think about which the most important/ relevant standards are to include.
- How do you think using the tool with these standards would work?
- Can you think of any problems there might be using specific standards?
- What do you think about the proposed approach to scoring?
- Think about the different types of 'evidence' that might link to each standard. Can you make a list of relevant sources of evidence?

For all of these points, the groups worked on identifying relevant issues, rationalising the number of standards, clarifying language, simplifying the scoring system, and ideas for refining the tool. Web

designers, *shopcreator,* were commissioned to create the digital version of the tool, portable via tablets. An accessible, easy read version was also produced using *widgits* software; hovering over a word brings up a picture on the screen. The tool will be used by all services collaboratively benchmarking themselves on the 12 key areas monthly and inputting their data on to the online portal. The process by which the tool is used involves attribution of scoring in relation to specific standards and collection of supporting evidence; the latter then serves the collaborative goals of the network through sharing of evidence. There is also a strategic aim across the network to identify any gaps in provision, which then can be prioritised for action.

Aim of the study

This study aimed to evaluate the SeQuin benchmarking tool's development and implementation from the perspective of network participants who had been involved in both. This was to be accomplished using a participatory ethos, to complement the participatory practices of the network.

Methodology

We utilised two sources of data: field notes from attendance at network meetings and data collected at purposively arranged focus groups. It should be understood that the routinely organised network meetings would focus a portion of their time on discussion, debate and review of the benchmarking tool. As such, the tool itself must be understood as being subject to a process of continuing development and reflection on implementation. Iterations of the tool and distinct elements within it were thus designed and implemented in cycles over time. The field notes and focus group data thus offered the possibilities for both current and retrospective reflection and expression of viewpoint on an ongoing development process.

Our participatory ethos ensured this evaluation was conducted 'from within', with the support of academics who joined the group to understand and reflect upon their practices. In this way, the research was conducted in the context of a dialogue conducted in a shared language, within their usual setting and organisation arrangements. This approach is based upon a premise that 'only participatory research creates the conditions for practitioners, individually and collectively, to transform the conduct and consequences of their practice to meet the needs of changing times and circumstances' (Kemmis *et al*., 2014 p6). We locate this approach within a critical realist

epistemology (Potvin et al., 2010). Considered as service evaluation, full NHS ethics approval was not required but all steps were taken to ensure the study was undertaken ethically. Network participants were informed that researchers from the University of XXX would be attending the meetings for the purposes of the evaluation. Authors of this paper include individual participants from the development group, in line with principles of our overall participatory approach.

Participatory inquiry is ideal for drawing together the voices of those who have personal experience of the phenomenon in a collective way, enabling us to make sense of a complex endeavour. Participatory inquiry and action are intended to spark the imagination and enable people to think about things differently. In so doing, change is possible and can be realised in a way which is interactive, contextualised and creative (Allchin et al, 2020; Heron and Reason, 1997). Ongoing reflexivity enabled a consideration of our position within the group, and was vital to this evaluation where we shared in the involvement group's meetings (van Draanen 2017). Hence, field notes were made during the meetings to record observations and reflections and post event discussions took place on each occasion.

Three focus groups were convened alongside the service co-development days, to elicit the views of staff and service users. The audio recordings of the meetings with the development group, contemporaneous field notes and collations of flip chart activities from the larger network meetings were all collected as data. Recorded material was transcribed and thematically analysed by the 2 lead researchers (XX and XX), with reference to the wider team for agreement at each analytic stage. Following the approach of Braun and Clarke (2006), the analysis graduated through six stages: initial familiarization with the data, assigning preliminary codes felt to describe the content, seeking patterns or themes in the identified codes across the data set, reviewing themes, finalising, defining and naming themes, then writing up an account of the themes.

The three research focus group meetings were convened over a period of six months with key members of the benchmarking tool development group, including the network involvement leads (initials) and a member of clinical staff (initials) from one of the participating units, who took up an additional involvement lead role in the course of the project. There were a total number of 18 participants across the three focus groups. The purpose of these meetings was to elicit reflections on the development and early implementation process. Other feedback of this kind was drawn from two meetings of the whole involvement network (each meeting involving up to 80 services users and staff, the majority being service users) using facilitated small-group work. In between these meetings

the views of service users within the secure units were gathered during focused conversations initiated by the personnel most closely involved in the development working group (initials).

