



Culture of Care

National Learning Session

Tuesday 31 March 2026 | 10:00 – 15:30

Edgbaston Stadium

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH



Neurodiverse
Connection

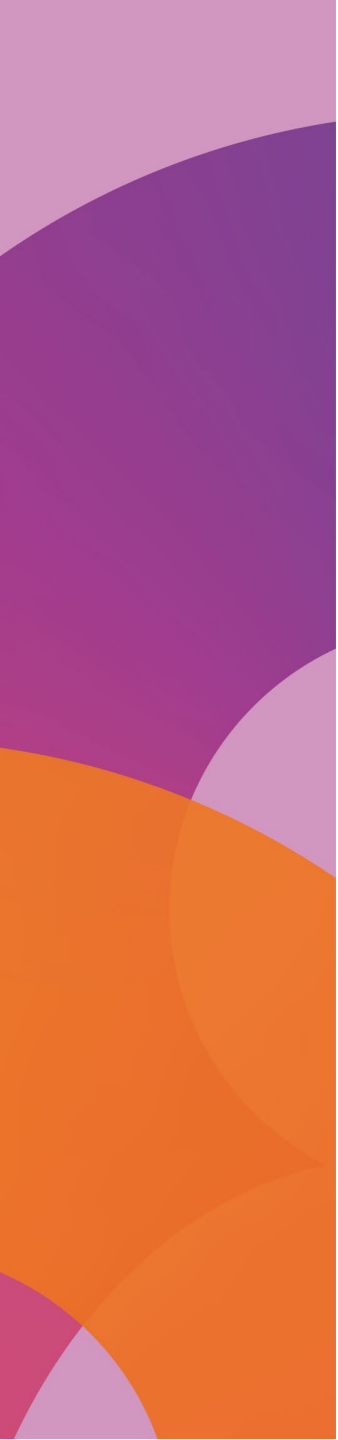


NCISH

Welcome



Tom Ayers
Director
NCCMH



Introduction to the day

The aims for today:

"A pat on the back and a kick up the arse"

Sal Smith

Head of Lived Experience and Co-production

Introduction to the venue

- Main meeting room:
Banqueting Suite
(2nd floor)
- Catering / Refreshment:
1882 Suite
(2nd floor)



- There are a few additional spaces that we invite you to use at any time:
 - The balcony at the back of the room
 - The catering room (1882 Suite)

Introduction to the venue

- There is a **wellness room** and a **sensory room** available throughout the day.

They are a couple of minutes' walk from this room. People wearing red or yellow lanyards will be able to guide you to these rooms.

Wellness room



Sensory room



Housekeeping

- There are **no fire alarm tests planned** for today. If the alarm does go off, please follow the 'green man' signs.
- **Toilets** are in the **lobby near the lifts**.
- Some of the material we cover may be **triggering**.

If you need to step away, please do so and make use of the wellness room and additional spaces. If you need to speak to someone, please approach anyone wearing a **red or yellow lanyard**.



Housekeeping

- We have made a few adjustments today to try and meet everyone's needs.

If there is anything the team can do to help or you have any questions, **please let us know** (we are spread out across the room and are wearing **red and yellow lanyards**).



Today's agenda (part 1)

Time	Event
10:00 – 10:15	Welcome, housekeeping and grounding
10:15 – 10:40	Learning and reflections from Culture of Care
SECTION 1: Showcasing the work from Culture of Care	
10:40 – 10:50	Celebrating the shift towards Lived Experience Leadership
10:50 – 11:05	Ward Stories
11:05 – 11:20	Table reflections
11:20 – 11:35	BREAK
11:35 – 12:05	Organisation stories
12:05 – 12:20	Table reflections
12:20 – 12:25	Wrap up / reflections
12:25 – 13:25	LUNCH

Today's agenda (part 2)

Time	Event
13:25 – 13:35	Quiz time!
SECTION 2: FOCUS ON CONTINUING THE WORK	
13:35 – 13:55	Personalised Approach to Risk
13:55 – 14:25	Learning from our lived experience approach
14:25 – 14:40	BREAK
14:40 – 15:00	Equity focused ward reviews
15:00 – 15:10	Table reflections
15:10 – 15:30	Close

How we want to work together



Collaborative learning – *Make the most out of the day, whatever that looks like for you.*



Respect privacy – *Protect carefully the privacy of the storyteller. Ask what parts, if any, you can share with others.*



Approach with kindness and curiosity – *We've all been through stuff so let's look after each other in this space.*



Diversity of views – *Respect different views and experiences and be okay with sometimes disagreeing.*



Language is important – *If you want to improve culture, the way you speak to and about the people around you, needs to support the building of trusting relationships.*



Be kind to yourself – *Take breaks if needed, use our quiet space at any time.*

2-minute check-in

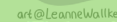
What am I feeling in my body right now?

Am I grounded, regulated and present?

Am I feeling depleted, overwhelmed or dysregulated?

Do I need connection, rest or support?

art@LeanneWalker



Sustaining QI on inpatient mental health wards

Common assumptions (✗) to avoid and alternatives (✓) to try instead when sustaining and expanding the Culture of Care Quality Improvement programme

1

- ✗ We're involving someone with lived experience – co-production will take care of itself.
- ✓ Ensure the way you work & behave is inclusive of people with a range of talents and experiences including those who have had poor experience of care.

2

- ✗ Equity principles are best treated separately, one idea at a time.
- ✓ Consider how inequities show up everywhere, any time. Think about every issue & idea through the equity lens.

3

- ✗ Everyone knows what the Culture of Care is about now.
- ✓ Give people time to explore and apply the principles, methods and resources for themselves.

4

- ✗ It worked well on this ward – let's roll it out everywhere.
- ✓ Be clear about which aspects of the idea are essential & leave the rest for each team to adapt to their needs.

