NATIONAL
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Safety in Mental Health Settings Project Evaluation

Final report

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a www.rcpsych.ac.uk/improving-care/nccmh/improving-care/nccmh/reports-and-research/evaluation-of-simhs-training-programme

Abbreviations

LEAD	Leadership Exploration and Development
NCCMH	National Collaborating Centre for Mental Health
NoMAD	Normalisation MeAsure Development
PICU	Psychiatric intensive care unit
SiMHS	Safety in Mental Health Settings
STA	See Think Act
UCL	University College London

1. Executive summary

1.1 Background

This report presents the method and findings from the evaluation of the Safety in Mental Health Settings (SiMHS) project. The components of the SiMHS project that were evaluated comprise a See Think Act (STA) facilitator training programme, a leadership training programme called Leadership Exploration and Development (LEAD) Safely and a community of practice. The evaluation was carried out by the National Collaborating Centre for Mental Health (NCCMH).

1.2 Method

The evaluation was structured using the Kirkpatrick model[b], and was carried out using tools such as questionnaires, a knowledge test and one-to-one interviews.

1.3 Key findings

Overall:

- Both the STA facilitator and LEAD Safely training programmes were viewed positively, with participants enjoying the group format and teaching styles of the trainers.
- There was an indication that the LEAD Safely training programme was most beneficial for people who actively sought to engage with it rather than those who had been 'pre-selected'.
- There was some uncertainty about the suitability of the length and intensity of the LEAD Safely training programme. This could be addressed by:
  - developing the training for staff who are not familiar with the topics covered and spreading it out over a longer period of time or
  - delivering the training at separate times to different staff groups according to their level of knowledge and experience of topics covered.

b www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model

Confidence, understanding and knowledge:

- The STA facilitator training programme increased trainees' confidence in understanding and using the STA framework, and improved their knowledge of the STA framework concepts.

Leadership skills and experiences on wards:

- There was a self-reported improvement in leadership skills and, subsequently, improvement in ward culture for staff teams following the LEAD Safely training programme.
- There were also reports of improved experiences on wards for inpatients, and of an increased use of trauma-informed approaches following the LEAD Safely training programme.
- There was also some evidence that approaches associated with trauma-informed care had been used by STA facilitator training participants.

Lived experience input:

- Facilitation of the training programmes by experts with lived experience had been a positive experience for the majority of attendees.
- The opportunity to facilitate the training programmes was also a positive experience for experts with lived experience.

Implementing the training:

- There was a noticeable commitment from trainees to adopt the concepts learnt in their day-to-day roles and implement the principles on their wards or in their services, with clear implementation plans made.
- There was general consensus among the trainees that being good role models for other staff and contributing to culture change on the wards were important first steps in implementing the training.
- There was evidence of some sustainable implementation of the training content on wards, although there were wider concerns about resources and skills.

- There was a call from the trainees for more staff from the same organisation, both staff working on the wards and team leaders, to attend the training to make implementation easier and to increase skills more widely in psychological safety, the STA framework and trauma-informed care.
- Reports that staff attitudes and networking have an important impact on implementation suggest that an important consideration may be the interface between the LEAD Safely and STA facilitator training programmes, and how people trained on either course can learn from and support each other to improve ward culture.

Maintaining learning:

- The importance of maintaining the learning was emphasised by trainees, with follow-up and refresher courses being suggested.

Community of practice:

- This forum provided a useful and easy way to share learning and experiences with others, and build a network.
- There was some indication that it was not being utilised by everyone who had attended the training.

2. Background

2.1 The SiMHS project

The aim of the SiMHS project is to address issues of violence and aggression in adult acute mental health care wards and psychiatric intensive care units (PICUs) across London by developing staff capability, skills and confidence. It is also anticipated that this project will help improve staff morale, strengthen staff recruitment and retention, and improve patients' experiences of acute mental health care services.

From 2019–20, the SiMHS project team undertook investigatory work and also piloted the application of the STA framework for relational security[1] in a number of acute mental health care and PICU wards in London. This successful pilot led to the project acquiring more funding for 2021–22 and developing a programme of work, the key deliverables of which are summarised in the box in Section 2.2.

The SiMHS project was established in 2019 by the London Cavendish Square Group of all London mental health trusts and funded by NHS England and Improvement and Health Education England. The project is led by a steering group. There is more information about the project on the Cavendish Square Group website[c].

2.2 Key deliverables in 2021–22 for the SiMHS project

The key deliverables for this period included:

1. A pan-London roll-out of the STA framework in acute mental health care and PICU services through the STA framework facilitator training programme, with an associated acute care STA framework toolkit.
2. Developing and disseminating a trauma-informed approach position statement to achieve a common understanding across London, and establishing support for trusts in adopting a trauma-informed approach and measuring progress.
3. Identifying, mapping out and describing how the STA framework and a trauma-informed approach are interconnected and make an important contribution to safer care as part of an integrated approach to strengthening safety culture on wards, and providing an integrated leadership for safety programme (LEAD Safely).

c www.cavendishsquaregroup.co.uk/safety-in-acute-mental-health-settings

4. Establishing and taking forward an acute care community of practice with trusts and key partners[d] to support standardising practice and transferable skills related to safer care, including frontline clinical staff and experts by experience.
5. Undertaking an independent evaluation of the key elements (above) required to embed a safety culture in acute mental health care environments.

The fifth deliverable is the subject of this evaluation, which was conducted by the NCCMH, in consultation with the NCCMH Equality Advisory Group and the Expert Reference Group (see Section 8).

2.3 Commissioning and funding of this evaluation

The Tavistock and Portman Foundation Trust commissioned this evaluation of the SiMHS project on behalf of the Cavendish Square Director of Nursing Group. The Cavendish Square Director of Nursing Group are leading the SiMHS project. Project funding is from Health Education England, NHS England and NHS Improvement.

d These include the London Psychological Professions Network, the London Academic Health Science patient safety networks and the Royal College of Psychiatrists.

3. Objective and aims of the evaluation

3.1 Overall objective

The overall objective of this evaluation is to understand the impact of the SiMHS project interventions on safety and culture changes in adult acute mental health care wards and PICUs. These interventions included: (a) the STA facilitator training programme, (b) the LEAD Safely training programme and (c) the acute care community of practice.

3.2 Evaluation aims

The broad aims of the evaluation are to assess the:

- experience, and effectiveness, of the STA facilitator training programme
- experience, and effectiveness, of the LEAD Safely programme
- experience, and effectiveness, of the community of practice
- impact of working towards a common understanding and commitment to a trauma-informed approach
- overall impact of the programme on safety culture changes in acute mental health care wards and PICUs that are participating in the programme, both from the perspective of frontline clinical staff and that of service users.

Relational security: *'the knowledge and understanding we have of a patient and of the environment, and the translation of that information into appropriate responses and care'*.

3.3 Overview of the components of the SiMHS project

3.3.1. STA facilitator training programme

The aim of the STA facilitator training programme was to provide people with knowledge and skills around the STA framework for relational security.

Some of the key learning objectives of the training included:

- Familiarity with the learning and practice outcomes desirable for staff at all levels in mental health trusts.
- A clear understanding of the breadth of relational security within the wider organisational strategy and the opportunities to deliver connected strategies (either fully or in part) through the application of strong relational security approaches.
- Confidence to facilitate discussions with staff at all levels on the domains covered by the model.
- The ability to empower staff to create safe environments by taking considered therapeutic judgements.

3.3.2. LEAD Safely training programme

The stated aim of the LEAD Safely training programme was to 'provide a leadership development programme focused on safety improvement'.

It was also designed to provide a 'safe and brave space' for participants to 'share challenges and share learning', 'build their confidence as leaders', 'reflect on their leadership styles and behaviours', and 'put experts by experience at the heart of delivery'.

The intended learning outcomes covered the following topics:

- **Just culture** – To develop leaders whose values, attitudes and behaviours create a safety culture where ward staff, service users and their carers feel confident to escalate concerns, speak up and ask for support, knowing what is communicated will be listened to and acted on.
- **Inclusive leadership** – To develop leaders who are inclusive and who actively seek to address inequalities, striving to ensure all service users and staff are treated fairly and with respect, compassion, civility and transparency.
- **Leading for improvement** – To develop leaders who apply systems thinking, human factors, quality improvement and co-design approaches to continuously improve safety.
- **Being trauma-informed and proactive** – To develop leaders who role model leadership behaviours that reflect trauma-informed values and understand how to lead the implementation of the STA framework in adult acute mental health care wards and in PICUs.

3.3.3. The community of practice

Communities of practice are 'self-organising and self-governing groups of people who share a passion for their field and strive, through collaboration, to become better practitioners'; these communities are often cross-professional and cross-organisational and 'have an established place in improvement work', enabling professionals to explore complex issues that cut across professions and organisations.[1]

The aims of the community of practice for the SiMHS project were to: (a) support standardising practice and transferable skills related to safer care, and (b) to provide a space in which acute care clinical staff and experts by experience, as well as key partners, could share learning and positive practice. This was delivered by stand-alone events and via the FutureNHS Collaboration Platform.

3.3.4. Timeline of the training programme, community of practice and the evaluation

The STA facilitator training programme was delivered in two cohorts in May and September 2022, and the LEAD Safely training programme was delivered to one cohort between March and June 2022. The community of practice was established in March 2022.

The evaluation tools were developed between January and March 2022, and administered before and after each training cohort, and before and after the community of practice was established.

4. Evaluation method

4.1 Kirkpatrick model

The evaluation was structured using the Kirkpatrick model,[e] [2] which was the model that the SiMHS project steering group chose because it is a commonly used and tested evaluation method for training interventions.

The Kirkpatrick model follows four levels of training evaluation: (1) reaction, (2) learning, (3) behaviour and (4) results. This evaluation looked at levels 1–3.

4.2 Level 1: Reaction

This level of the Kirkpatrick model assesses the participants' experience of the training received, including if they found it engaging, how relevant the training was to their jobs and the extent to which the community of practice has helped support this.

4.2.1. Evaluation questions

- What are the experiences of staff attending the STA facilitator training programme?
- What are the experiences of staff attending the LEAD Safely training programme?
- What are the experiences of lived experience facilitators involved in delivering the training?
- What are the experiences of members of the community of practice?

4.2.2. Method

Questionnaires were used to obtain feedback from participants attending the STA facilitator or LEAD Safely training programmes, and from members of the community of practice, about their experiences. These questionnaires were co-designed with lived experience advisers (copies of the questionnaires can be found in Appendices 1.1 and 1.2).

The questionnaires used Likert scales and free-text boxes. Questions covered basic demographic and job role information, previous experience with concepts covered in the training, staff perspectives of the training and its relevance for their jobs. Trainees were also asked about the most and least useful aspects of the training. The results of the questionnaires are presented using summary statistics and descriptions of free-text responses with accompanying quotes.

e www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model

Both the STA facilitator and LEAD Safely training programmes benefited from facilitation from lived experience facilitators who assisted with programme delivery alongside a programme lead. Three of these lived experience facilitators participated in semi-structured interviews to give a different perspective on reaction to the STA facilitator and LEAD Safely training programmes, including on their experience of co-facilitating the training and their thoughts on the training programmes overall. The key points from the interviews are summarised.

4.3 Level 2: Learning

The learning level of the Kirkpatrick model considers to what extent participants have acquired new knowledge and skills as a result of the training, as well as their attitude, confidence and commitment to applying this new knowledge to their job roles.

4.3.1. Evaluation questions

- What is the effectiveness of the LEAD Safely training programme?
- What is the effectiveness of the STA facilitator training programme?

4.3.2. Method

Questionnaires were also used to understand the effectiveness of the training programmes in understanding how participants' learning improved after training. A knowledge test was developed by the NCCMH project team (see Section 8) and completed before and after the STA facilitator and LEAD Safely training programmes (see the pre- and post-training questionnaires in Appendices 1.1 and 1.2, respectively, for the knowledge tests). The questions were multiple choice, and tailored to the learning objectives and content of the training sessions. In addition, questions using a Likert scale explored participants' attitudes, confidence and commitment to using the knowledge acquired during training in their job roles. The results were interpreted by the research team and are presented using descriptive statistics (see Sections 4.2 and 4.3).

4.4 Level 3: Behaviour

This level of the Kirkpatrick model determines whether participants who attended the training have applied their new knowledge to their work.

4.4.1. Evaluation question

What has been the impact of the SiMHS project on achieving a common understanding and commitment to a trauma-informed approach?

What has been the impact of establishing a community of practice on supporting standardising practice and transferable skills related to safer care?

4.4.2. Method

Individual interviews with members of staff (ward-based staff, managers and leaders) from participating acute care and PICU wards were conducted to explore participants' understanding and commitment to a trauma-informed approach as an outcome of the training provided. The interviews also explored how staff have applied the training to their work, and the potential barriers and facilitators faced when applying the training and the STA framework to their work. The interview questions (see Appendix 2) were co-developed with the lived experience advisers and reflected the training programme content. The key themes were identified by the evaluation project team and discussed with the lived experience advisers.

Staff who attended the training sessions were also asked to complete the Normalisation MeAsure Development (NoMAD)[f] [3 4] questionnaire, to explore how the STA framework had impacted on their work and their expectations for it becoming a routine part of practice. This instrument consists of 23 items based on normalisation process theory.[3 4] This posits that working collectively is the best way to integrate new practice, and that implementing such practices is a continuous process that is highly influenced by contextual factors. The four constructs of normalisation process theory are used to structure investigations of staff participation in the implementation process within the NoMAD questionnaire. These are:[5]

1. **Coherence**, which facilitates 'sense-making' of the training
2. **Cognitive participation**, which captures how invested and committed training participants might be in promoting use of what they have learnt in practice
3. **Collective action**, which refers to the actions taken by the training participants to promote (or inhibit) the use of the STA framework and related learnings
4. **Reflexive monitoring**, which highlights the extent to which people assess the effects of the new practice, appraise how it is working and update their practice accordingly.

Responses to questions are described according to these constructs and used to draw conclusions regarding the sustainability of the training outcomes.

4.5 Questionnaire responses and analyses

Although a general group change in responses can be observed and reported, people's responses could not be individually matched because the questionnaires were anonymised.

An incentive (entry into to a raffle draw with the prize of a £50 shopping voucher) was offered to encourage completion of questionnaires.

f https://implementationoutcomerepository.org/implementation-outcomes/sustainability/normalisation-measure-development-questionnaire-nomad

5. Findings: 1. Reaction and 2. Learning

5.1 The questionnaires and knowledge test

Questionnaires, which included a knowledge test, were administered before and after the STA facilitator and LEAD Safely training. A questionnaire was also sent to all participants of the training programme about the community of practice; this was administered before and after the community of practice was established. We aimed to incorporate the views of as many training participants as possible and therefore did not purposively sample according to any particular role, experience or demographic characteristic. Copies of the questionnaires, as well as demographic and occupational information for the respondents of each questionnaire, can be found in Appendices 1.1, 1.2 and 1.3.

For the reaction level, the questionnaires were used to understand trainees' experiences of the STA facilitator and LEAD Safely training programmes, and the community of practice.

For the learning level, the questionnaires were also used to understand the effectiveness of the training programmes in understanding how trainees' learning improved after training.

5.2 STA facilitator training programme

Forty-nine participants (including 29 from cohort 1 and 20 from cohorts 2 and 3) responded to the pre-training questionnaire and 25 responded to the post-training questionnaire (including 13 from cohort 1 and 12 from cohorts 2 and 3). The questionnaires can be found in Appendix 1.1.

5.2.1. Respondents' previous experience of the STA framework

Thirty-one (63%) respondents to the questionnaire did not have any previous experience of the STA framework, leaving 18 (35%) with previous experience.

Responses showed that several respondents had been introduced to the principles of the STA framework through inductions or training provided by their workplace, discussions with colleagues or had encountered some elements of the STA framework through their day-to-day work. Some respondents had also attended introductory STA training sessions and others had been trained as facilitators to deliver the training.

Examples of respondents' previous experiences of the STA framework are presented in Table 1.

Table 1: Previous experiences of the STA framework

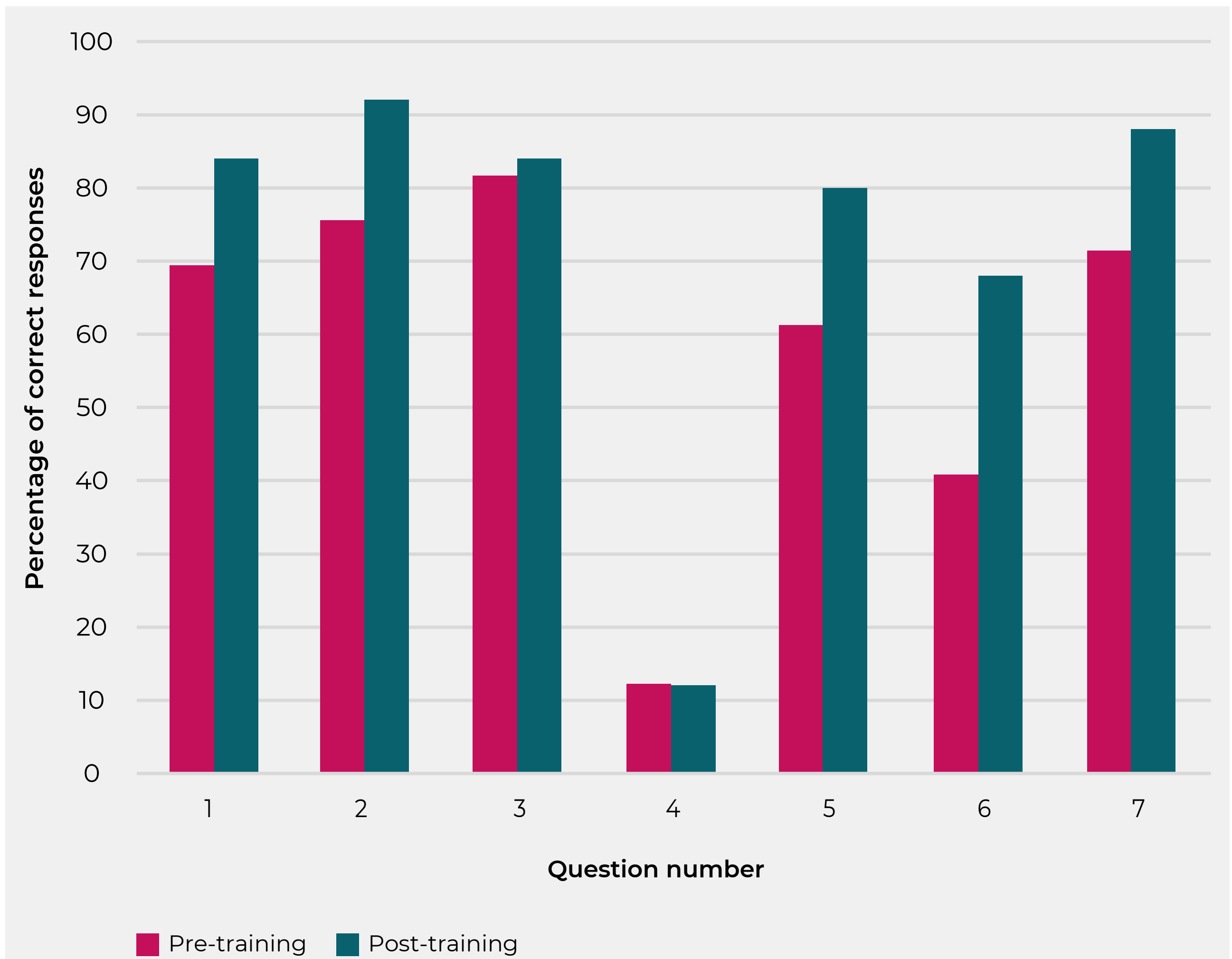
Theme	Responses
Encountered through work/work training/ colleagues	"Had some experience when working in a medium secure setting, however not received any official training for the framework. No current experience in acute setting." "Was introduced See Think Act relational security, as part of my induction, when I started working in [a] CAMHS [child and adolescent mental health services] unit." "I've been introduced to the principles by a colleague and have had the chance to look through the development workbook." "I have discussed with my colleagues but haven't actually used it in practice before." "Introduced to STA framework by one of the current facilitators." "It was introduced to the [name of hospital] slightly over a year now." "I have received in-house training in STA some years ago and also cover this in my current trust within our Search and Security Training." "I attended a half-day training regarding STA principles. We also utilise it regularly on our LSU [low secure unit] ward during security meetings and handover." "Introductory and leadership day within the trust provided for the ward. As part of the trust we have started to roll out aspects of relational security looking at patient mix and have reviewed handover to include each aspect of relational security." "The See Think Act framework is currently used in my place of work (low secure forensic) during security meetings, safety huddles and other handover meetings."