Four themes were identified which we have titled: *Taking time, taking care; The value not the label; An instrument of the network;* and, *All people working together*. These are discussed below in relation to recent theorising of co-production.

Taking time, taking care

Having time to devote to the development of progressive and innovatory practices was appreciated, along with the sense of importance that would flow from seeing time allocated to this. Thus, taking time over this work, taking care to get it right, was seen as a way of asserting its value, as can be seen in the field note below:

> *The facilitators are genuine in their commitment to offer time to participants undertaking work in small groups. This appears to be consistent across all of the tables. Feedback and dialogue with the whole group is shared between service users and staff. There is mutual encouragement to get messages across and stumbles are gently coaxed into a refinement of the idea or clarifications offered in supportive spirit.* [field note, network meeting]

Availability of time and consistency of relationships over periods of time has arguably been an important factor in supporting developments such as the design of the benchmarking tool and the wider development of involvement practices it is aimed at appraising. Participating service users and staff were thus aware of a lengthy history of cooperative alliances and coproduction across the Yorkshire and Humber network, even if these were not necessarily referred to in such terms:

> *We know what we are doing now because we have been at this for ages now*. [FG, staff 01]

Another interesting temporal dimension of this work was also a key challenge. Participants acknowledged there had been a process of evolution of relevant developments over a substantial

period. It was remarked that many of the people who started work on these involvement initiatives were not around anymore. Whilst there were certain staff continuities, similarly for some service users involved at the start of the process, many of the latter group hoped, indeed, that they *wouldn't* be around when the benchmarking tool was implemented. This was not surprising given the carceral environment and recognising service users would be on a recovery journey, hoping to be discharge to a step down or community level of support.

Within activities occurring across such timespans, development as an organic process was highlighted; developments not needing to rely upon individuals, although some individuals were identified as significant catalysts. Indeed, rather than seeing these individuals as leaders, the very philosophy of the collegiality, co-production and equality across contributors ensured that any sense of hierarchy was limited. People reported getting involved and making their own contribution because 'it felt right' rather than necessarily being influenced by policies or theories of coproduction. Individuals seen to be associated with the development activities were commended for 'creating the right conditions' for others to be involved rather than leading the agenda. Care was taken with facilitating discussions to engender a sense of safety to be involved and contribute. The group of contributors personified the features of the benchmarking tool, demonstrating authentic commitment to the goals and participants. A 'gentle and compassionate' position was taken, enabling those with past experiences of trauma to voice their opinion without fear of criticism.

Different people have different ideas about what's working well. The facilitation skills within the development work were felt to demonstrate empathy for participants with a commitment to make space for all to be involved and express their views. This was accomplished amidst a sense that nothing is rushed. Groupwork would be structured and organised to enable time to be thoroughly devoted to necessary tasks. Thus, the mechanisms for expression provide a route to inclusion, for example utilising small tables of workers and service users or creative approaches to expression and involvement. Taking care to include all voices in this way was seen as a contrast to some previous experiences for individuals who may have been excluded in other circumstances because they were not confident, articulate, or assertive.

The value not the label

There was a strong sense amongst staff and service users, especially those closely involved, of valuing the involvement practices. This sense of value translated into the expressed reasoning for establishing the benchmarking project; to meaningfully account for this worth. Across the region there was pride in various accomplishments of the network, and the feeling that these had been driven by recognition of implicit importance and mutual benefits, rather than for more instrumental reasons or paying lip service to policy prescriptions:

> *We were doing it because we felt it was the right thing. We do it because it feels right, we've always done it this way. Things have moved on a lot because we are now all working together rather than in isolation or working against each other.* [FG: Staff 03]

Wrapped up with this, for some, there was a rejection of some of the contemporary professional and policy language bound up with involvement practices. While the essence of the tool is about co-operation and co-production, there was scepticism of policy 'buzz words', which were felt to be of little use without a commitment to ideals and real evidence of action. For this participant, the coproduction concept, though available to make sense of achievements, had not been part of the participants' vocabulary when first instigating the work:

> *Words like coproduction come along, ends up explaining what is happening rather than prescribing.* [FG: Staff 01]

The extent to which the benchmarking initiative is valued can, however, be variable. Certain members of some Multi-disciplinary Teams were reported as asking:

> *is this [the benchmarking tool] in our contract? Is it mandatory? How does it sit within competing priorities? If we don't have to do it, we won't*. [FC: Staff 06]

Such views necessitated dialogue with NHSE, who were able to bring the use of the benchmarking tool into contracting discussions even though it is not formally in the contract. That said, it was reported that most services see the value of using the tool as a means of demonstrating good

practice, regardless of whether it is mandated. Indeed, the ability to evidence good practice was acknowledged as an important justification for the tool, aligned with broader commitments to quality assurance and not separate from overall contract compliance.