Introductory STA session/ STA experience	"Attended a session on See Think Act earlier this year to introduce the programme." "I have attended a training session back in 2019. We have implemented several change ideas based on the See Think Act framework and have adapted our team Reflective Practice to ensure the team reflect on the elements as a core functioning of the team." "I have had training on STA and starting to roll it out." "I helped to co-facilitate the last cohort of See Think Act in May 2022."
Personal research	"General reading about the topic in my personal time however no direct learning or training from this." "Self-exploration of the 'yellow book' to share with [the multidisciplinary team] the importance of relational security in therapeutic work."

5.2.2. Knowledge of relational security: comparison of pre- and post-training responses

In the knowledge test, we asked a series of questions about relational security. The percentages of correct responses to these questions are presented in Figure 1. The questionnaire containing the knowledge test can be found in Appendices 1.1.1. and 1.1.2.

Figure 1: STA training responses to questions about relational security[g]



Question 1. Which of the following statements are TRUE about relational security?

Question 2. Which of the following statements are TRUE about how you can improve relational security on the ward in the context of setting boundaries on the ward?

Question 3. Which of the following statements are NOT true about how you can improve relational security on the ward in the context of therapy (select all that apply)?

Question 4. Which of the following statements are NOT true about how you can improve relational security on the ward in the context of patient mix and dynamic (select all that apply)?

Question 5. Which of the following statements are TRUE about how you can improve relational security on the ward in the context of a patient's personal and physical environment?

Question 6. Which of the following statements are NOT true about how you can improve relational security on the ward in the context of patients' visitors?

Question 7. Which of the following statements are NOT true about how you can improve relational security on the ward in the context of patients' outward connections?

g Percentages have been rounded to the nearest whole number.

Overall, there was an increase in the percentage of correct responses to the knowledge questions post-training. The exception to this was question 4, correct responses to which remained low before and after training. This could be explained by the fact that this question required two correct responses.[h] However, similarly worded questions (for example, question 6) did not produce this result. No definitive conclusions can be drawn, although this may indicate that respondents might have needed more clarification during the training about factors that do not help to improve relational security (in the context of patient mix and dynamics).

Furthermore, no conclusions can be made as to whether changes in knowledge were significant because statistical tests could not be conducted (see Section 4.5).

5.2.3. Understanding, confidence and experience with the topics covered: comparison of pre- and post-training responses

In the pre- and post-training questionnaires (see Appendix 1.1), we asked the training participants to rate a series of statements about the course objectives and their understanding of, and experience and confidence in, the relevant topics.

Overall, confidence levels in the topics increased after the STA facilitator training programme (see Figure 2 for pre-training responses and Figure 3 for post-training responses).

h Correct responses: '*Continuity of care is very important and patients should not be moved from one clinical area to another*' **and** '*Staff should not act on their suspicions that patients are acting in a subversive way until completely sure*'.
Incorrect responses: '*Understanding what is really happening on the ward may rely on gathering information from outside of the clinical team*' **and** '*all of the above*'.

Figure 2: Understanding, confidence and experience with the topics covered (pre-training responses)[g]

Ability to plan creative, flexible, and inspiring sessions with individuals or teams on a formal or informal basis, on strategies for improving relational security.

Ability to empower staff to create safe environments by taking considered therapeutic judgements.

Confidence to facilitate discussions with staff at all levels on subjects covered by the See Think Act Relational Security Framework.

Ability to consider and utilise the opportunities for co-design and co-delivery of relational security strategies with other experts

Confidence to use the See Think Act Relational Security Framework resource in the organisation where you work.

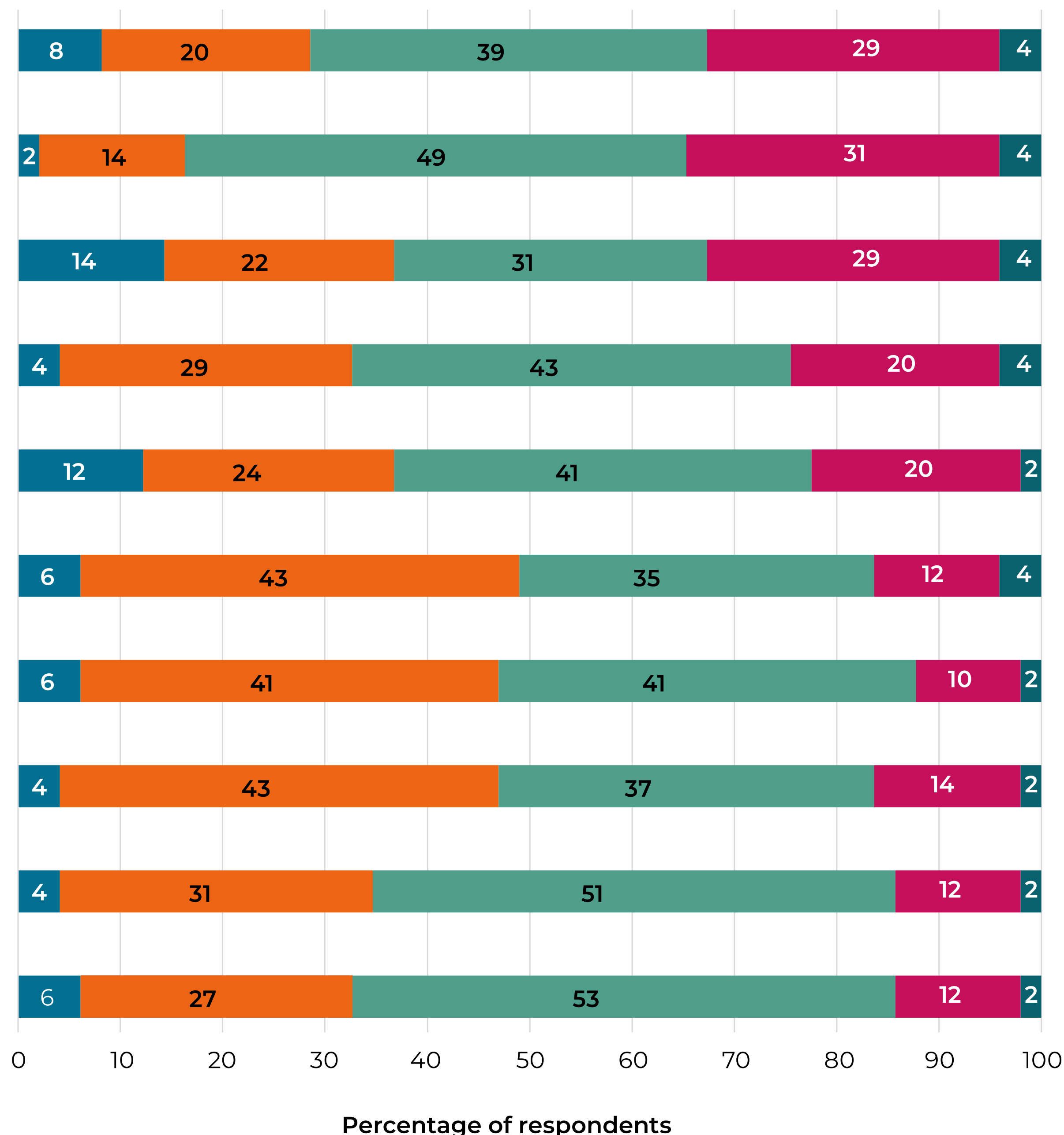
Familiarity with the See Think Act Relational Security Framework resource.

Understanding of opportunities to deliver connected strategies (either fully or in part) through the application of strong relational security approaches.

Understanding of the breadth of relational security within the wider organisational strategy.

Familiarity with the learning and practice outcomes.

Knowledge of the See Think Act Relational Security Framework.



Very Low | Low | Average | High | Very high

Figure 3: Understanding, confidence and experience with the topics covered (post-training responses)[g]

Ability to plan creative, flexible, and inspiring sessions with individuals or teams on a formal or informal basis, on strategies for improving relational security.

Ability to empower staff to create safe environments by taking considered therapeutic judgements.

Confidence to facilitate discussions with staff at all levels on subjects covered by the See Think Act Relational Security Framework.

Ability to consider and utilise the opportunities for co-design and co-delivery of relational security strategies with other experts

Confidence to use the See Think Act Relational Security Framework resource in the organisation where you work.

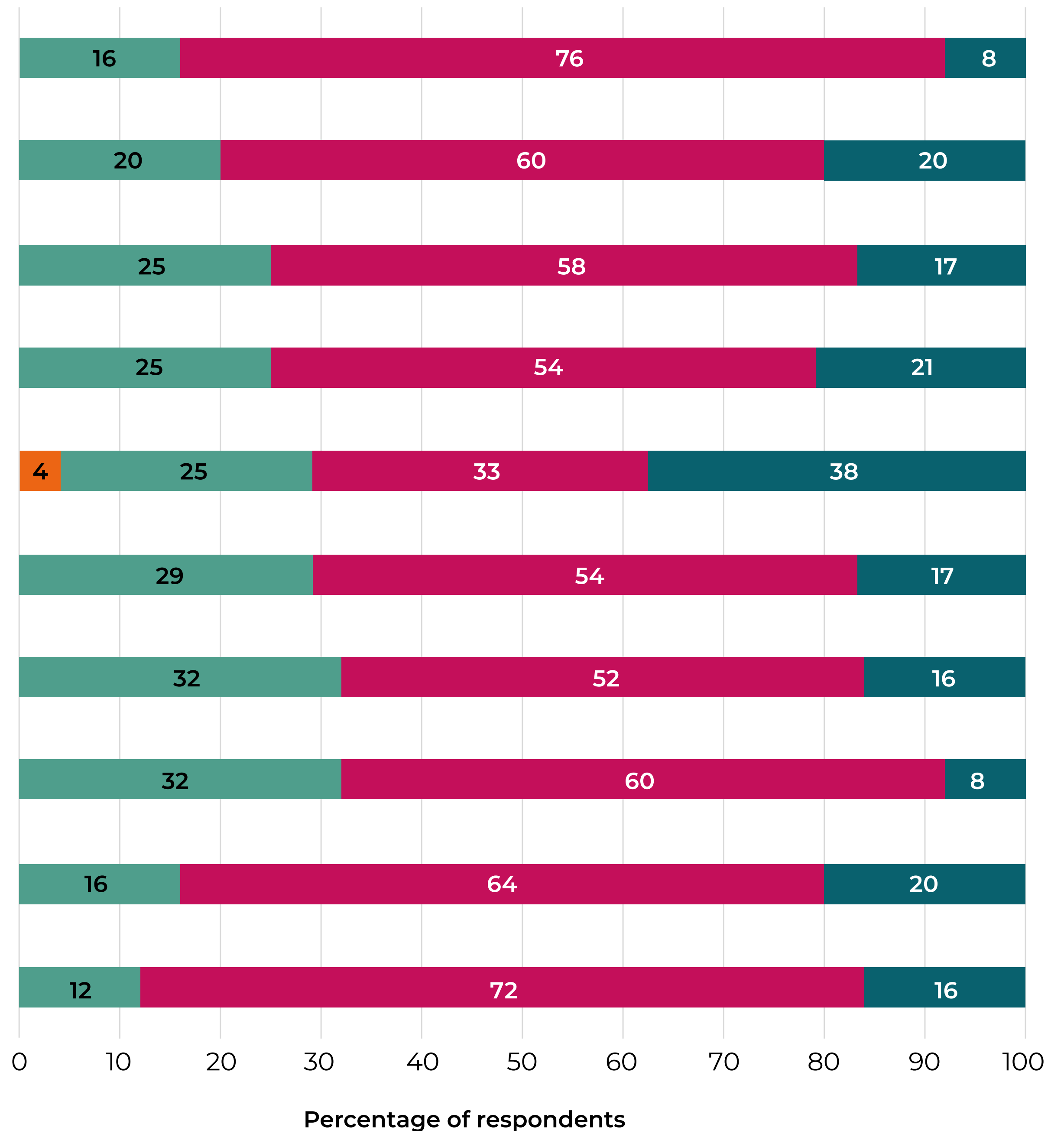
Familiarity with the See Think Act Relational Security Framework resource.

Understanding of opportunities to deliver connected strategies (either fully or in part) through the application of strong relational security approaches.

Understanding of the breadth of relational security within the wider organisational strategy.

Familiarity with the learning and practice outcomes.

Knowledge of the See Think Act Relational Security Framework.

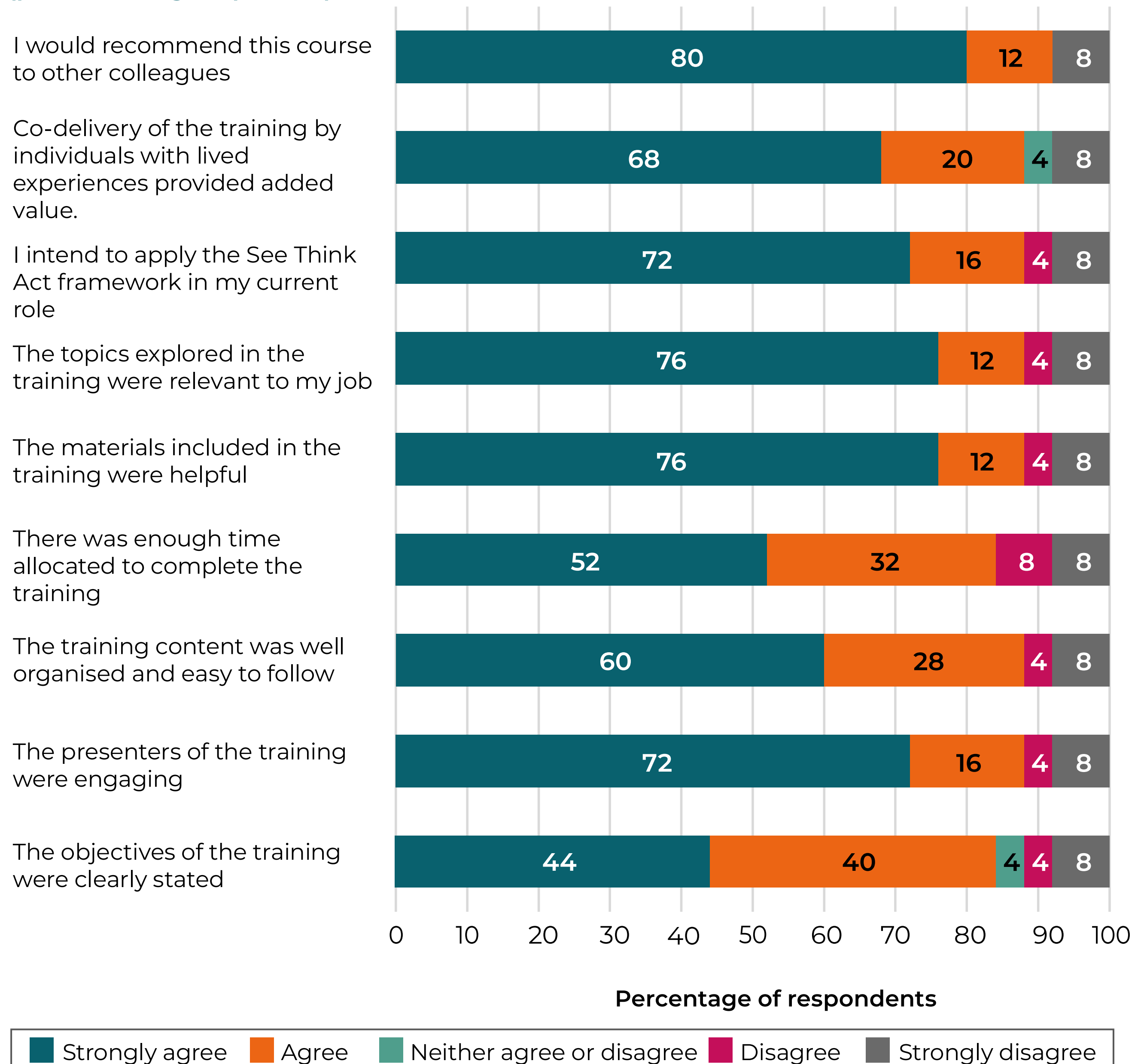


Very Low ■ Low ■ Average ■ High ■ Very high ■

5.2.4. Clarity of training objectives and likelihood to recommend the training: post-training responses

Following the training, most respondents strongly agreed or agreed that the training objectives were clearly stated, that the training was helpful and well-run, and that they would recommend the course to other colleagues (see Figure 4).

Figure 4: Clarity of training objectives and likelihood to recommend the training (post-training responses)[g]



5.2.5. Expectations about the training and plans for implementing knowledge and skills gained

Respondents could describe in free-text boxes what they expected to gain from the STA training. In both the pre- and post-training questionnaire, training participants were asked how they planned to implement the knowledge and skills they had gained.

Expectations about the training

Before the training, respondents expected to learn ways to reduce violence, aggression and use of restrictive practice, to create a safer environment for staff and patients. Most respondents expected to increase their knowledge of elements of the STA framework, including relational security, and be equipped to deliver training on the STA framework. This reflects the desire of people who work in mental health settings to be better informed so that they can create a safer working environment through relevant training and tools. Respondents also anticipated that the training would increase their confidence in using the STA framework, giving them the ability to empower and support other colleagues and team members by using it through training, and improve the quality of care they provide.

Plans to use the STA framework in their current role before training

Before the training, respondents had quite clear ideas about how they would use the knowledge gained and the STA framework in their role. The most common ideas were about plans to implement and roll out the training, sharing knowledge and increasing awareness of STA principles more widely, and supporting and empowering staff to use the STA framework. Respondents also mentioned improving services, safety culture and patient experience, quality improvement and expert by experience input.

Examples of respondents' plans to use the STA framework in their current role, before training, are presented in Table 2.

Table 2: Plans to use the STA framework (pre-training responses)

Theme	Responses
Plans to implement the STA framework and roll out the training on the ward/in teams	"To implement throughout practice on the ward and provide training and support for junior staff to do the same." "Plan to roll out to my wider team through away days etc." "What I learn I hope to share when I co-deliver relational security training." "To take this back to my team and plan training." "Utilise it daily in the ward environment."

Theme	Responses
	"The aim will be to skill up other staff throughout the ward team to ensure a consistent and safe response to relational security incidents, issues and difficulties. Training sessions and improved induction sessions will be delivered." "Develop strategy for wards which includes a training package and roll it out." "To use this in our local inductions and also to include as part of our debriefing sessions." "Train and develop staff." "To facilitate the training to staff." "To help with the roll-out of See Think Act framework in improving relational security within the ward environment." "Use framework resource to put relational security plans in place within my unit." "To inculcate into daily safety huddle meetings, weekly debrief meetings and discuss in supervisions."
Sharing knowledge and increasing awareness of STA principles	"To share my knowledge with other ward managers and across my directorate structure." "Working on an acute ward requires vigilance in order to keep all patients and staff safe. I intend to use relational security to ensure same by making sure all colleagues are aware of same." "I am hopeful that attending this course, it will broaden my knowledge and skill which can be incorporated into the security and search training to educate staff as well as supporting clinically in improving safety on our wards." "To develop and improve staff knowledge." "I hope to use what I learn to cascade to the team and wards at our hospital." "To transfer the knowledge from this training to my colleagues." "Get a better understanding of the See Think Act framework in order to cascade information to colleagues. Raise awareness during staff meetings; handovers."

Theme	Responses
Supporting and empowering staff	“Support colleagues in roll-out of STARSF [See Think Act Relational Security framework] across inpatient settings.” “To be able to support my team.” “I plan to use the See Think Act relational security framework to support both my own ward (low secure forensic) and the wider directorate of acute wards to implement relational security effectively. This will involve acting as a representative for relational security across different wards in my organisation.” “To empower staff, deliver relational security training to all staff, ensure there is clear communication between patients and staff involved in their care.” “To support staff across the inpatient wards in implementing the STA framework. To support leadership team in using STA principles when planning and developing services.” “To add this to supervision discussion and weekly debrief meetings.” “To empower both patient and colleagues to utilise the right tools.”
Improving services, safety culture and patient experience	“Improve my service.” “Improve the safety huddle, consider relational security in terms of the unit and ward, teach staff ways in which we can observe, monitor and improve security on the ward, improve understanding of risk and how to formulate necessary plans.” “I hope this can reduce restrictive practice, reducing restraint, the use of IM [intramuscular rapid tranquillisation], etc.” “To ensure a consistent and safe response to relational security incidents, issues and difficulties.” “To be able to ... improve patient experience’.” “To ensure patient safety is maintained and prioritised.”

Theme	Responses
Quality improvement	"As part of a pan-London QI [quality improvement] looking to reduced restrictive practice." "Patients should have care plans with health outcomes that are reasonable and measurable." "We are hoping it will help influence our [quality improvement] in reducing restrictive practice and the decommissioning of seclusion."
Expert by experience input	"I will introduce it in many aspects of presentations I give to staff as an expert by experience."

Plans to use the STA framework in their current role after training

Responses after training mirrored some of the pre-training responses. Respondents again mentioned the importance of implementing the STA framework on the ward or in their teams, and spoke about how they had done or planned to do this, for example during an away day or a reflective practice session. Some respondents also spoke about challenging current practice as a way to implement what they had learnt. There were some differences or changes of emphasis, however; for example, several respondents planned to facilitate/co-deliver the training with other colleagues in their trust. Others recognised the importance of securing managerial buy-in and embedding the STA framework in the structures of the wider organisation.

Examples of respondents' plans to use the STA framework in their current role, after training, are presented in Table 3.

Table 3: Plans to use the STA framework (post-training responses)

Theme	Responses
Implementation and roll-out	"Small sessions of reflection on the ward – weekly meeting and with the unit for training days." "I got to deliver a chunk of the framework to my team during away days." "Facilitate STA discussion during away days and whenever the opportunity arises on a daily basis." "I have started reflective exercises to support my team using the framework." "In teams/meeting/ward round/handover."

	"Embed See Think Act in the organisation from induction to team processes and link to trust strategy." "Firstly arrange a meeting with management and introduce my ideas and then with their support introduce it to the team." "To use the STA framework to embed relational security as everyday practice within my place of work. This could take the form of exercises during security meetings, safety huddles, etc., but could also be bespoke to respond to current events happening on the ward at the time."
Co-facilitating the training	"Facilitating the groups with co-facilitation." "I will be running training both [on] my ward and others, and running STA-informed reflective practice groups for my ward and others. I will be engaged in an STA work group explaining how principles may be covered at a more strategic senior planning level." "I will liaise with other facilitators from my trust." "Co-facilitating the relational security model with other STA framework facilitators within the trust." "Deliver training through team meetings and team days." "Beginning on my current ward we will aim to design and deliver sessions, to both new staff and current staff and also to include wherever possible in handover, safety huddles and other meetings. We also aim to work with other wards to co-facilitate sessions."
Challenge current practice	"By re-emphasising the need for RS [relational security] during our safety huddles, business meetings and supervision." "To review the need for blanket restrictions."
Expert by experience input	"I see myself being a consultant as an expert by experience." "I will use the framework to teach others about the framework in my lived experience role."

5.2.6. Summary of findings

The responses to the post-training questionnaire showed that the training generally met respondents' expectations; this is reflected in their increased confidence in understanding and using the STA framework, and in the increase in the number of correct responses to the knowledge test in the questionnaire.

In terms of plans to implement the training, respondents had clear plans to implement the training before they started. Some of these plans were implemented post-training, while others were still being put into action.

5.3 LEAD Safely training programme

Nineteen training participants responded to the pre-training questionnaire and 12 responded to the post-training questionnaire. The questionnaires can be found in Appendix 1.2.

5.3.1. Previous experience of leadership programmes

Almost all (89.5%) pre-questionnaire respondents reported having attended leadership programmes. Their previous experiences covered a broad range, including Master's/Bachelor's-level courses in leadership and management (N=7), workshops, NHS training and other advanced skill courses.

5.3.2. Leadership styles

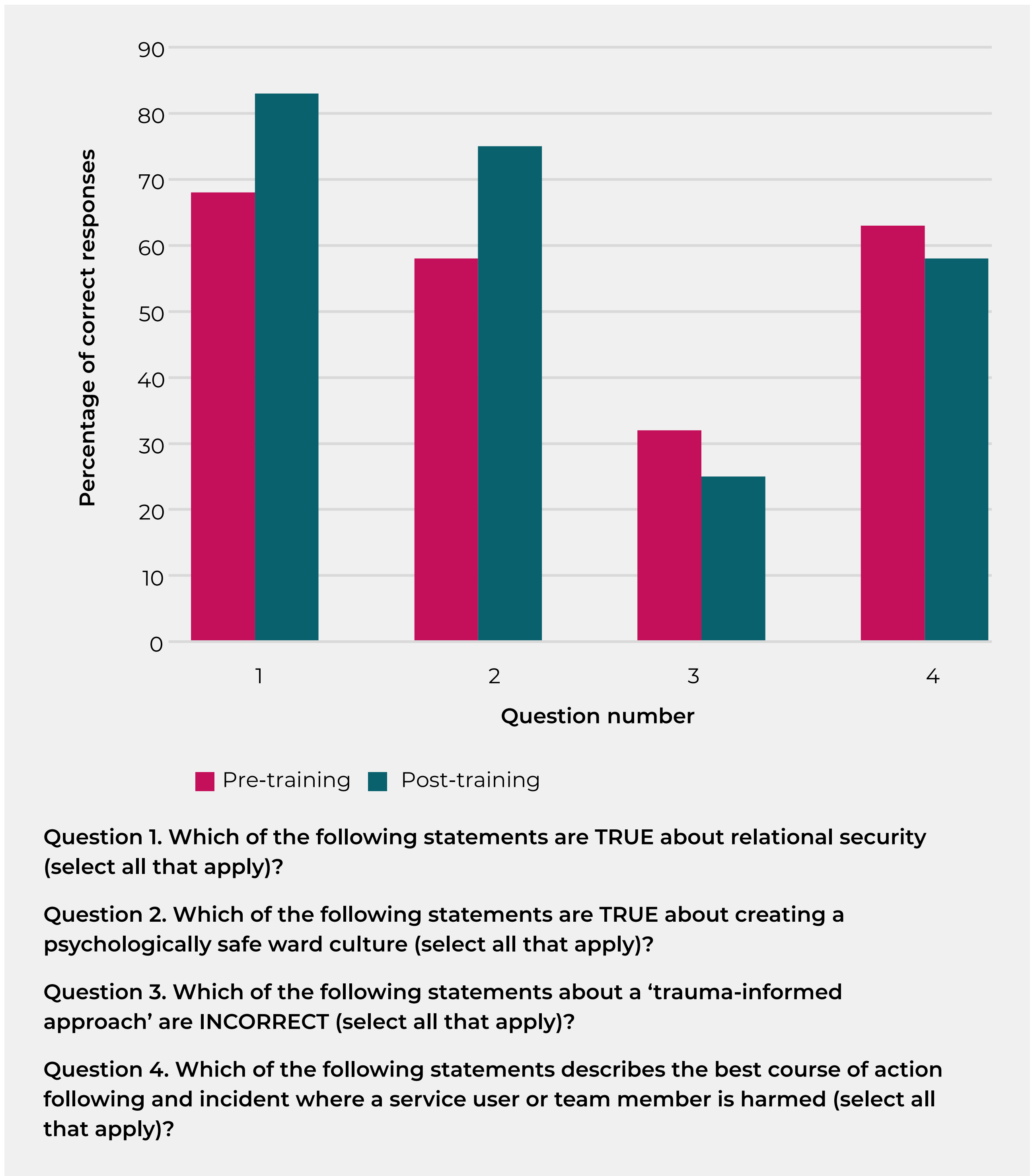
When describing their leadership styles, 57.9% of respondents said they adapted them to suit individual differences. The proportions of respondents identifying with different leadership styles are shown in Figure 5.

Figure 5: Leadership styles

5.3.3. Knowledge of relational security: comparison of pre- and post-training responses

In the knowledge test, which was part of the pre- and post-training questionnaire, we asked a series of questions about relational security, trauma-informed care and leadership. The percentages of correct responses to these questions before and after training are presented in Figure 6.

Figure 6: LEAD Safely responses to questions about relational security[g]



Question 1. Which of the following statements are TRUE about relational security (select all that apply)?

Question 2. Which of the following statements are TRUE about creating a psychologically safe ward culture (select all that apply)?

Question 3. Which of the following statements about a 'trauma-informed approach' are INCORRECT (select all that apply)?

Question 4. Which of the following statements describes the best course of action following and incident where a service user or team member is harmed (select all that apply)?

Overall, some increase in knowledge was seen in the percentage of training participants who correctly responded to questions about relational security and creating a psychologically safe ward culture. However, a small decrease in the percentage of correct responses was observed for questions 3 and 4, which asked about trauma-informed approaches and responding to incidents on the ward. It is not clear if the change in responses was significant (see Section 4.5), but it is possible that more clarification in these areas would be helpful for participants of the training.

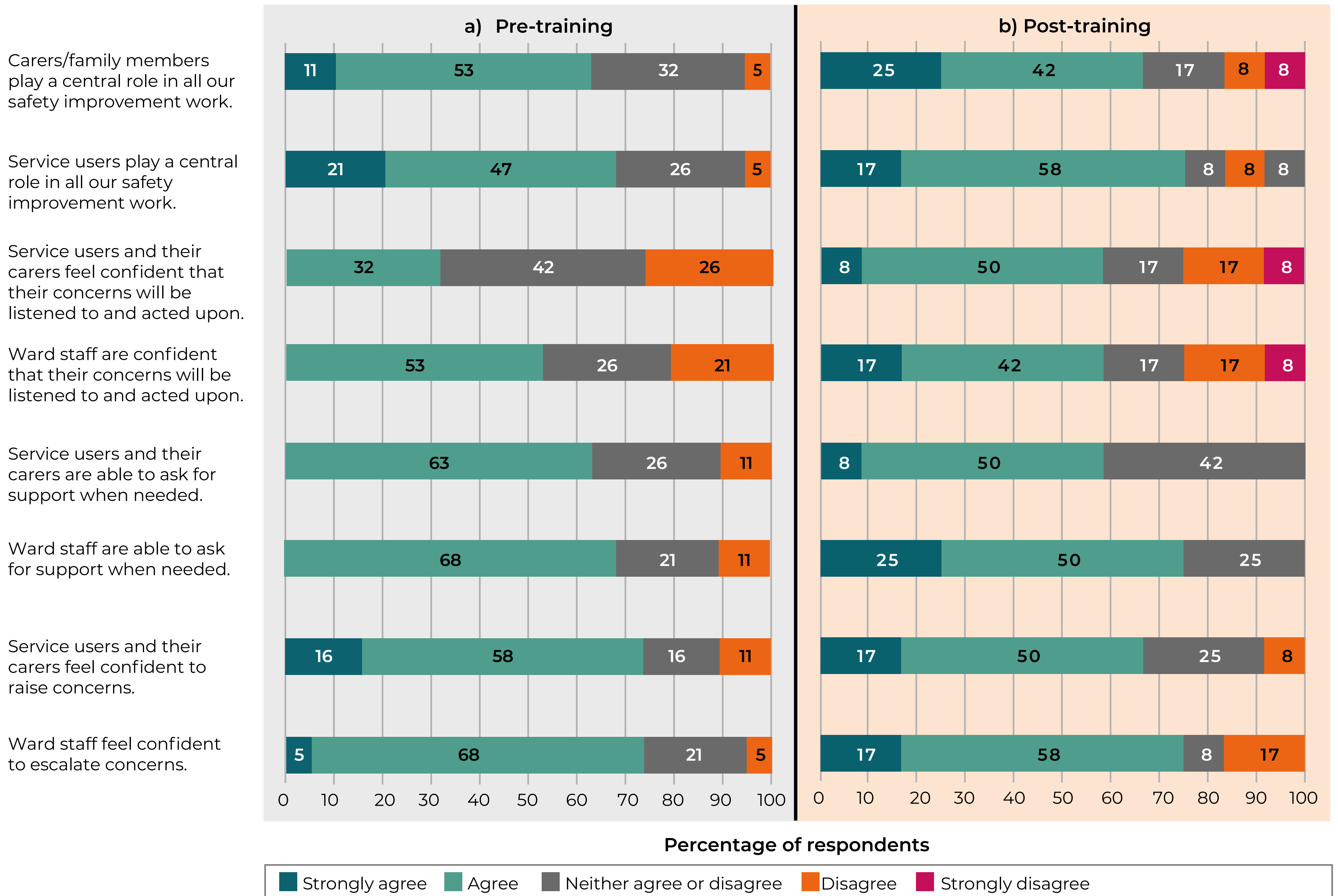
5.3.4. Understanding, confidence and experience with the topics covered: comparison of pre- and post-training responses

In the pre- and post-training questionnaires (see Appendix 1.2), we asked training participants to rate a series of statements relating to: (a) experiences of ward staff and service users and their carers on adult acute inpatient mental health care wards and PICUs, and (b) current opinions of, and confidence in, their leadership styles.

Views of the experiences of ward staff, service users and their carers

Before training, few respondents disagreed with any of the statements about experiences of ward staff, service users and their carers. However, comparatively fewer respondents agreed that service users and their carers feel confident that their concerns will be listened to and acted on. After training, more respondents provided strong agreement and disagreement responses, which could indicate that respondents felt more confident in their perceptions of the culture of their wards. Despite this, similar proportions of respondents agreed (or strongly agreed) with most statements, although a comparatively higher proportion of staff agreed post-training that service users and their carers feel confident that their concerns will be listened to and acted on. Post-training, a comparatively higher proportion of respondents disagreed that ward staff feel confident to raise concerns, and that service users and their carers play a central role in safety improvement work; more respondents reported neither agreement nor disagreement on these statements before training. Summaries of the responses are provided in Figure 7.