An instrument of the network

Participating staff and service users remarked upon the congruence between the content and aims of the benchmarking tool and the overarching aims and spirit of the involvement network. The benchmarking tool thus belonged to the network and its members and served their interests in the broader support of involvement practices. In this sense the tool was seen to serve the aims of the network and, as such, could be seen as an instrument of the network. This might especially be the case in supporting communication of successes across the network:

> *Individual to organisations, individual to individuals ….. requires tools, hence part of our mission* [FG: Staff 04]

Enmeshed with this view of instrumentality was an appreciation of benchmarking as a process, beyond simple consideration of the tool alone:

> *The tool is nothing on its own it is about how you use it. Not an end in itself, part of an ongoing process.* [FG: Staff 03]

There was something celebratory about participants' affinities for the benchmarking tool. Its creation by virtue of involvement practices and the process of benchmarking in action were both 'markers' of a more profound sense of progress or commemoration for people:

> *It celebrates where we are up to.* [FG: Staff 01]

In this sense, there is a certain symbolic expressiveness at play in the idea of this tool as a 'marker' of collective progress, and its actual function in marking service level progress, as a bench-marking instrument:

> *This is a marker of where we are now, there is a history to this, but if people invest in this then we can move so much further in the future if you see how far things have come already.* [FG: Staff 01]

Without necessarily contradicting the desires to celebrate successes to date, there is also a curiosity to define and understand 'what good looks like' which could be served by application of the tool. To this end, implicit in the benchmarking process is the gathering of supportive evidence that describes and accounts for changes, and renders them available for further dissemination across the network. Moreover, the tool can also contribute to other processes of quality appraisal and peer review, such as that mandated by the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services.

Certain strategic matters were remarked upon that assist in driving the involvement agenda. For example, an approach to 'buddying up' services for facilitating support and dialogue. Most notably, there is extensive appreciation for the peripatetic Involvement Leads, who operate to catalyse and disseminate new practices across all of the secure units in the region, and how the benchmarking tool can consolidate this:

> *We have always done it this way but there are pockets of good practice and this happening in certain places, but where there are dedicated involvement leads to help drive this practice and culture change this starts to change the culture and then involvement and co-production starts to happen organically. There will probably always need to be Involvement Lead roles, not to do the work but to ensure that everyone works together in a joined up way, the tool can help to do this by bringing some structure and focus and help people to drive the change that is important in a way that is done together and is measurable.* [FG: Staff 07]

The development of specific usable resources were a hook for further involvement practices and promoted 'choice for what works with people, relationships are then built around working on the resource, like *My Shared Pathway'* and the benchmarking tool.

All people working together

The character of working relationships were remarked upon by participants, with a particular appreciation for aspects of cooperation between the people involved. Staff responsible for facilitating involvement at unit level and also involved in developing the benchmarking tool remarked upon culture change in their unit such that it was now 'second nature to involve people'. The nature and quality of cooperation was seen to have evolved and strengthened over time, and its existence also seemed to indicate positive changes to identity, with implications for relationships and safety.

There was some complexity to participant reflections on identity. One of the regional involvement leads [XX] had previously worked as a nurse and used mental health services. Having such a dual identity was useful in facilitating service user groups, but also raised some dilemmas regarding appropriate circumstances for disclosure, particularly when 'to be or not be a nurse'. As an involvement lead in a particular low secure unit, XX had experience of developing that role from a point of minimal involvement practices within the service, echoed in this FG contribution:

> *Bringing the culture of the service from 'doing to' to 'working with' and bringing a fragmented culture to one of synergy. Interestingly, this also resulted in a reduction in conflict within the service, making it a more productive and proactive environment*. [FG: Staff 03]

Service users also recognised how more cooperative cultures affected a sense of personal safety, reinforcing the case for relational security. Thus, cooperative approaches become part of a panoply of efforts that may work to reduce conflict and render services more peaceful places. For this service user there is a positive impact on conflict which flows from mutual recognition:

> *Staff respect service users and in turn service users respect them and each other, there are less incidents than where I have been before and no arguments or fights, I feel safe here.* [FC: SU 09]

For certain service users active in the development of the benchmarking tool, this cooperation and recognition was an extension of wider working practices and culture perceived in their home secure unit, and contrasted with other experiences in the system:

> *In previous placements you were made to know who were staff and who were patients, a 'you're poorly, we're not' attitude! Here we are treated as an equal, we are all people and there is an understanding anyone can become ill at any time.* [FC: SU 12]

For many of the participants, co-production and co-operation becomes an antidote to previous experiences of a 'them and us' binary between service users and staff. As such divisive distinctions are dismantled more constructive relationships are possible and all parties become more assured in cooperative ways of working:

> *Things have moved a lot … we are now all people working together.* [FC: SU 05]

This also assists in a broader commitment to person centred care:

> *The importance of confidence to be able to act on what feels right and the tool will support the change that needs to happen across a variety of areas to treat everyone as an individual. Nurturing the essence of everyone involved to be able to contribute in their own way and come together to make the most of the collective voice.* [FG: Staff 01]

This sense of working together under a person-centred ethos has various important impacts, including for service users an authentic engagement with their individual personhood, as expressed in this biographical disclosure:

> *Your life before [hospital] is taken into account at* [name of unit]. *I* [had previously experienced working in mental health services] *before I was hospitalised, it is scary going from one side to the other having your rights taken away, I have lived both sides and it hasn't been ignored here like it has elsewhere. I'm treated as an individual.* [FC: SU 04]

Discussion

This study aimed to evaluate the SeQuin benchmarking tool's development and implementation using a participatory ethos, to complement the participatory practices of the network. The descriptive account of experiences in the development of a unique benchmarking tool shows how coproduction can be done organically, even without recourse to relevant theories or policy or adoption of specific terminology. In the view of participants, the development of this benchmarking tool has been an important extension of a wider history of developing involvement practices, in turn supported by an established network. Clearly, the findings have captured an example of good practice and pride in service delivery as regards both the involvement network and the dissemination of involvement practices into services. Furthermore, the participatory process of creating the tool itself reflected an ethos of involvement and the founding principles of the network. In the earlier evaluation of the work of the network, the innovatory work was referred to under a nomenclature of 'involvement practices' (Author ref). Yet, to some extent, this was a misnomer, as the team on the ground responsible for initiating these developments preferred not to frame their work in terms of service user involvement, preferring instead a notion of joint development work in an alliance-based process of co-creation between service users and staff. Similarly, despite the recent vogue for a lexicon of co-production, the Yorkshire and Humber network participants did not rely on this term. They do, however, recognise value in the concept and to some extent see vindication of their initial defence of a co-creative approach.

The work of the wider Involvement Network has highlighted the importance of different types of space within secure care services. Involvement practices appear to thrive in spaces that have a distinct relational character. Participants engaged in developing the benchmarking tool offered various insights into aspects of identity and interpersonal relations that flowed from this involvement and could be contrasted with other, more negative, experiences within secure care settings. This ties in with creative attention to the processes by which relationships between

participants are rendered more equal and democratic. Such considerations clearly chime in with a recovery-oriented ethos of practice and represent something of an anti-dote to the sort of 'them and us' cultures that have been noted in certain secure and mainstream mental health settings (Lelliott and Quirk, 2004; Verbeke *et al*., 2019) and were explicitly remarked upon here. Such 'them and us' thinking can bound up with processes of othering (Author ref; Corfee *et al*., 2020). In a context of othering, individuals become thought about as distinctly different from an idealised view of self, and this can adversely affect relationships in care services and extend stigma (MacCallum, 2002; Peternelj-Taylor, 2004).

In contrast, there was a sense amongst participants that improved relationships offered a means to communicate mutual respect and recognition. Participants also suggested that under these circumstances relational conflict might be minimised and, hence, safety and security improved. An important recent development in mental health care has been a focus on trauma informed care, which can offer a less contentious, more consensual basis for service provision and therapeutic engagement that arguably cannot proceed without respect for service user voice (Proctor *et al*., 2017; Sweeney *et al*., 2018). Ultimately, democratising the spaces of secure mental health care arguably engenders potential for greater safety through minimising risk, with greater degrees of involvement compatible with an increasing emphasis upon relational models of security (Department of Health, 2010; MacInnes *et al*., 2014). Optimising safety is clearly something that staff and service users have a mutual interest in and increasing the extent that service users take personal responsibility for risk and safety is a key goal of secure care; helping make the case for extending and evaluating involvement practices.