Figure 7: a) Pre-training views of experiences on the ward, b) Post-training views of experiences on the ward[g]

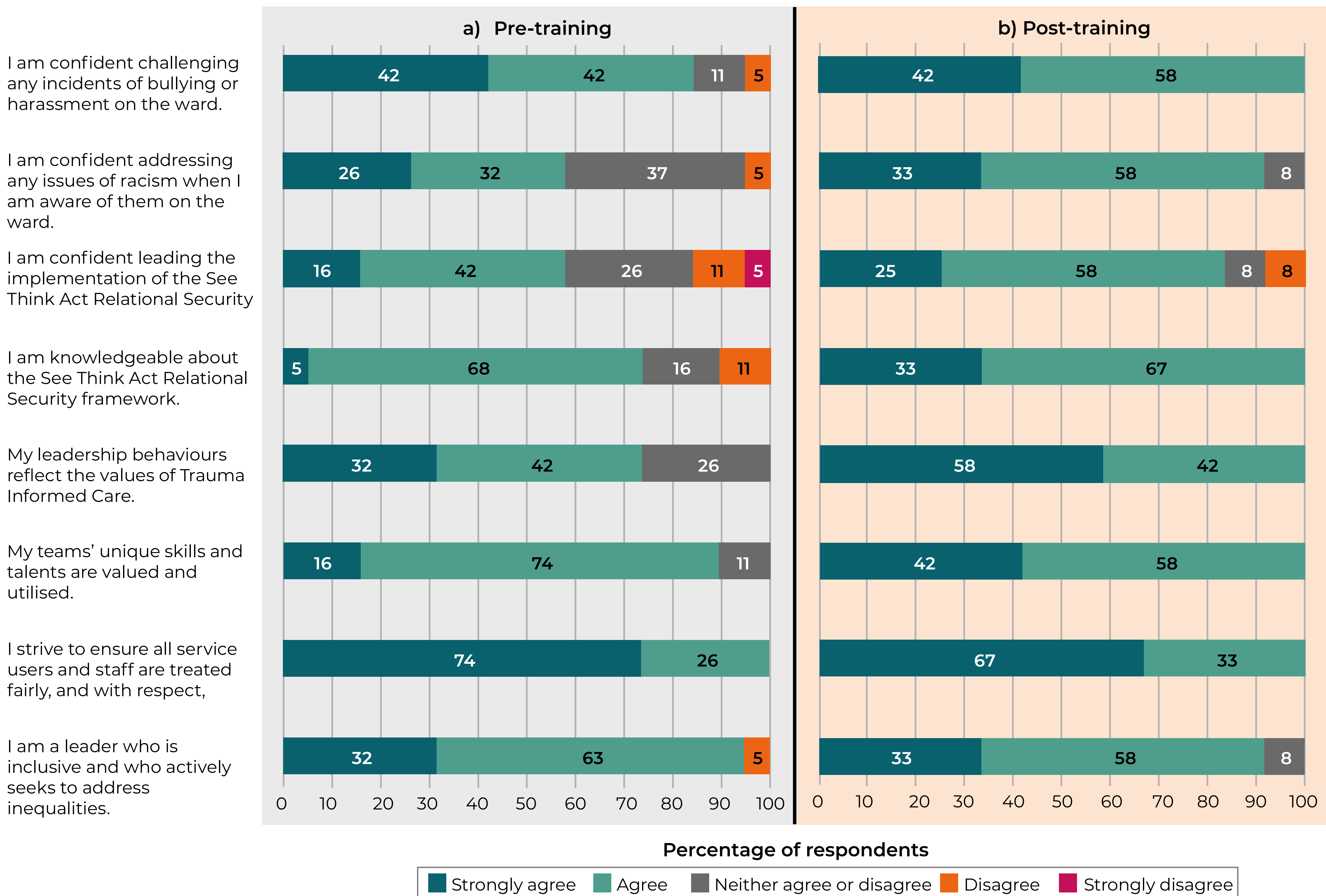


Current opinions of and confidence in leadership styles

Before the training, most respondents agreed that they were confident in challenging incidents of bullying or harassment, that their teams' skills are valued, that service users and staff are treated fairly and with respect, and that they are inclusive leaders who actively seek to address inequalities. Comparatively more staff did not agree that they were confident in addressing racism (37% neither disagree or agree, 5% disagree), leading implementation of the STA framework (26% neither disagree or agree, 10% disagree, 5% strongly disagree) or knowledgeable about the STA framework (15% neither disagree or agree, 10% disagree).

After the training, very few respondents did not agree with statements about leadership styles, although 8% (one respondent) disagreed that they felt confident in leading implementation of the STA framework. Larger proportions of respondents strongly agreed with most statements rather than agreed with all statements, except 'I strive to ensure all service users and staff are treated fairly and with respect, compassion, civility and transparency' (pre-training: 74% strongly agree, 26% agree; post-training: 67% strongly agree, 33% agree). However, there were no respondents that disagreed with this statement for either the pre- or the post-training questionnaires, likely reflecting the commitment of training attendees to fair treatment of service users and staff. Summaries of responses are provided in Figure 7.

Figure 8: a) Pre-training opinions of and confidence in leadership styles, b) Post-training opinions of and confidence in leadership styles[g]



5.3.5. Plans for implementing knowledge and skills gained from the training

Expectations about the training (pre-training questionnaire)

Over one-half of respondents hoped to enhance their leadership skills as a result of the LEAD Safely programme. Respondents also commonly reported wanting to increase ward safety, influence change in ward culture and share learning with others. Less frequently, respondents hoped to improve patient care, staff experience and career progression. See Table 4 for examples of the responses.

Table 4: Expectations about the training (pre-training)

Example	Total endorsements	Example responses
Enhance leadership skills	9	"Enhance my leadership skills" "New skills to lead the staff in a compassionate way" "More in-depth knowledge and confidence to lead"
Enhance ward safety	7	"Further enhance ward safety and trauma-informed care" "Implementing safety improvements on the ward" "Improve on good practice and patient safety"
Influence change	6	"Be more able to influence and bring change" "More competence and skill to implement and inspire change" "Toolkit for leading the change to this model"
Network with and learn from others	6	"Shared learning" "Learn from experiences of others" "Building on ideas and practice from shared experience within the collaborative"
Improve patient care/ reduce restrictive practices	4	"To be able to take learning to improve the care provided to patients" "Improve on good practice" "Reduce psychological morbidity"

Improve staff experiences	2	"I hope to attain and transfer positive culture within the team"
Progress in career	1	"Progress my career"
Gain a better understanding of STA	1	"Better understanding of the long-term implementation of See Think Act vs other violence reduction models"

Plans for implementing the training (post-training questionnaire)

Five respondents to the post-training questionnaire described their plans for implementing the STA framework. Two respondents reported the implementation of training in relational security, and another three reported the addition of safety huddles (two) or reflective practice (one). Provision of one-to-one supervision was suggested by one respondent and one mentioned a trust-wide review of trauma-informed approaches.

5.3.6. Summary of findings

Overall, although most respondents had previously attended leadership courses of various types, including Masters' courses, local training seminars from other NHS trusts and modules included in other training programmes, some did not feel completely confident in some aspects of their role (in particular, addressing racism and implementing the STA framework). More responses provided after the training represented strong views (for example, strong agreement or disagreement in place of 'neither agree or disagree'), suggesting that staff felt surer about what aspects of ward culture needed improvement. Further, although there was an indication that the experiences of staff and service users on the ward or PICU were good before training, there was an increase in reports of feelings that service users and their carers had their concerns listened to following the training, suggesting that some change in ward culture had already taken place. Respondents reported that they hoped the LEAD Safely course would improve their leadership skills and improve experiences on the ward, and this was evidenced by almost all respondents agreeing or strongly agreeing with statements about leadership styles post-training, and reports of plans to implement training and supervision to support staff to implement trauma-informed approaches and the STA framework.

5.4 Feedback from lived experience facilitators

We interviewed three lived experience facilitators (two of whom facilitated the LEAD Safely programme, and one who facilitated the STA facilitator training). All talked extensively about how their participation had impacted them positively, for example by increasing their sense of self-worth, providing a learning opportunity and giving them enjoyment.

All of the lived experience facilitators also said they felt that their participation had positively impacted the training, and that the inclusion of different perspectives that the training participants may not otherwise have considered was a great addition. One lived experience facilitator also reported that the opportunity to directly contribute to the content meant that they were happy with the training provided, while another reported that encouragement to speak up as well as lead discussions resulted in particularly positive lived experience contributions.

However, one lived experience facilitator did express concerns that some lived experience insights from others were unhelpful, and may not have been relevant to the course, which could have negatively impacted participants. Despite this, all interviewees mentioned that they, as well as participants of the training, would benefit from follow-up information or a refresher of what they had learnt, highlighting the level of engagement from all in the training. One interviewee highlighted the importance of considering diversity in any future training provision. Example supporting quotations for these themes are shown in Table 5.

Table 5: Feedback from lived experience facilitators

Theme	Example quote
Sense of self-worth	"It was empowering because it's such an important role and for me to have that role and to have been given that role was very uplifting and like, good for my confidence." "So, for me being accepted as an equal. Priceless. It's hard to describe that feeling."
Learning opportunity	"There were lots of components to it that I found quite interesting and I didn't know lots of interesting stuff." "A great opportunity for me to learn as well as to help teach others." "The training has consolidated my understanding."
Enjoyment	"Just kind of reiterating that you know, I loved it. I loved being a co-facilitator." "I didn't really find any of it dull or boring to be honest. And some of this stuff towards the end ... but it was quite fun towards the end as well. I enjoyed that." "I enjoyed the programme, we interacted well ... the open space aspect of the ... programme ... you're allowed to make an input."
Improvement of training through the addition of a different perspective	"I feel that it helped the trainees to see ... a reminder of, like, we're all human ... see it from a different perspective." "I think it probably made quite a difference because you very rarely get to hear that lived experience anywhere else."

Opportunity to directly alter training content	"We were asked to, like, have a little kind of review ... and raise as much or as little as we wanted and to feedback anything we felt could do with a bit of adaption or improvement or word changing or anything like that. And I didn't actually have that much to say. I thought it was great actual content for the course." "I led a focus group discussion ... we made immense contributions."
Concerns	"Sometimes the information that [a facilitator] would share wasn't particularly relevant to the training...kind of telling people what to do rather than sharing [their] lived experience, but being a bit too like 'don't do it this way'. Kind of talking to people as if they've done something wrong a bit."
Follow-up information/future training	"The professionals that we trained to be facilitators of the STA training were all very keen to attend a reunion/refresher STA session." "Actually it would be good if they could produce like a small maybe little booklet from that for people to look at." "Are we going to do this some other time next year? And if we are gonna do, are we going to improve on that, include new things, to better serve the ... diverse group of patients we are serving."

5.5 Community of practice

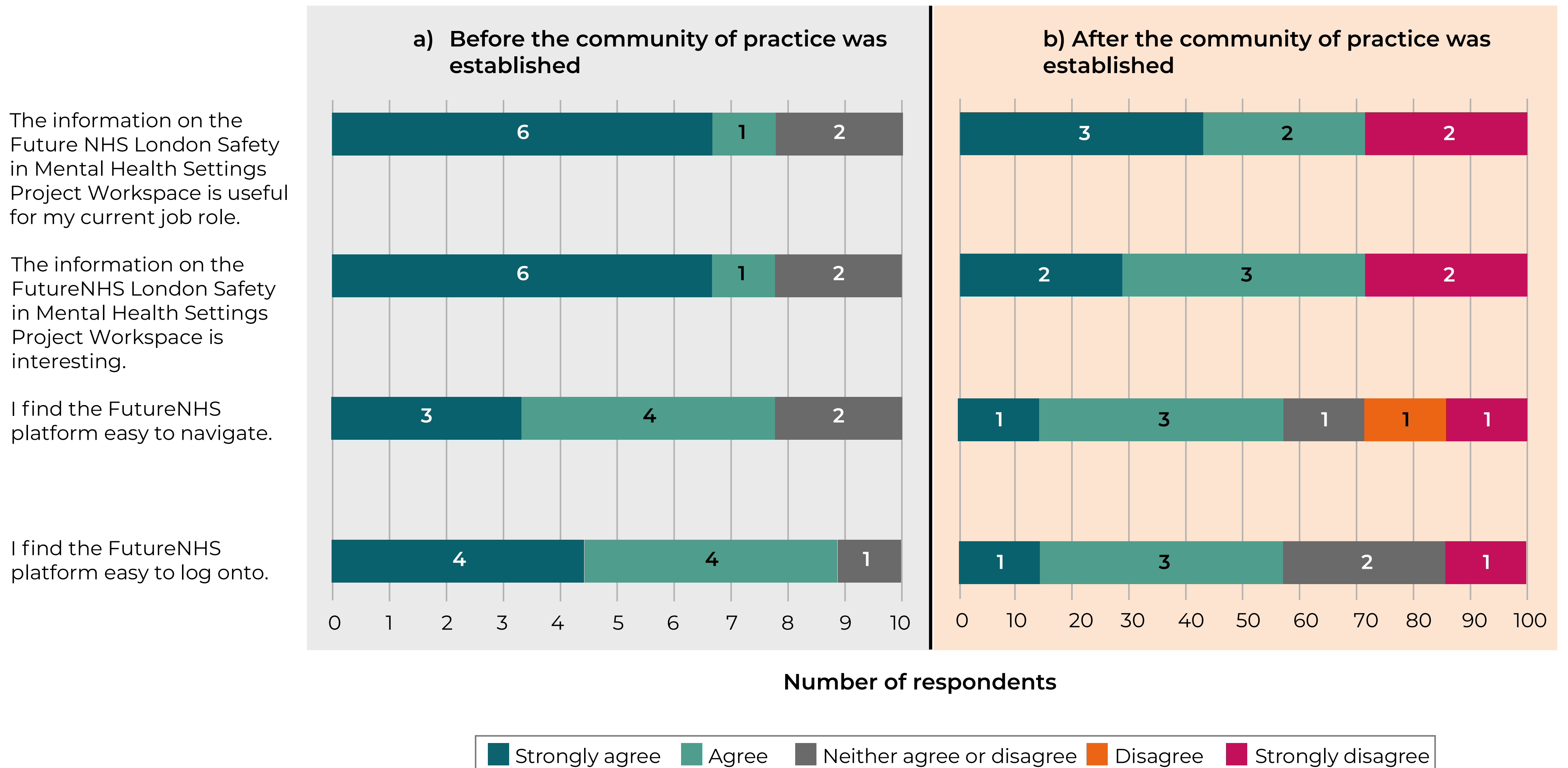
Thirty training participants responded to the questionnaire administered before the community of practice was established and 10 participants responded to the questionnaire administered after the community of practice was set up. The questionnaires, as well as demographic and occupational information of respondents, can be found in Appendix 1.3.

5.5.1. Questionnaire responses

Pre-training experience with the FutureNHS Collaboration Platform

Nine of 30 (30%) respondents to the pre-establishment questionnaire reported accessing the London SiMHS Project Workspace on the FutureNHS Collaboration Platform. Of these, most agreed that the information provided was useful (7/9 respondents) and interesting (7/9), that the platform was easy to navigate (7/9) and easy to log into (8/9). Seven (70%) respondents to the post-establishment questionnaire reported accessing the workspace. Of these, most agreed that the information was useful (5/7) and interesting (5/7), that the platform was easy to navigate (4/7) and easy to log onto (4/7). However two participants did not agree with any of these statements. Summaries of responses are provided in Figure 9.

Figure 9: a) Responses to questions about the FutureNHS Collaboration Platform before the establishment of the community of practice, b) Responses to questions about the FutureNHS Collaboration Platform after the community of practice was established



Expectations about the community of practice

Training participants were asked to report what they wanted from the community of practice prior to its establishment. The most frequently endorsed expectations were learning from the experiences of others (15/30) and sharing ideas for ways to improve services (11/15). There are examples of responses in Table 6.

Table 6: Expectations about the community of practice

Expectation	Number of endorsements	Example
Learning from experiences/ sharing knowledge	15	"Learn from both staff and service users' experiences" "Honest feedback" "Learning from one another"
Sharing ideas for improvement	11	"Ideas for building the community" "Inspiration to continue to develop and evolve trauma-informed care" "Ideas to test my clinical areas"
Collaborative working	8	"Space to discuss ideas collaboratively" "Collaborative working" "Connect with others in a similar role"
Facilitate change	3	"Building momentum" "Enact positive change"
Improve understanding	3	"Understanding" "Full awareness of the different routes to access" "Learn about restrictive practice/trauma-informed and ways to implement it for inpatient wards"
Allow voices to be heard	2	"User voice – from a psychological professions perspective" "To be heard, acknowledged"
Improve outcomes	1	"Improve outcomes"

What was gained from the community of practice?

Training participants were asked what they had gained from the community of practice. Of the 10 respondents, eight answered this question. Four participants reporting gaining information, two respondents reported that they had gained from the networking involved, one participant reported that the community of practice had increased their motivation from sharing learning and one participant reported that they had refined their skills as a result of the community of practice. However, one participant reported that they had gained 'nothing' from the community of practice.

What could participants offer the community of practice?

Training participants were asked what they could offer the community of practice before and after its establishment. Respondents to the pre-establishment questionnaire primarily reported that they could share their lived experience (14/30) and promote best practice (8/30) through this process. Similarly, respondents felt that collaboration could be encouraged through the platform, with 3/30 reporting that they could help to facilitate more lived experience perspectives being heard, 3/30 reporting that they could give advice and share their knowledge on specific topics, 2/30 reporting that they felt they could contribute to mutual support and 3/30 reporting that they could share enthusiasm for improving care with others. Six of the 10 post-establishment questionnaire respondents answered this question, mentioning sharing their experience (3/6), expertise from their job in the hospital (1/6) and education about trauma-informed care (1/6). One participant reported that they were not sure what they could offer.

Shared priorities for the future

Training participants were asked what shared priorities for the future should be. In responses to the questionnaire that was sent out before the community of practice was established, the most frequently endorsed priorities were to improve wellbeing and outcomes for service users as well as staff (8/30), to share learning with each other (8/30) and to achieve a trauma-informed care approach more consistently (7/30). In the questionnaire sent out 6 months after the establishment of the community of practice, only four participants responded to this question, with reported priorities being improving care and service user experience (3/4), staff retention and recruitment (1/4), and sharing experiences (1/4).

Other reported priorities are reported in Table 7.

Table 7: Shared priorities for the future

Priority	Number of endorsements pre-questionnaire (from 30 responses)	Number of endorsements post-questionnaire (from four responses)
Improve wellbeing/outcomes	8	3
Sharing learning	8	
Good implementation of trauma-informed care	7	
Encourage change	4	
Emphasise service user perspectives	3	
Collaboration	2	1
Sustainability	2	
Address inequalities	1	
Enhance rights-based practice	1	
Measure progress	1	
Personalised service	1	
Recruitment	1	1

5.5.2. Summary of findings

Overall, responses from the questionnaire administered before the community of practice was established suggested that although the FutureNHS Collaboration Platform had been utilised by just under one-third of participants, who found it useful and easy to use, respondents wanted more opportunity to learn from the experience of others, including sharing of ideas to improve services and practice. Respondents felt that they could facilitate this through the sharing of their own experiences, by promoting collaboration and by sharing perspectives on the community of practice. Limited responses were gained from the questionnaire administered after the establishment of the community of practice, although respondents mainly reported gaining information from the community. One participant reported negative views of the FutureNHS Collaboration Platform and that they did not use the community of practice.

5.6 Overall summary of findings: Reaction and learning

We found that, overall, the STA facilitator training programme increased trainees' confidence in understanding and using the STA framework, and improved their knowledge of the STA framework concepts. For the LEAD Safely training programme, we found a perceived improvement in leadership skills and improved experiences on wards for inpatients. For both training programmes, there was evidence of clear plans to implement the training.

From speaking to the lived experience facilitators, we found that their participation had generally been a positive experience because it had fostered a sense of self-worth and provided a learning opportunity.

Finally, we found that, in general, the community of practice provided a useful and easy way to share learning and experiences with others, and build a network, although there was some indication that it was not being utilised by everyone who had attended the training. One reason for this could be that communication about the community of practice was not sufficient to reach all trainees, or that staff did not feel they had enough time to access the resources alongside their work commitments, given training attendees' reports of needing time to digest information.

6. Findings: 3. Behaviour

6.1 Interviews

One-to-one interviews were conducted to further explore trainees' experiences of the STA facilitator and LEAD Safely training programmes, the impacts of the training on achieving a common understanding and commitment to a trauma-informed approach, and on the interviewees' day-to-day work. The themes emerging from interviewees' responses to the questions are summarised in the sections below. Further information on the structure of the themes, including the number of interviews and interview themes, is in Appendix 2.2.

6.2 STA facilitator training programme interviews

Five interviews were conducted with participants in the STA facilitator training programme. The interviewees' job roles included violence reduction, peer support worker, clinical nurse manager, head of psychology and clinical trial designer. One interviewee contributed to some aspects of the LEAD Safely training as well as participating in this programme. Interviewees provided a rich source of information regarding their experience of the training, and the subsequent impact on their day-to-day work. Interviewees highlighted several positive elements of the training, how it could be improved and their future plans to implement what they have learnt.

6.2.1. Motivation and prior exposure to the STA framework

Interviewees gave a number of reasons for taking part in the STA facilitator programme. Some had some experience of using the STA framework as part of their role, although there was a desire to add to or improve on their knowledge. Other reasons included a desire to learn and share learning with others in a group format (3/5 interviewees), a recognition of how important the topic was in improving healthcare (4/5 interviewees), and recommendations from colleagues or line managers (4/5 interviewees). There are quotes from the interviews that exemplify these areas in Table 8.

Table 8: Motivation and prior exposure to the STA framework

Theme	Example quotes
STA already informally part of job role:	P1: "I think during that See, Think, Act relational security plays quite a big part in violence reduction … and so informally, I've been doing [it] for probably about 6 years, but more kind of formally for the past sort of 12 months, 18 months or so."
Desire to add to or improve knowledge	P5: "I had a brief background of STA, but I should say when I attended the training I gained a lot of knowledge." P1: "Although I had sort of a good awareness of it [STA framework] and how it worked and how the principles work in practice … I'd never had proper training on it before."
Recognition of the importance of improving healthcare	P2: "I've got a real passion about trying to improve mental health services wherever I can." P3: "It just seemed like … something that was really grounded in theory. [It could] enable me and my team and other teams within this unit to take a different approach to the way we see relational security and safety on the wards. We do have a lot of violence and aggression here."
A desire to share learning with others	P3: "I was eager to learn more about something that seemed really grounded in theory and actually quite fun and something that would be accessible to different people within my team, whether they'd be kind of a brand new HCA [health care assistant] or an experienced psychologist. It's accessible for a lot of different people. So that's why I was interested." P4: "My personal interest was about wanting to just work better with colleagues and support their development and it felt like a nice way to do that … The framework naturally sort of lent itself to that."
Colleague recommendation	P1: "It was actually my line manager … although he'd only been my line manager for a couple of months here, I'd worked with him previously and so he knew the work that we've done and the collaborative work … so it was actually him who got the flyer through and he sent it to me saying 'what do you think of this?'." P4: "So I used to be based at [another mental health trust] with [another training participant in a previous cohort] and he's quite a lead for the STA framework. So I was interested in it through him and it feels like … its part of transition into this new role as well."

6.2.2. Experience of the STA facilitator training programme

Interviewees spoke about what was positive and helpful about the STA facilitator training, and also what was less helpful. Some aspects that were positive for some interviewees were viewed more negatively by others (such as the training environment). However, the less positive or unhelpful elements were outweighed by the positive and helpful elements of the STA facilitator training programme.

Positive experiences and helpful elements

Almost all interviewees reported that overall they enjoyed the training, and all mentioned that the energy and teaching style of the STA trainer was a key factor in that enjoyment. Participants felt that the content supported them to confirm and update their knowledge (3/5 interviewees); some reported that the resources provided were beneficial in giving them the confidence to implement what they had learnt (2/5 interviewees). Almost all interviewees spoke about the importance of the lived experience perspectives in the training, because they validated what was being taught, and provided a different lens to view interviewees' own practice and their patients. Similarly, two interviewees said that the content gave them the means to see things in a new way, which helped them to formulate how to improve things. All but one interviewee mentioned that the ability to work with others and network was a major aspect of their enjoyment of the course.

There are quotes from the interviews that exemplify these positive experiences and helpful elements in Table 9.

Table 9: Positive experiences and helpful elements of the training

Theme	Example quotes
General comments about a good learning experience and the facilitators' approach to training	P1: "It was really, really enjoyable." P3: "I thought it was great." P5: "So all these, to be honest, from day one up to the end, everything was really constructive and beneficial. And I think not only myself, [but] everyone enjoyed the sessions … [it] was from morning till four o'clock, it was all day long. But you don't feel tired because you know every time you learn a new thing and you know there will be contributions from other colleagues also as well. It was very, very crucial for our roles, yeah." P3: "I found [the STA trainer] really quite inspiring and I thought she was a great teacher." P4: "She [the STA trainer] was amazing … She had such a knowledge, such detail and such stamina. So I was really impressed."

	P5: "Everything was covered, I think [the STA trainer] is the best. The way she delivered the training. Honestly, even if you feel tired, you want to sleep, you cannot. Every time you feel you are alerted and you want to hear more."
Suggestion to have a co-trainer	P4: "I did wonder though if she [the STA trainer] would have benefited from 'co-running' it with someone a bit more actively. I think it's a lot for one person to do … if you're co-facilitating and you've got lived experience facilitators that's a lot of people to think about before you've even started the training."
Confirmation and update of prior knowledge	P1: "There was a lot of stuff that I was like, 'yeah, that's what I'm doing, that's what I'm comfortable with'. But there were lots of things that were educating or updating or validating as well. So yeah, it was really enjoyable." P5: "Every time during the session, there's something new which [I] said 'oh I knew about it but I didn't think [about it] this way'. So this can be done in the other way."
Working with other staff and networking	P2: "And the sharing and the thinking and the awakening to certain things. For some people, including myself it was just really good to get people of a like mind together 'cause obviously the staff coming from various hospitals and trusts, they're obviously passionate about what they're doing and care about what they're doing … it was really good to get that positivity." P4: "I was able to connect with my network. And helpfully I've also met someone from [another mental health trust] that I'm actually meeting tomorrow about developing the work so it was both: it was good training in itself, but it also just helps you network and plan." P4: "I really liked doing the presentation. I sort of underestimated joining a small group, focusing on a particular part of the framework, and presenting it back to colleagues. So I really liked that. I underestimated how helpful that would be to practice …. I thought 'this can be a really good way to focus on particular parts t of inpatient work'." P5: "I learned a lot of things during the training, especially when we were having one-to-one group sessions and the presentation."

The opportunity to think about practice on the ward differently or change practice	P1: "Actually when we went into [it] and delved more in depth, and looking at all the different areas that you can start to consider and the impact of those on the greater ward environment, and it just made me think outside the box a little bit, that we'd also become a little bit institutionalised, that we only follow very specific patient dynamics and we always stick to that, but actually the dynamics of your patient group also changes." P3: "I guess the framework can force you to think about boundaries in a different way, in terms of some being negotiable and non-negotiable. I think in mental health services where we … only see non-negotiables."
Lived experience perspectives:	
Seeing service users and one's practice in a different way	P2: "The words 'don't judge a book by its cover' come through, like trying to look at somebody holistic[ally]. I do that anyway, but those of us that were there, and some of the ideas that some of the staff had already implemented and were sharing and the other staff were looking at taking up. It was just the whole scenario, the whole picture. It's about people thinking outside the box and looking at new ways to be with those who find [themselves] in the mental health system." P5: "Having somebody who is stable having been treated and maybe several times in an acute ward and come to talk about their experience was something different because we don't get that opportunity every time. So how do they feel? And also there are some things which they talked about like both sides, like how [well they are treated] and the bad side of it when they're an inpatient. So they talked about it, then, in the back of your mind, you think 'Oh wow, okay, this is what happened'."
Validating the training	P1: "I think it validates it more, you know, rather than having … as people in nursing go through their careers and then they're sitting in offices … and they're kind of dictating what the floor staff do and the general sense is 'oh God, they are so far detached' … and I think having the involvement from lived experience … it kind of validates the training and that the right people are involved, so you know the staff involved are passionate about it and they really care and they're knowledgeable … but it's not done in a condescending way. It's not done … like it's a tick box. It actually was valuable to the session I felt." P3: "To have these things first hand and to be having conversations with people who have experienced this stuff, that was really, really powerful. I think actually that training without the people of experience would have been, nowhere near as good, I think it's a really crucial part of it."

Helpfulness of resources provided	P1: "I actually found ... specifically the [work]book [had] really in-depth detail." P3: "It's great to come away with a lot of tools and a load of exercises. I think the workbook is excellent. It's not something I've approached with my team here in terms of 'we're doing this framework', but just picking little bits out of it on away days and stuff and then on team meetings has been really useful. Some of the exercises are really fun."

Unhelpful elements and areas for improvement

Interviewees highlighted only a few unhelpful elements and areas for improvement for the STA facilitator training programme. While two interviewees felt that a longer course would allow more in-depth, less rushed coverage of content, some wanted extra content to be added to the course, including more information on how to implement learning (1/5 interviewees) or discussion of 'spirituality' (1/5). Another interviewee mentioned some concern around how people with lived experience were included in the training, and suggested check-ins with them, as well as structuring the programme in a such a way that allows participants to share freely and without hesitation.

There are quotes from the interviews that exemplify these unhelpful elements and areas for improvement in Table 10.

Table 10: Unhelpful elements and areas for improvement

Theme	Example quotes
Length and intensity: Longer course to cover topics in more detail	P1: "I think lots of it could have been covered in more detail and that's not in a negative way. I think it's just because it's such a big, big topic and actually cramming it [the course] into [3 days], the first day being a sort of introduction isn't really going into the nooks and crannies of it ... I know time pressures and people's availabilities. You know you're never going to be able to make it too big, but I think it's such a huge topic that I would have happily have done it over a 5-day course. But I know that's not realistic." P5: "I should say it was tiring but tiring because it is a long day, but in the head you feel like I'm absorbing a lot of knowledge."
More information on how to implement learnings	P3: "It would have been nice to have a bit more practice facilitating maybe, and maybe more of a think about individually [how] you would work with your team to do it ... you would need more time, I guess, to do that, like it would be really useful to do some kind of tailored planning towards your team and the issues that your team face."

More topics: spirituality	P2: "If there is any way of getting somebody to deliver something on spirituality because the mental health system really is seeing what happens to us in completely the wrong light."
Lived experience concerns	P4: "It's a good thing to have [lived experience facilitators], but ... some of the things we were talking about just seemed to take [them] back to [their] own experiences and I just thought, 'Oh, is that ok?'."

Different views on face-to-face and online training

Participants had conflicting views on the best format for training. Of the three participants who talked about the format, one reported liking the online format due to mobility issues while two reported that, having experienced both formats, the face-to-face sessions were better, although one reported that despite this, 'The learning environment wasn't the greatest and the rooms were small and hot'.

6.2.3. Adopting and implementing new skills from the STA facilitator training programme

Interviewees suggested several methods that could help teams adopt the STA framework and enable individuals, and the wider ward or unit, to implement what was learnt during the training. Two interviewees spoke of ways to challenge current practice, and there was some discussion of the importance of more lived experience input into ward culture.

All five interviewees mentioned that being a role model was a key way to implement change, including role modelling by leaders and STA facilitators. Moreover, the importance of teaching more staff about the STA framework because of the importance of staff attitudes in supporting implementation was mentioned by all. Almost all interviewees also felt that follow-up courses with attendees to refresh their memory of the training, and the opportunity to continue the conversation by sharing experiences post-training with other teams, would be beneficial.

There are quotes from the interviews that exemplify adoption and implementation of the STA framework in Table 11.

Table 11: Adopting and implementing the STA framework

Theme	Example quotes
Lived experience input into ward culture (ward champions)	P1: "I do it already informally, but I think we need to be probably more structured in our approach in actually identifying a ward champion to be able to work with us in terms of embedding the principles on a more structured scale …. I think we need to probably do it [implementing ward champions] … moving this system forward … a little bit more structured and identifying a champion or someone who we can work with." P4: "I don't get the sense many [lived experience facilitators are] working on the wards, but that's obviously something that we'll try and think about and include that in the training as well." P5: "We are planning to invite one of the lived experience [facilitators] to come and talk to us in our team."
Teaching more staff about the STA framework: ***The importance of staff attitudes and support of the STA framework*** ***Culture change***	P1: "All it takes is for you to get a couple of members of staff, particularly influential staff, on board with what it is that you're trying to do, and then suddenly the hard work or the big barriers [are] overcome and then the rest kind of plods along and that's the kind of idea." P3: "I have trouble engaging certain members of the team in anything I do and then on an away day, it's not necessarily to do with the content, it's a staff attitude thing and eye rolling, kind of 'here we go'." P1: "Probably the biggest challenge with this … people start to become very anxious and potentially scared of the unknown. And if they sometimes only look at it – and I've done it myself – when you look at it as a bit of a tunnel vision rather than the wider picture." P5: "I found after the training, there's some things I had to educate to my colleagues … because we have this kind of … old school treatment."

More training for more staff	P1: "I definitely do feel that we need to, if the trusts are keen to enhance on it and really push forward with this … a See Think Act training event … something that goes into a little bit more in depth …. I've added onto my agenda in terms of what I want to do as part of my objectives and I've incorporated the relational security stuff and that as to how we can pioneer these services." P5: "I would suggest that everyone should attend the training … from top to bottom. When I say that, I mean nurses, HCA [health care assistant] support workers, everyone should attend the training because if everyone has this knowledge, it means we will be able to deliver our service efficiently."
Sharing of experiences with other teams	P2: "My initial thought is, get them to talk about how they found it, what their experience was, what they gained from it … and not only that, maybe include the benefits to the trust as a result of that. What's changed? What's improved? What's worked? What hasn't?" P3: "We're thinking of doing a bit of cross-covering and doing some work with each other's wards. Because I think actually doing it in the team that isn't necessarily your team could be quite powerful as well."
Provision of refresher courses for attendees	P3: "I think having some refreshers would be nice. Pulling us back. Even if it's not a course recap or update or whatever, even if it's just a reflection. Because I guess you can feel like you've had this multiple day training and then you're just out there and you're a bit detached from it. And I guess there's the risk that over time, things just begin to fade."
Role modelling	P1: "In terms of what my role is and the work that we do in our team, [it] is very much role modelling and on-the-floor education. You can have people in a classroom for a day or longer, but actually until they see it in practice and they see the people who are preaching do it, that's the only way that they start to identify the values and benefits …. It's definitely 'monkey see, monkey do' in this type of work, and if you can have a senior manager saying, 'you can't do that' or 'you have to do this way', unless that manager comes down and actually does it, people are not going to buy into it." P3: "I am a firm believer in behaviour breeding behaviour. I think, often, the way we approach and understand a situation results in negative outcomes and … we make things worse sometimes."

Challenging the way things are: ***Seeing things from the patient's perspective***	P5: "Previously, you know, when [a] patient comes in the middle of the night, two to three in the morning asking for a cup of tea, you think, 'oh you should be in bed. You have to go back to bed'. But you know, having the discussion there you can see why they want [a] cup of tea. Even myself sometimes, maybe if I cannot sleep, I'll just get up out of my bed, go in the kitchen, have some water or sometimes have a cup of tea. So you think, 'If someone asks for a cup of tea, why can't I give at that time?'."
The confidence to speak up	P2: "But I have been using the skills and what have you, I've acquired, when I do other stuff, meetings wise ... and basically my voice has got a lot louder."

6.2.4. Summary of findings: STA facilitator training programme interviews

Interviewees talked about their reasons for joining the STA facilitator training programme, including their own desire to update their knowledge, colleague and line manager recommendations, and to share learning with others. This demonstrates the perceived importance of diffusion of learning of the STA framework so that everyone working on inpatient mental health wards can have a shared understanding of relational security. This is further evidenced by the discussion of the importance of staff attitudes in implementing the framework.

Overall, interviewees found the training to be a positive experience, with reports of a deeper understanding of the framework, and enjoyment of the group format and teaching style of the trainer. Although trauma-informed approaches were not specifically mentioned, interviewees described fundamental aspects of such approaches such as consideration of patient perspectives and treating them with care and respect, suggesting that the training would facilitate further implementation of trauma-informed approaches.

Generally, interviewees showed a willingness to adopt the framework in their day-to-day roles, and suggested several ways to implement the STA framework. There was a general consensus that being a good role model for other staff and contributing to culture change on the wards were important first steps alongside the provision of more training for more staff.

6.3 LEAD Safely training programme interviews

Six interviews were conducted with participants in the LEAD Safely training programme. The roles of interviewees included clinical psychologist, consultant psychiatrist, medical practitioner, team lead and nursing lead. One interviewee also contributed to some aspects of STA training as well as participating in the LEAD programme.

Interviewees shared their motivation for training, experience of the actual training itself, the impact of the training, and how they had started to or intended to implement the skills gained.

6.3.1. Motivation for training

Interviewees reported a number of reasons for participating in the LEAD Safely training, which included its perceived relevance to their day-to-day work, a wish to improve their knowledge, and a wider desire to improve healthcare. One interviewee joined the training because they had been encouraged to do so. There are quotes from the interviews that exemplify motivation for training in Table 13.

Table 12: Motivation for training

Theme	Example quotes
Relevance to current work style and role	P2: "It fits very well into my current role … it's about safety, so very much very relevant to my role and that's why I went for it and I had a support from my manager as well. So you know, I thought about it and he was totally supportive of me attending." P5: "I saw the agenda and it was, you know, very much touching on the sort of things that I feel that the staff here need to know a bit more about so, for me, and for the staff I guess."
Desire to update or expand current knowledge	P5: "It was more about kind of getting more information and having the time really I think, to actually sit down and listen to a bit more about it and have a discussion about it. And so I could be clearer in my mind about what we were doing." P6: "I was interested when I saw the content of the programme, particularly around trauma-informed care, and I wanted more knowledge about it and so that's what made me interested to join the programme. So … there were areas that I wanted more in depth and more up-to-date knowledge of."
Encouraged to do training	P1: "I started this job back in January and my head of department was desperate for me to go on some kind of training because there was money left in the budget. And all the stuff he was suggesting, it was just not appropriate for me …. But there was also this one … I've never done any leadership programmes. So it's just new to my role and I said yes."
Passion for improving healthcare and reducing restrictive practice	P3: "My philosophy is that we shouldn't be harmful to our patients because when we are treating our patient, sometimes our anxiety is affecting our attitude, so we want to be perfect, we want to be safe, completely safe, but actually at the end of the day, we are treating ourselves or anxiety and not the patient. So I was very interested in what is the least restrictive practice, how much we can reduce this atmosphere that can lead to aggression." P4: "So originally, we had done the relational See, Think, Act. So I was a facilitator for that. So off the back of that I was asked if I would like to be part of [LEAD Safely] because they know that the passion that I have for ensuring that mental health services are the very best that they can be, and everyone does have the skills and knowledge to ensure that they are able to provide the best care and experiences for those in their care."