Key commentators such as Albert Dzur (2019) have noted wider ranging successes of co-production approaches in seemingly unpropitious settings, including mental health care where power imbalances between participating stakeholders can pose serious challenges to democratisation ideals. In this regard, the forensic mental health context might be supposed to be somewhat inhospitable to supporting co-production (Chandley and AB, 2022) yet the Yorkshire and Humber network have shown such developments to be both possible and valued. Indeed, the reflections of participants in this study appears to exemplify quite sophisticated democracy. The acknowledged notion of taking time and care resonates with Marian Barnes' (2008) identification of care-full deliberation as an ideal of democratic communication within disability movements and transferable to dialogue within and about services. The coproduced involvement practices that the tool

appraises, along with the coproduction of the tool and its deployment, resonates with recent thinking about procedural justice within forensic services. The perception that systems are fair is implicated in the act of being democratically involved. This can mitigate the detriment to therapeutic relations often experienced within mental health care environments seemingly defined by aspects of coercion, which may be more evident in forensic environments. Procedurally just processes and relationships are characterised by, amongst other things, 'fairness, patient inclusion in the process, and benevolence on the part of authority figures' (Galon and Wineman, 2010 p307); all of which are apparent in the relational turn of these involvement practices.

The creative approaches to involvement and inclusion evident in the processes underpinning the development of the benchmarking tool and the wider working of the network resonate with other fields of knowledge development and inquiry such as participatory action research (Boog, 2003) or Appreciative Inquiry (Cooperrider and Srivastva, 2017). Hence, participants demonstrate a capacity for creativity that often belies previously experienced denigration of their capabilities, stigma and low self-esteem, necessitating a renegotiation of positive identity (Coffey, 2012). Perhaps at some sort of fundamental level this stress on the relational and democratic aspects of practice connects with a deeper understanding of humanity and human development (Haigh and Benefield, 2019). Indeed, the history of mental health care is replete with a litany of approaches that have variously emphasised relational, democratic, and cooperative ideals, such as therapeutic communities, or denied them within overly oppressive restrictive regimes. Negative aspects of restrictive environments and their amelioration arguably go beyond consideration of the more obvious exemplars, such as seclusion, restraint and forced medication (Tomlin *et al*., 2020).

Conclusion

Original and novel methods of co-production have been described, where off-site creative workshops enabled a unique approach. For staff and service users involved with the initiative there were two distinct perceptions of value. First, the involvement practices associated with creating the tool, its implementation, and the wider practices it is designed to appraise are felt to be beneficial at various levels within secure care services. Not least of this impact is the improvement of relationships between staff and service users and a sense that this in turn has a progressive impact upon conflict and risk. Second, the tool itself offers an opportunity to systematically demonstrate the worth of these wider efforts to enact involvement. The location of this work within a networked

system of secure units shows how ideals of coproduction and collaboration can extend to the relationships between different services, within both NHS and independent sector: a triumph of cooperation over competition.

Implications for practice

Several recommendations can be made based on this study; these are:

- The benchmarking tool provides a readymade mechanism to appraise quality
- The adoption of participatory process enhances involvement to promotes co-produced strategies and standards for practice.
- Staff and service users can work together effectively as cooperation leads to enhanced quality.
- Utilisation of environments with relational security characteristics promotes positive involvement practices and erodes 'them and us' cultures to the benefit of each other and overall forensic services.
- The use of creative, dynamic and visual approaches enables inclusive involvement, personal value and understanding.
- Involvement practices described here are transferable to other secure services nationally.
- Results of using the benchmarking tool have potential for digital open access perhaps, for example, allowing for friends and family to concur or disagree with services' ratings.
- The devolution of commissioning to provider collaboratives are compatible with the networked cooperation amongst services demonstrated here.
- Arguably, greater involvement of service users within their own care is congruent with enhancements to personal responsibility and, potentially, risk minimisation; a desirable set of outcomes for services and society at large.

Acknowledgement

We would like to express our appreciation for all the service users and staff who contributed to the development of the benchmarking tool and to InMind Ltd for providing funds to take the project forward.

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