6.3.2. Participants' experience of the LEAD Safely training programme

Positive experiences and helpful elements

Almost all interviewees spoke positively about the training, and many specifically mentioned how the facilitators positively impacted their training experience. The helpfulness of lived experience elements of the training and the opportunity to network with others were also often mentioned. Two participants reported positive experiences with flexible ways of engaging with the training.

There are quotes from the interviews that exemplify positive experiences and helpful elements of the LEAD Safely training programme in Table 13.

Table 13: Positive experiences and helpful elements

Theme	Example quotes
General comments about a good learning experience and the facilitators' approach to training	P2: "I think all the topics were very helpful to be honest. If you ask me personally, I was probably very attracted to the training format. That's because it's very much something that I'm very keen about, but all the areas have been really helpful." P2: "Think all the facilitators were absolutely lovely … they've got that very kind of humanistic approach to things when it comes to patients, but also to staff and people in the course and it's very lovely, really felt like a very relaxing and good atmosphere to learn things like being around people who think in the same manner, who have that open mind." P3: "Overall, the sessions … went well in my opinion. I learned a lot of things." P5: "The facilitators were … amazing." P6: "I think in terms of content I would say [it] was [a] very rich programme in terms of content, and that different concepts that we explored in the programme, including leadership, including psychological safety in teams, trauma-informed care and relational security." P6: "The facilitators were very knowledgeable in the topics and brought a lot of their own experience to it."

Helpful insights from people with lived experience	P2: "I don't think we have this opportunity often enough to actually hear the voice. So, you know, I absolutely loved that bit too. The fact that, you know, we were able to hear them … how their experiences were and you know, you understand things better when they come directly from people who have used the services." P3: "The way they will say things that differ from yourself or somebody who has a professional background … and there should be no conflicts, because they will say things according to their emotions. Sometimes it doesn't fit with our professional standards, but it is very important to understand." P4: "Quite liked the fact that you had involved representatives there to give their perspective and their views, that was really good …. I think its nice hearing it from their perspective as well and recognising that, I mean we do a lot of work like that anyway, but it's just nice recognising that we're all one and everyone's got their own view." P5: "I really liked working with the experts by experience because that's always quite sobering and thought-provoking."
Opportunity to network and learn from different views	P3: "One of the things that is maybe unrelated to this, to the material, is to meet people, to talk about this with other people, to see what they are doing, at other trusts. This is a huge advantage." P4: "[I liked] being able to share ideas [about] what's happening in other services, what are people doing, the networking element of things as well." P6: "It was rich in that sense being able to hear from colleagues from different trusts in terms of how they were dealing with different challenges. So it was a good opportunity to learn from each other and share sort of good practice."
Flexibility with when and how participants could engage with the training	P1: "If I'm brutally honest, the bit I enjoy is, I just stayed home to do the trainings." P2: "With the flexibility as well, because obviously we all have got like busy jobs and sometimes you know the ward had called and I had to go for you know, and come back and listen, there's been quite a bit of understanding around that which is great."

Unhelpful elements and suggested improvements

Interviewees highlighted a few unhelpful elements and suggested improvements to the running of the LEAD Safely training course. These improvements included:

- pitching topics at an appropriate level
- more support with linking with other teams and staff
- encouraging more staff members from within the same organisation to attend the training.

However, for individuals who found the course to be thorough, they wanted more time to reflect and think about the information being taught.

There are quotes from the interviews that exemplify unhelpful elements of and suggested improvements to the LEAD Safely training programme in Table 14.

Table 14: Unhelpful elements and suggested improvements

Theme	Example quotes
Presenting topics at an appropriate level	P1: "To be honest, the whole thing was not pitched at the right level and some of it was just, I mean, trauma-informed care. It was so basic … bearing in mind, I'm a principal psychologist. There were matrons, there were some directors, consultant psychiatrist…. I would have introduced that as part of an induction for newly qualified nurses or even health care assistants. It was that basic…. I switched off for quite a lot of it. And as I said a lot of the concepts we looked at were interesting but they were not presented in any depth."
Inclusion of more staff in the training	P2: "I was a bit disappointed by the fact that it was only me and my previous ward manager attending this course. I would have loved to have seen more people from [my] organisation … attending." P4: "I don't think it should just be a leads programme. I think the programme should be for everyone. I actually got feedback from a lot of people [that] actually it's the frontline staff that probably needs more of this … I think more of the leaders know a lot of this stuff. It was just reinforcing and updating the most up-to-date elements of it."

More time to reflect on what was being taught and reduced course intensity	P2: "It felt like a significant amount of information came in, you know, I wouldn't say short period of time because it wasn't necessarily short … but I think it was so much, that I think maybe it required a bit more time to digest." P2: "The only thing I can think of that could be improved with this course is intensity. So you know, maybe given a bit more time for digesting, reflecting, let that information kind of sink in. I think because it's been such a comprehensive course that's why it maybe felt like the information was at times a bit overwhelming and the pace was a bit too fast." P4: "I feel like if the programme was maybe a week, I think that might work face to face. I quite liked … that it was every couple [of] days. I enjoyed it, but I'm going by not just my own perspective, I was receiving how everyone else was thinking as well." P5: "For me at times I felt a little bit overwhelmed with the amount of information there was and one of the things I suggested at the end was that perhaps at the end of each session we could have a think as a group about 'what have you learned today?', 'Is there anything from today that you might want to take forward and have a little bit of time to think about that?' …. There was so much information, it was great, but it was, like, when am I going to do anything with this?" P6: "The amount of information that we were engaging with during the day … because, you know, we're doing this course alongside the day-to-day work. While we had protected time to join in the training session, we were still dealing with the day-to-day work pressure, so I think … in that sense, absorbing the material, it did feel heavy some of the days. The session did feel heavy in terms of the amount of information that we were absorbing."
Improved linkage with others (from own and different teams) to support implementation	P2: "I think what people are asking at some point was, is there any way this programme could actually link people with the relevant people in their trusts, to kind of start some working?...Because I would love to get involved with some of these things, but it's difficult." P4: "Sometimes there were topics or we had exercises to do and it would have been nice to have done them with those from your actual organisation, because that's what we're working towards. I think that's the only [downside]."
Online versus face-to-face training	P4: "I didn't like it [on] the day when, and I know it couldn't be helped, when some people met face to face, but the option of virtual was there. To me it just doesn't work." P5: "It was a shame about COVID because … when we actually did manage to meet face to face it was so lovely and so helpful … there was a lot of material but I think trying to take it all in on the screen [when meeting virtually] was difficult."

6.3.3. Impact of the LEAD Safely training programme

Changes to leadership style

All interviewees reported that the training led to changes in their leadership style, creating positive changes in how they lead others and employ a trauma-informed approach. The interviewees felt that they had a greater understanding of how to support their team, increased self-awareness, and updated knowledge to give them the confidence to challenge and change current practices.

There are quotes from the interviews that exemplify changes to leadership style as a result of the LEAD Safely training programme in Table 15.

Table 15: Changes to leadership style

Theme	Example quotes
More in-depth knowledge and an appreciation of the importance of trauma-informed care	P1: "Being familiar with these concepts kind of enriches or enhances your leadership skills …. I can think of the session on civility, which seems so basic but so important. I mean, I'm always civil to everyone, don't get me wrong, but it's kind of having that knowledge of some of the concepts that really made a difference and kind of thinking, actually, I always try to be nice to people and respectful but it gave me a kind of even newer appreciation of how important it is. So I suppose, yes, in that sense it had an impact." P2: "The concepts brought up in the programme were … in a non-formal or not necessarily [in an] academical [sic] way familiar to me … it fitted very much [with] the way I was doing things anyway. But I think having that theoretical knowledge around that enables me to do it maybe in a more structured manner, being more aware of the fact that I was doing it …. Be more aware of it, be more able to articulate it in discussions with my staff and you know, supervision and so on. So you know, it did help because it made me much more aware of myself and the things that [I] was doing and also more able to actually bring them out to others." P3: "At the end of the day you will have something precipitated in your mind. And maybe it is useful, and maybe you are aware about this, but you weren't. For example we know that assessment at the start of admission is very important. But we weren't at the time much interested in the dynamic of the patients." P5: "I feel like there is more in my toolkit to hand out to people and you know, different scenarios.".

Team awareness and support	P4: "So I think there's that element of providing that awareness and knowledge 'cause not everyone in my team's from a mental health background. So there's that side of things anyway. But I think for me, the psychological safety has been the main key and thinking about how I am as a leader .... How I support my team as a leader, but also thinking about my management skills as well. So they are the main things that I would feel that I've probably considered more than anything." P6: "The information on psychological safety in teams made me think about how I create space for discussions within the teams ... so thinking about how we offer opportunities for different groups of staff to come together to feel able to not just say the things that they think we want to hear but also be able to say what it's like in reality. What are the difficulties."
Challenging and changing the status quo	P3: "We are not talking about things in a different way. We knew before that activities are important. But now [because of the] programme the trust is paying attention to these things. There is a lot of innovation in my ward. They created a sensory room downstairs." P5: "I think that it was one of the most useful things that I just had the confidence to ask those sort of questions .... I do challenge people, but I don't find it easy and I'm much better at saying, 'you've done a really good job'. So it gave me the confidence to think about how I could do that without people feeling criticised or demoralised." P6: "Trauma-informed care means a whole new way of looking at things and a new way of approaching things."
Self-awareness	P1: "When we did the psychometric test ... that was really spot on and did say some things, and I thought 'yeah, that's really explained why I'm struggling in certain aspects of my role'." P4: "I think the element of being able to think about my idea, what I want to do is really good, but it's just getting it in place really. I'm having that time [to] really reflect on who I am and, as a leader, how I support others."
Provision of a structure for knowledge	P3: "When I came to the training it was very good because it gave me a structure, how one can do this. So I have the background as a psychiatrist, but ways to solve the problem. It was very helpful and then implementing all these things, all this structure within the team."

Changes to ward culture

Interviewees discussed the effects of the training on ward culture, specifically regarding a deeper understanding of trauma-informed care. While three interviewees mentioned how they were contributing to a more trauma-informed approach, one did not feel that the ward culture had changed as a result of the training.

There are quotes from the interviews that exemplify changes to ward culture as a result of the LEAD Safely training programme in Table 16.

Table 16: Changes to ward culture

Theme	Example quotes
Trauma-informed care	P2: "What I made a big case about was that my juniors do a very good read of patients' history after patients get admitted, and in the first MDT [multidisciplinary team meeting] after the patient gets admitted, we do a comprehensive review of the person's history, focused on traumatic experiences. Or, you know, we're trying to do a bit of a formulation regarding that, identifying triggers. And so that's definitely something that wasn't necessarily happening as regularly before. And it's happening now." P3: "We have a huddle every morning for 1 hour, and I'm using this huddle to discuss risk … to discuss the reason for the behaviour to give the team insight and trauma-informed service." P4: "One of the main things that I would say … a bit more on trauma-informed care …. I think I probably learnt a lot more on trauma-informed care that what I already knew."
Treating people as human beings	P2: "Really, it's about treating people as humans and treating them alike. You're equal, really, and this is what I keep saying too. Let's say somebody wants something. 'Oh no, no, we can't just …', I say 'Why? Why can't we do that?', 'Because it's a patient.' 'What if it's a patient? What would you do if you'd been at home?' … so, I think mostly it's about that. It's about having an open mind … and really just treating people with respect." P4: "The patient was quite challenging and you could see the exasperation, so I think those nurses approached that patient in a different way, which helped."
No change to ward culture	P1: "No I wouldn't say so, no change … I do that [involving patients and their carers] as part of my job, but I can't say training has made a difference there."

6.3.4. Implementing new skills and knowledge

Interviewees highlighted several ways that implementing the skills gained from the LEAD Safely training programme could be accomplished. Although challenges such as high staff turnover and lack of time were mentioned, interviewees demonstrated their enthusiasm for more involvement of service users, training and role modelling. Some also reported that implementation is easier when more staff members and stakeholders subscribe to the messages of the training. Many discussed how to continue the learning from the training despite the challenges, for example through 'refresher' courses or similar.

Quotes from the interviews that give examples of suggested methods for implementing skills and knowledge from the LEAD Safely training programme are in Table 17.

Table 17: Implementing new skills and knowledge

Theme	Example quotes
Challenges to implementation:	P2: "If you don't have a good core team, it's extremely difficult to implement anything really ... I mean, even now we've got some gaps and I'm still waiting for the new ward manager to start .... I had a ward manager, when they sent the programme, it was me and the manager attending the programme. He's now left."
High staff turnover	P3: "Our problem is that the staff are leaving ... they burn out ... then we need to have to repeat ourselves again with the new command. And this is life ... this will never change." P5: "Since I have done the course, there's been quite a high turnover of staff."
Lack of time	P4: "I would say my main challenge at the moment is just time. I've done the programme now and there's a project I want to do but it's having the time to formalise it and implement it." P5: "I think time really and we're talking a lot about that because ... people are doing long days all they time ... so there isn't that opportunity." P6: "So many different pressures to show results I suppose with these things. So I think creating time to make changes to ... and I think the pressure comes from being able to show results straight away and some of those things we can't change overnight."

Encouraging more buy-in: ***From stakeholders***	P6: "So the challenge has been about bringing those changes in, you know, in the way our policy is written our operational policy needs to reflect those approaches, that philosophy. So yeah, I think for me because I've had good support as well from the exec team, from the director of [trust] and also my sort of immediate line manager and director, it's been easier to have those conversations, to put those items on the agenda."
From other staff members	P2: "I'm going to be actively encouraging some individuals based on my experience, and say this is a good one to go for and encourage them to attend that." P4: "I think the programme should be for everyone." P6: "I think I'd like more people to go on the course. Because I think I come across people who would mention the concepts but don't have the same in-depth knowledge of it. So I think opportunities for a wider group of leaders to have the same opportunities, same depth of knowledge would be great."
Involvement of more service users and carers:	P2: "We had a few patients who've been on the ward and expressed their wish to become peer support workers. They wanted to come and work with us in themselves. The process is not as straightforward as I was hoping ... but I would love to have some peer support workers on the ward." P4: "Thinking about how to be a bit more well informed of how I coordinate co-design." P4: "We have what's called patient safety partners as they're like involvement representatives. So going forward the aim is that they will be part of some of the training delivery. So they will co-design some of the training to support going forward and be part of the training."
Sharing learning with others	P6: "I've been sharing that sort of new way of approaching incident reviews with others and that's well received and welcomed certainly by the senior management team and the exec team."
Role modelling	P2: "When I think, I think I'm using this case every day. I mean, it's the way you work, isn't it? So although maybe not necessarily in a formal manner, but not necessarily any kind of formal training that I give to my staff, but it's about that day-to-day role modelling, and it's about really, instilling that type of culture into the team." P5: "Part of my role is a bit of role modelling. When I go to the ward, I'll speak to the patients and the staff and try to do a bit of sort of positive role modelling so, I guess you know, again, from doing the course I had more confidence to do that."

Training	P4: "It's been really interesting to get people to really recognise and have the knowledge about relational security because my background is forensic. So that's my bread and butter, but I've always questioned why it was never rolled out to other services in inpatient in the first place." P6: "We have made progress in, for example, reviewing our prevention and management of violence policy to incorporate both relational security and trauma-informed care in the policy, and that means as part of our training that we are incorporating those elements as part of our induction of staff."
Challenge of communicating learning	P2: "It's a bit challenging because you don't have the connections, you don't know exactly what's going on. If it's not been communicated, then people don't have access to that knowledge. They can't use those skills."
Follow-up training sessions	P2: "Obviously if there is any other follow-up from the course or anything that's related to it, I'll be very much interested to attend." P3: "I'm very keen to know or to understand what kind of regular follow-up or feedback mechanism [there will be]. This is very good for everyone. I think we should think about what the initiative that could maintain the same level of the activities because people will attend conferences … but after a while they will go down." P4: "They said we're going to do follow-up sessions. I haven't heard anything, don't know when that will be. That'd be good to follow up, really, just to keep the momentum … because otherwise what's the point? Because I can see half the people going back and then that's it, because that's what will happen if I'm honest."

6.3.5. Summary of findings: LEAD Safely training programme interviews

Interviewees provided a variety of different reasons for joining the training programme, such as recognising its importance in navigating the inpatient setting, and relevance to day-to-day work. Some interviewees felt that the topics covered were highly relevant to their job role.

Although interviewees were generally very positive about the training and the facilitators, they did suggest a few improvements to content and delivery. Some interviewees felt that there was not enough time to reflect on all topics covered, or that the training was quite intensive.

Interviewees reported that the training had a positive impact on the way they lead their teams, and on their ward/working culture. They found the theoretical knowledge underpinning what was taught in the training provided a formal and structured

way to think about how they lead others. Interviewees also mentioned how the training has highlighted the importance of applying a trauma-informed approach to their ward culture and multidisciplinary team meetings, encouraging their colleagues to consider how a patient's history affects their present situation.

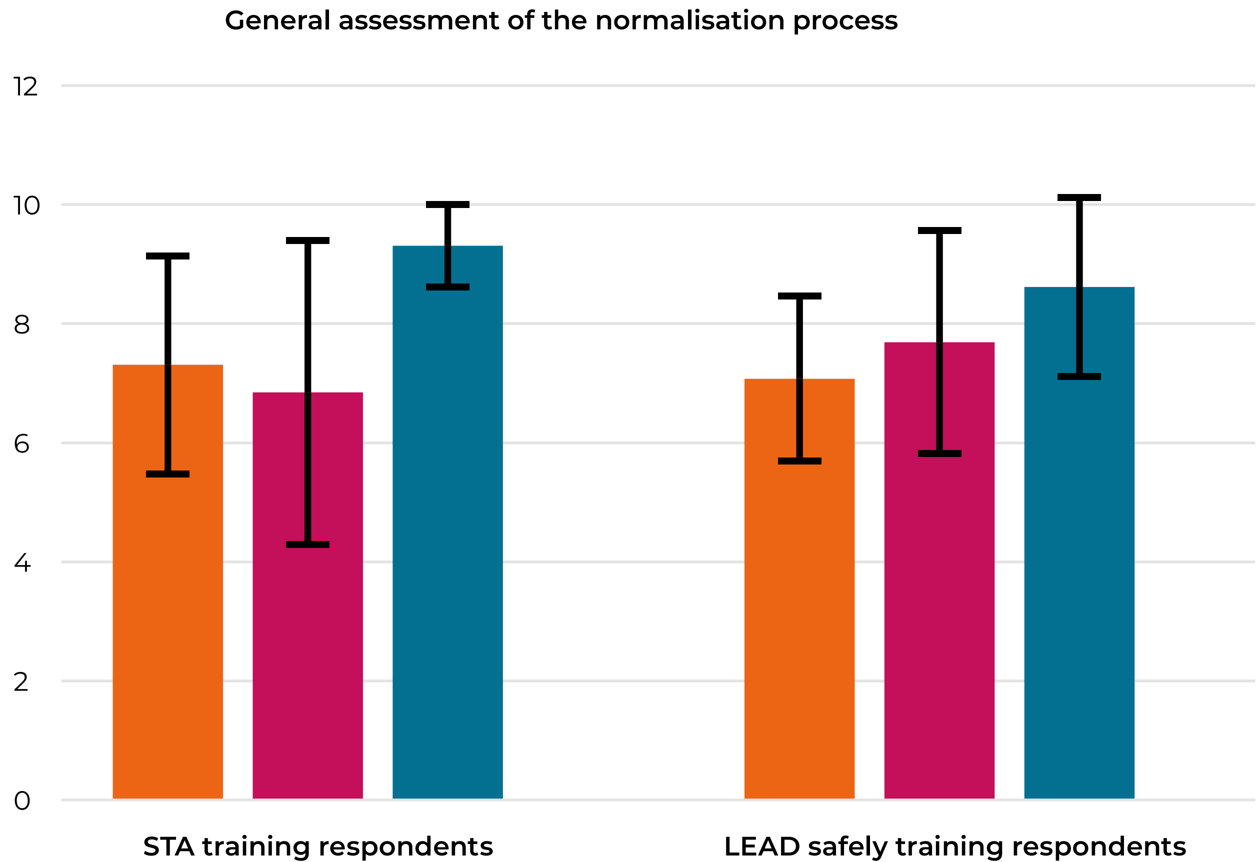
Interviewees mentioned several ways of implementing the skills and knowledge gained from training. They highlighted the importance of sharing learning with others, for example through training and role modelling, and of leaders setting an example of how to interact with service users on the ward. They were also keen for more staff to attend the training to make implementation easier, although it was clear that interviewees were aware of the limiting factor of high staff turnover in promoting further diffusion of concepts from the training. Some also mentioned involvement of service users (peer support workers) on the ward; however, this process might be hindered by formal recruitment processes. The importance of maintaining the learning through follow-up and refresher courses was also mentioned by some interviewees.

6.4 NoMAD questionnaire

The questionnaire asked three overarching normalisation (how practices become routinely embedded and integrated into their social contexts[6]) questions about familiarity with and normality of the STA framework. Response options ranged from 0 (not at all) to 10 (completely), followed by questions about the extent to which respondents agreed with each of the normalisation process constructs: coherence, cognitive participation, collective action and reflexive monitoring (see Section 4.4.2 for an explanation of the constructs).

Thirteen STA facilitator training participants and 13 LEAD Safely training participants responded to the NoMAD questionnaire (Appendix 1.4) after training. A reasonable level of familiarity with the STA framework was reported by STA facilitator (mean [M]=7.30, standard deviation [SD]=1.89) and LEAD Safely trainee respondents (M=7.08, SD=1.44). Respondents were more certain that the STA framework would become a normal part of their work in future (M=9.30, SD=0.75 and M=7.69, SD=1.93 for STA facilitator and LEAD Safely respondents, respectively) than they were that it was currently a normal part of their work (M=8.85, SD=2.61 and M=8.62, SD=1.56 for STA facilitator and LEAD Safely respondents, respectively). This is represented in Figure 10.

Figure 10: Overall normalisation responses (error bars represent SD)



When you use the STA Framework, how familiar does it feel? (0 still feels very new, 5 somewhat new, 10 feels completely familiar)

Do you feel the STA framework is currently a normal part of your work? (0 not at all, 5 somewhat, 10 completely)

Do you feel the STA framework will become a normal part of your work? (0 not at all, 5 somewhat, 10 completely)

6.4.1. Responses from STA facilitator trainees

Coherence

While most respondents could see how the STA framework differed from other ways of working, and understood its value and how it impacted their work, 61% were unsure or did not agree that all staff in the organisation had a shared understanding of the purpose of the framework.

Cognitive participation

Almost all (92%) agreed that there were people to drive the use of the STA framework forward at their workplace, that its use was a legitimate part of their role and that they were open to working with colleagues in new ways to use the framework. All 13

respondents strongly agreed that they would continue to support the STA framework and training in its use.

Collective action

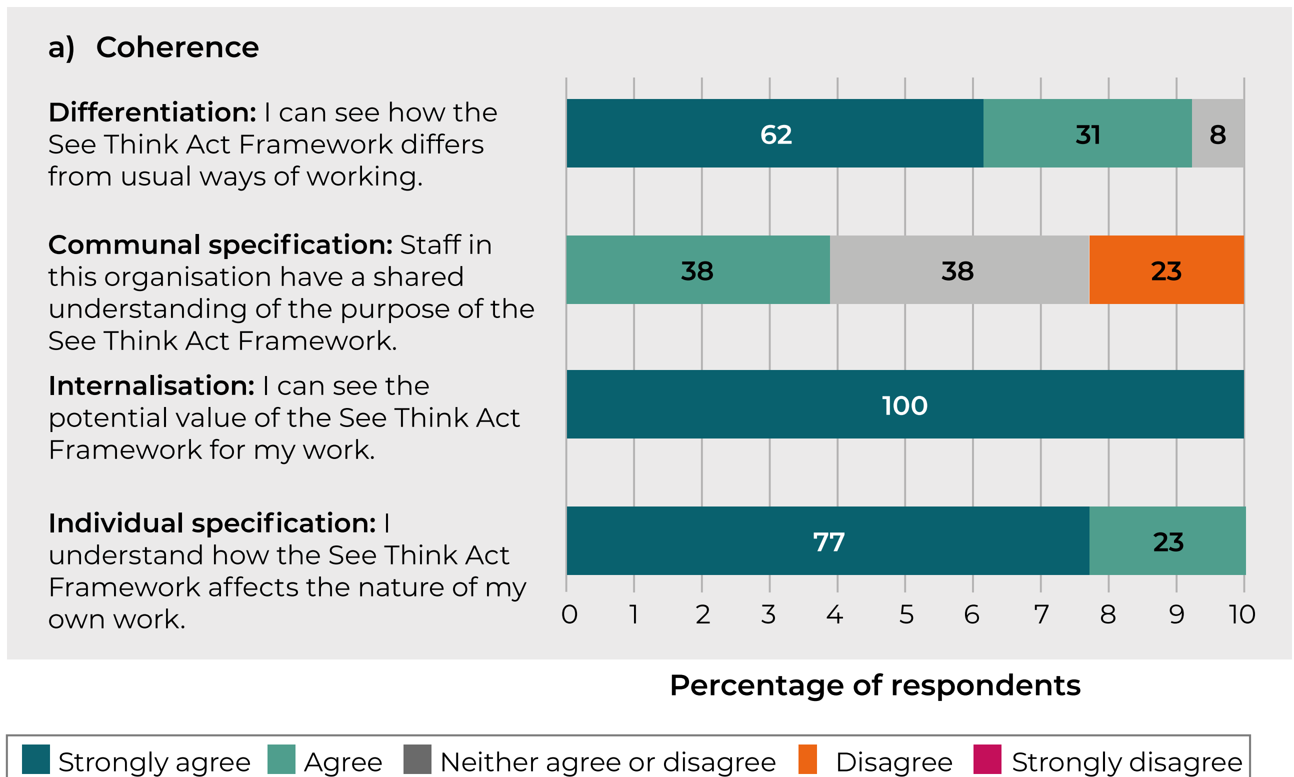
Overall, fewer respondents agreed with statements for this construct, with a higher proportion instead who neither agreed nor disagreed with statements about confidence in the ability of others to use the framework and the availability of people with the necessary skills to use it. Almost all (92%) respondents agreed that the STA framework could be incorporated into their existing work.

Reflexive monitoring

Although some (30%) respondents either 'neither agreed nor disagreed' or 'disagreed' that they were aware of reports of the effects of the STA framework, almost all agreed that they and other staff felt the framework was worthwhile and that feedback could be useful to improve or reconfigure the use of the STA framework in future.

A summary of responses is shown in Figure 11.

Figure 11: (a) Coherence, (b) cognitive participation, (c) collective action and (d) reflexive monitoring of responses from STA facilitator training respondents[g]



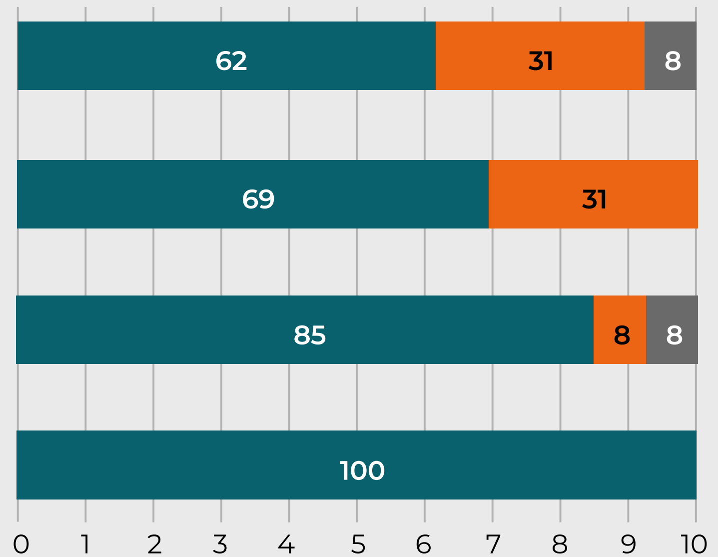
b) Cognitive participation

Initiation: There are key people who drive the See Think Act Framework forward and get others involved.

Legitimation: I believe that participating in the See Think Act Framework is a legitimate part of my role.

Enrolment: I'm open to working with colleagues in new ways to use the See Think Act Framework.

Activation: I will continue to support the See Think Act Framework/training.



c) Collective action

Interactional workability: I can easily integrate the See Think Act Framework into my existing work.

Relational integration (1)*: The See Think Act Framework disrupts working relationships

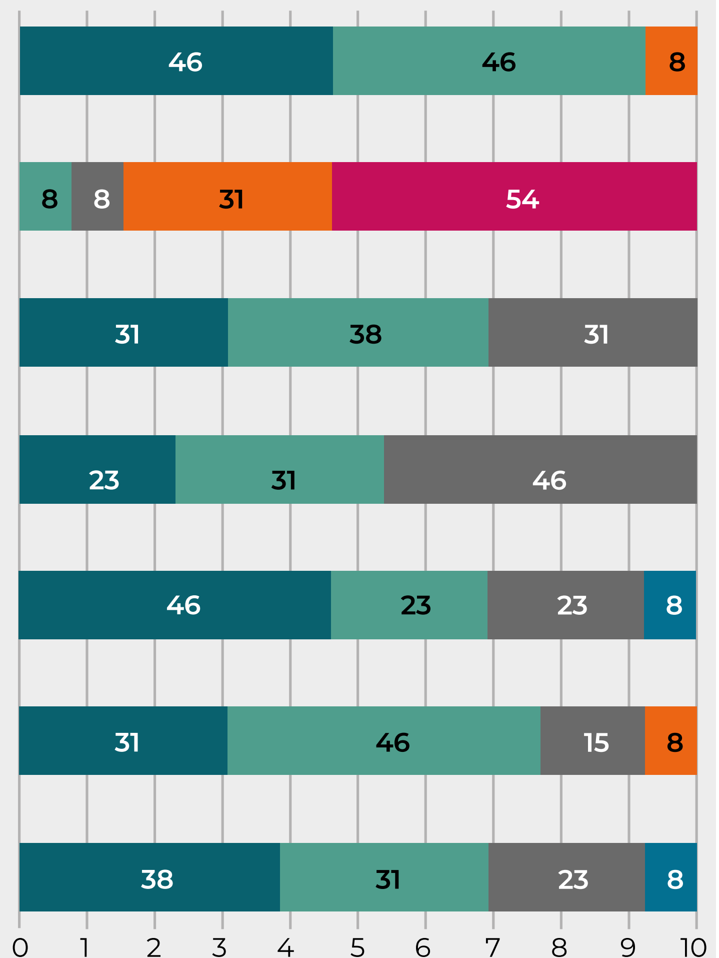
Relational integration (2): I have confidence in other people's ability to use the See Think Act Framework.

Skill set workability (1): Work is assigned to those with skills appropriate to the See Think Act Framework.

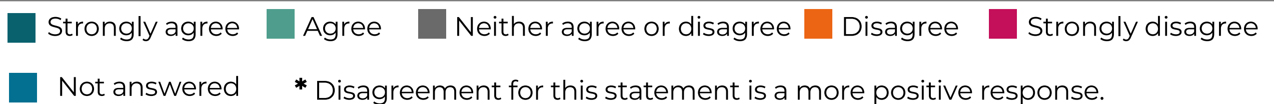
Skill set workability (2): Sufficient training is provided to enable staff to implement the See Think Act Framework.

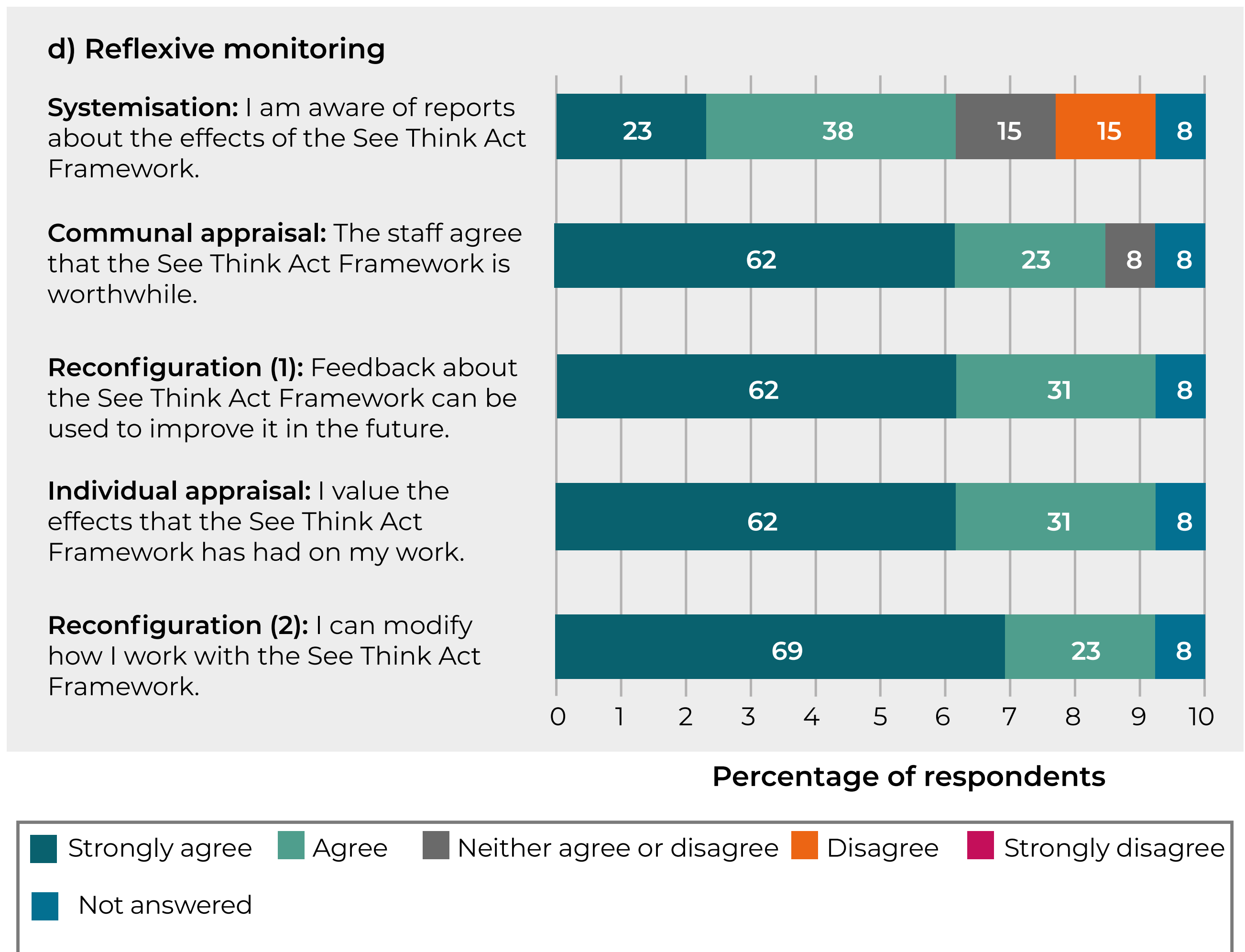
Contextual integration (1): Management adequately supports psychological safety, the See Think Act Framework and trauma-informed care.

Contextual integration (2): Sufficient resources are available to support psychological safety, the See Think Act Framework and trauma-informed care.



Percentage of respondents





6.4.2. Responses from LEAD Safely trainees

Coherence

Coherence was generally high. Almost all respondents agreed that they could see how the LEAD Safely training elements differed from usual ways of working, that the value of psychological safety, trauma-informed approaches and the STA framework was clear, and that they understood how the nature of their work was affected by these approaches. Fewer (60%) participants agreed that staff in their organisation had a shared understanding of the purpose of psychological safety, the STA framework and trauma-informed care.

Cognitive participation

Cognitive participation of respondents was also high. All participants agreed that the content of the LEAD Safely programme was a legitimate part of their role, and that they were open to working in new ways with colleagues and to continue to support psychological safety, the STA framework and trauma-informed care. Although still representing the majority of respondents, a comparatively smaller percentage (73% compared with 100% for other statements) of respondents agreed that there are key people to drive these things forward at their workplaces.

Collective action

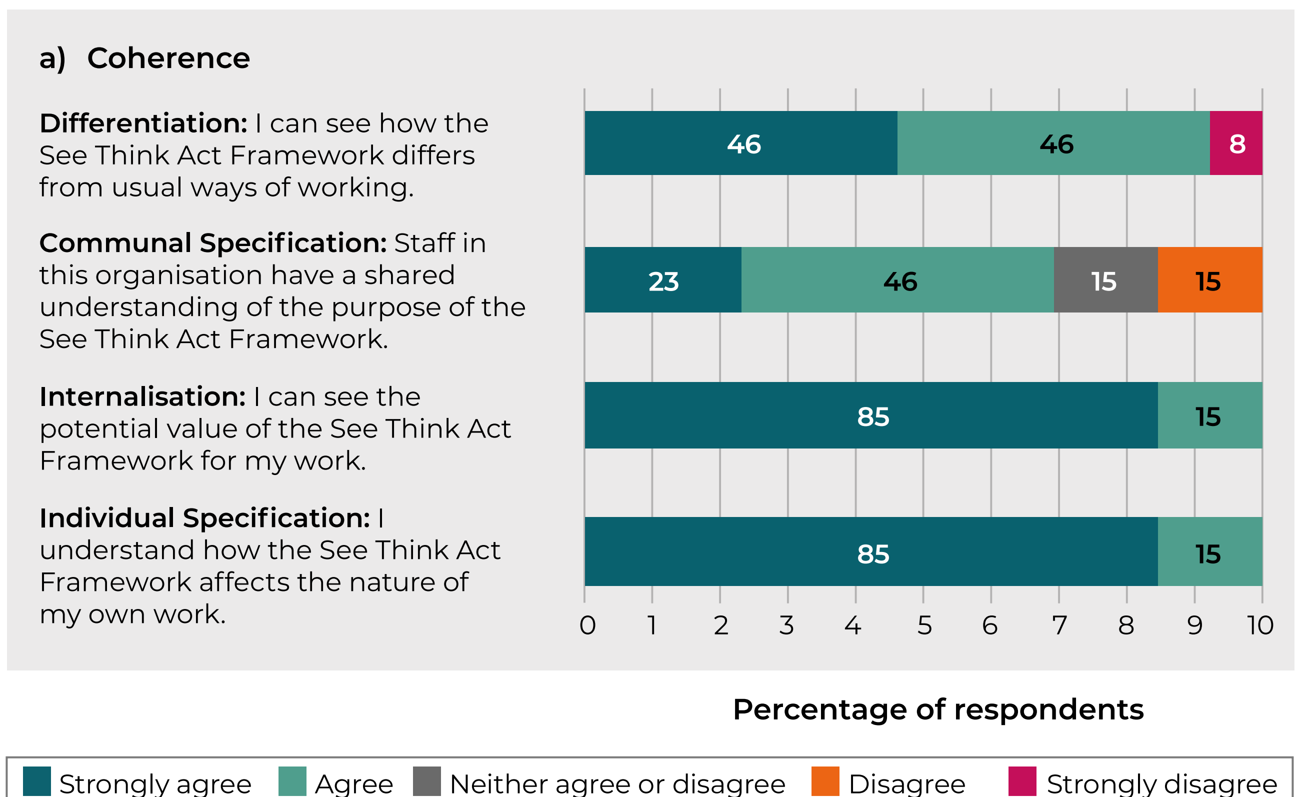
As with respondents who participated in the STA facilitator training, responses about collective action were mixed. However, most respondents agreed that they could easily integrate the concepts learnt into their existing work, that use of these did not disrupt working relationships and that management adequately supported the concepts. Comparatively fewer (69%) agreed that they were confident in the ability of others to utilise the concepts learnt, and some respondents did not agree with statements about the available skills of staff to employ psychological safety, the STA framework and a trauma-informed approach (38–62% agreement). Only 39% agreed that there were enough resources to support the use of these approaches.

Reflexive monitoring

All except one respondent (who did not answer questions about reflexive monitoring) agreed that they valued the impact of what they had learnt had on their work, and felt that feedback about it could improve it in the future. They also agreed that modifications to the approaches were possible. Fifteen percent of respondents neither agreed nor disagreed that they were aware of the effects of psychological safety, the STA framework and trauma-informed care, and that staff agreed that these were worthwhile, while 8% (one respondent) disagreed that staff felt they were worthwhile.

A summary of responses is provided in Figure 12.

Figure 12: (a) Coherence, (b) cognitive participation, (c) collective action and (d) reflexive monitoring of LEAD Safely trainee respondents[g]



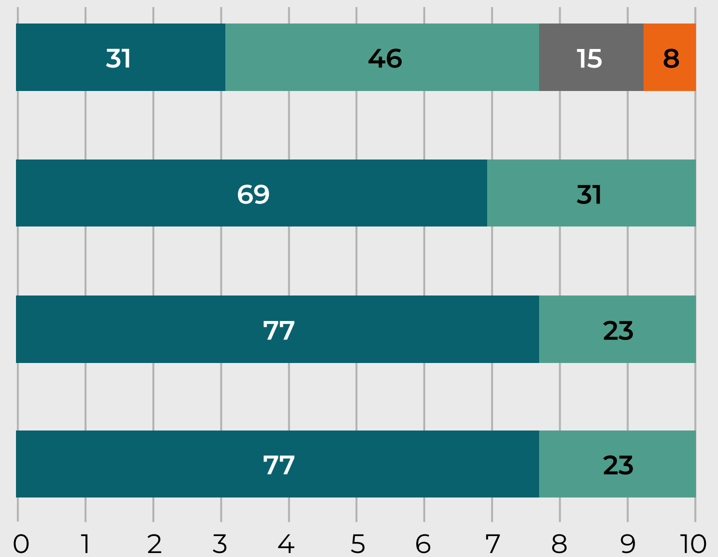
b) Cognitive participation

Initiation: There are key people who drive the See Think Act Framework forward and get others involved.

Legitimation: I believe that participating in the See Think Act Framework is a legitimate part of my role.

Enrolment: I'm open to working with colleagues in new ways to use the See Think Act Framework.

Activation: I will continue to support the See Think Act Framework/training.



c) Collective action

Interactional workability: I can easily integrate the See Think Act Framework into my existing work.

Relational integration (1)*: The See Think Act Framework disrupts working relationships

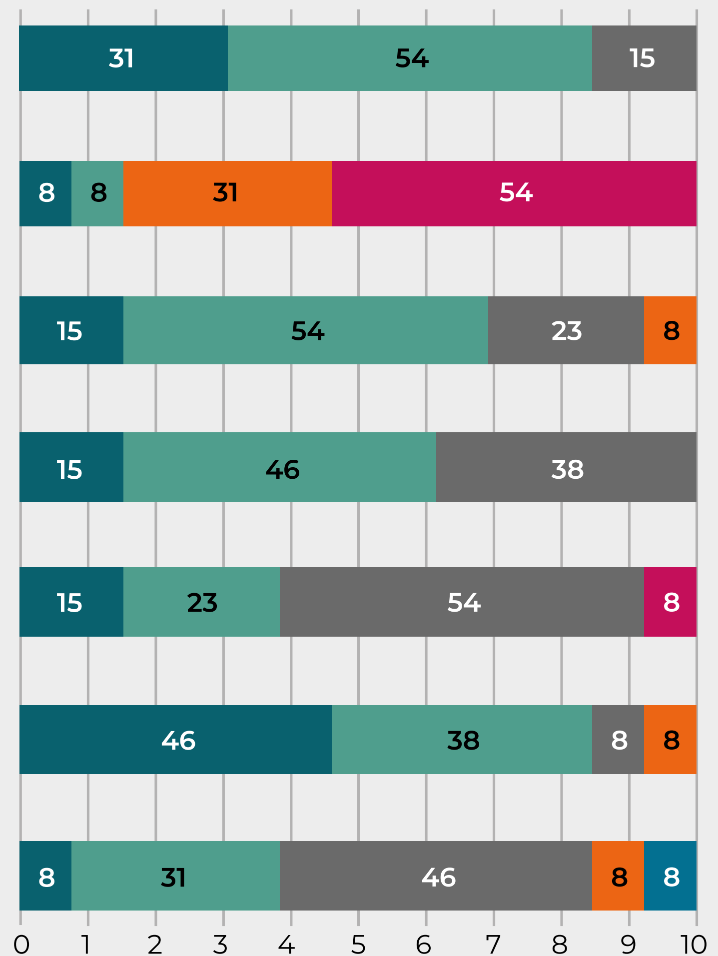
Relational integration (2): I have confidence in other people's ability to use the See Think Act Framework.

Skill set workability (1): Work is assigned to those with skills appropriate to the See Think Act Framework.

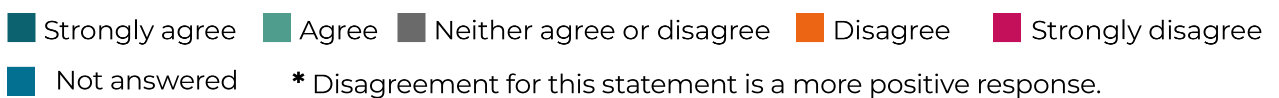
Skill set workability (2): Sufficient training is provided to enable staff to implement the See Think Act Framework.

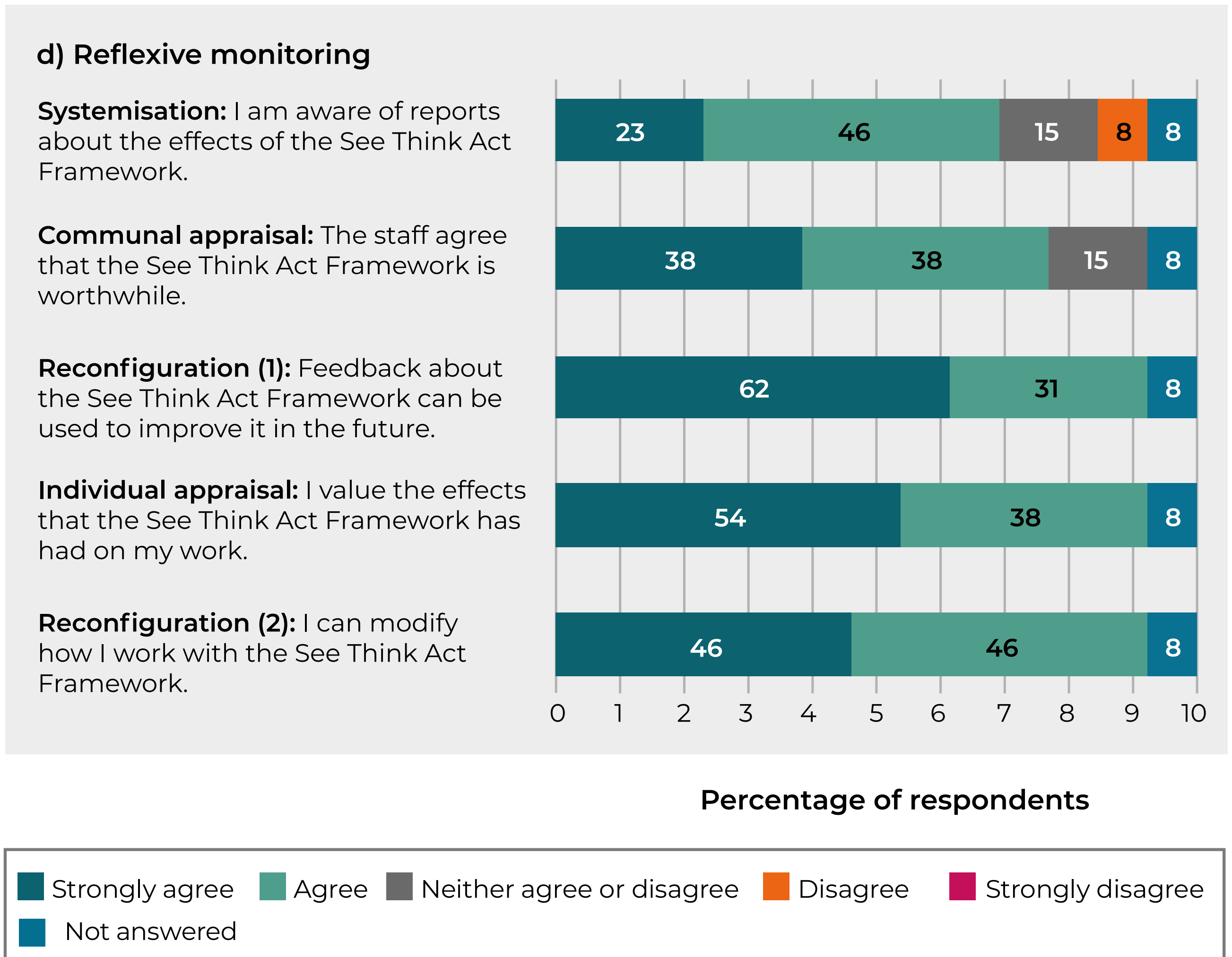
Contextual integration (1): Management adequately supports psychological safety, the See Think Act Framework and trauma-informed care.

Contextual integration (2): Sufficient resources are available to support psychological safety, the See Think Act Framework and trauma-informed care.



Percentage of respondents





6.4.3. Summary of findings: NoMAD questionnaires (STA facilitator and LEAD Safely training programmes)

Overall, responses to the NoMAD questionnaire indicated that there was some positive and sustainable implementation of the training content on wards.

There was good overall understanding of the new ways of working discussed in the training and how these ways may differ from current practice, and almost all respondents seemed committed to implementing the principles in their service. However, there was some uncertainty about certain aspects of collective action, particularly 'skill set workability' (which represents a belief that staff may not have the correct level of training and skills required to implement the training).

There was general consensus across both STA facilitator and LEAD Safely training NoMAD respondents that, although staff were committed to implementing what they had learnt in their practice, currently, staff were not able to do this due to lack of resource or skills of other staff who may not have attended the training. For example, less than one-half (46%) of respondents who took part in the STA facilitator training 'neither agreed nor disagreed' that work was assigned to people who had the appropriate skills to implement the STA framework. Furthermore, 62% of LEAD Safely training respondents either 'neither agreed nor disagreed' or 'strongly disagreed' that sufficient training is provided to enable staff to implement the training; this represented a comparatively higher proportion of responses compared with other statements. This

suggests that some learnings from the training may not be well embedded in the system as a whole at present.

This echoes what we learnt from the qualitative interviews: that interviewees were keen to extend the roll-out of the training to support more staff with the knowledge needed. In addition, over one-half of respondents from the LEAD Safely training (54%) 'neither agreed nor disagreed' or 'disagreed' that sufficient resources are available to support the implementation of what was covered in the training. Most respondents were able to assess the effects of implementing the STA framework, although just under one-third (STA facilitator training 30%; LEAD Safely training 23%) were unsure or did not agree that they were aware of reports on effectiveness. This suggests that there may be some desire to learn more about the efficacy of the STA framework, psychological safety and a trauma-informed approach.

6.5 Overall summary of findings: Behaviour

From the interviews that we conducted, both training programmes were viewed positively, with reports of a deeper understanding of the concepts and of patient perspectives, and enjoyment of the group format and teaching styles of the trainers.

Most trainees demonstrated a willingness to adopt the concepts learnt in their day-to-day roles, and suggested several ways to implement and roll out the training. There was general consensus that being a good role model for other staff and contributing to culture change on the wards were important first steps, alongside more training for more staff. There was a call for more staff from the same organisation to attend the training to make implementation easier, particularly given the high staff turnover experienced by some wards. The importance of maintaining the learning through follow-up and refresher courses was also suggested.

The interviews with LEAD Safely trainees indicated that the training was most beneficial for people who actively sought to engage with it rather than those who had been 'pre-selected'. There was some uncertainty about the suitability of the length and intensity of the LEAD Safely training, which could possibly be addressed by pitching the training to staff who are not familiar with the topics covered and spreading it out over a longer period of time, or delivering the training at separate times to different staff groups according to their level of knowledge and experience of the topics covered.

Responses to the NoMAD questionnaire were also generally positive and indicated that there had been sustainable implementation of the training content on wards. There was good overall understanding of new ways of working and a discernible commitment from respondents to implement the principles in their service. However, there was some uncertainty as to whether work on wards is always assigned to people with the appropriate skills in psychological safety, the STA framework and trauma-informed care, or if sufficient training is provided to enable staff to implement these approaches.

Staff were keen to extend the roll-out of the training to equip more staff with the knowledge and skills needed, which is also borne out by the interviews. However, there was some uncertainty about the availability of resources to support the wider roll-out of the training.

7. Conclusions and recommendations

Both the STA facilitator and the LEAD Safely training programmes were viewed positively, with participants enjoying the group format and teaching style of the trainers.

Following the STA facilitator training programme we found that: (a) there had been some use of approaches associated with trauma-informed care, (b) trainees' confidence in understanding and using the STA framework had increased, and (c) knowledge of the STA framework concepts had improved.

There was an indication that the LEAD Safely training was most beneficial for people who had chosen to apply to take part in the training rather than those who had been 'pre-selected' by their managers. For this programme, there was a self-reported improvement in leadership skills and, subsequently, improvement in ward culture for staff teams. There were also reports of improved experiences for inpatients and of increased use of trauma-informed approaches following the LEAD Safely training programme.

There was some uncertainty about the suitability of the length and intensity of the LEAD Safely training programme. We suggest that this could be addressed by:

- developing the training for staff who are not familiar with the topics covered and spreading it out over a longer period of time or
- delivering the training at separate times to different staff groups according to their level of knowledge and experience of topics covered.

Facilitation of the training programmes by experts with lived experience had been a positive experience for the majority of attendees, because their perspectives validated what was being taught, and provided a different lens through which clinicians would view their own practice and patients. The opportunity to facilitate the training programmes was also a positive experience for experts with lived experience.

In terms of implementing the training, we identified evidence of some sustainable implementation of the training content on wards. However, we also observed concerns about the necessary resources and skills for wider implementation, which might be a reflection of current NHS workforce pressures. Nevertheless, there was a noticeable commitment

from trainees to adopt the concepts learnt in their day-to-day roles and implement the principles on their ward or in their service, with clear implementation plans made. There was general consensus among the trainees that being a good role model for other staff and contributing to culture change on the wards were important first steps in implementing the training at an individual level.

While most respondents to the NoMAD questionnaire could see how the STA framework differed from other ways of working, and understood its value and how it impacted their work, 61% were unsure or did not agree that all staff in the organisation had a shared understanding of the purpose of the framework. This has implications for implementation of the training and suggests that additional focus on how the STA framework can be used on a day-to-day basis could be beneficial.

This was echoed in the interviews, where there was a clear call from the trainees for more staff from the same organisation to attend the training to make implementation easier, and to increase skills more widely in psychological safety, the STA framework and trauma-informed care to further assist implementation. We would recommend that organisation-wide training is considered in any future roll-out of the training.

Reports that staff attitudes and networking have an important impact on implementation suggest that an important consideration may be the interface between the LEAD Safely and STA facilitator training, and how trainees of both courses can learn from and support each other to improve ward culture.

The importance of maintaining the learning was emphasised by trainees, with follow-up and refresher courses being suggested, which we would endorse.

Finally, we observed that the community of practice provided a useful and easy way to share learning and experiences with others, and build a network. However, there was some indication that it was not being utilised by everyone who had attended the training. One reason for this could be that communication about the community of practice was not sufficient to reach all trainees, or that staff did not feel they had enough time to access the resources alongside their work commitments, given training attendees' reports of needing time to digest information.

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