5

- ✗ A few champions will keep us going.
- ✓ Be clear about who you need to succeed. Think widely to maximise impact.

6

- ✗ Hoping the work will continue means it will.
- ✓ Hope is not a plan. Be intentional, make a plan, measure progress, adapt. Align this work to your quality management system & priorities.

7

- ✗ It's a project.
- ✓ It's a mindset. Culture is all day, every day, forever. Think about your daily work & practice and how you can embed the principles as the norm.

8

- ✗ We can't do anything without money.
- ✓ Small changes can make a big difference. Think about what you can do to make your interactions more inclusive & enabling. Don't let perfect be the enemy of good.

9

- ✗ Learning is bound to spread. Success speaks for itself.
- ✓ Be specific about what enabled success. Use stories to inspire others. Look for opportunities to spread your learning widely.



**Culture
of Care**

Lived Experience
evaluation



**Culture
of Care**

Executive
coaching
evaluation



**Culture
of Care**

Peer Support
bite-size
videos



**Culture
of Care**

Data Report



**Culture
of Care**

Risk Assessment
in inpatient care
report



**Culture
of Care**

Intersectionality
guidance



**Culture
of Care**

Autistic patient
experience
evaluation



**Culture
of Care**

Ward environment
equity review
recommendations

**Culture
of Care**

Resource to
sustain
organisational
support



**Culture
of Care**

CofC Programme –
what we've done
differently



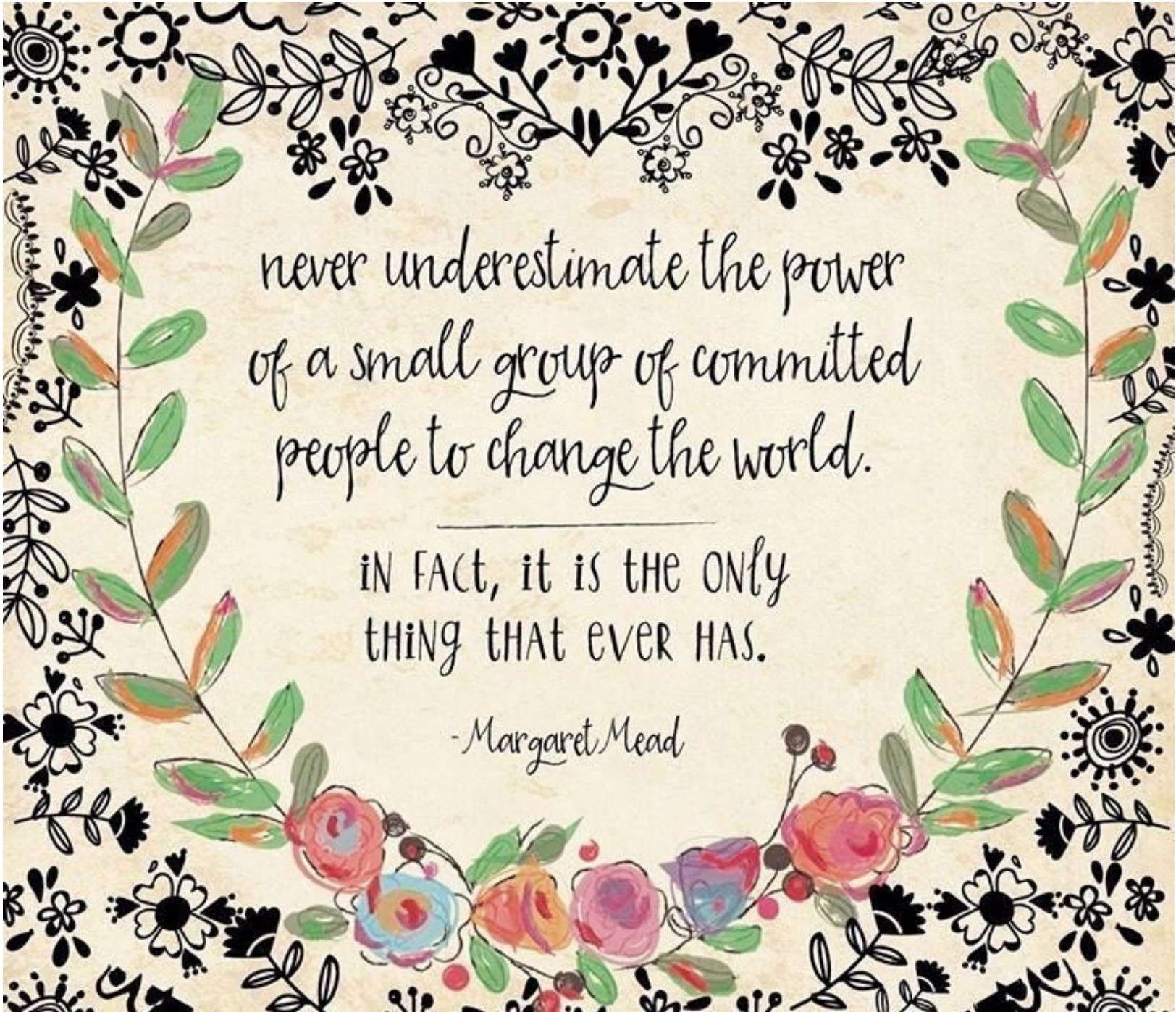
**Culture
of Care**

Bitesize induction
video for wards



**Culture
of Care**

CofC's
approach to
safeguarding report

A decorative border surrounds the text, featuring black line-art flowers and leaves. Interspersed within this border are watercolor-style flowers in shades of pink, orange, and blue, along with green leaves. The background of the card is a light beige color.

never underestimate the power
of a small group of committed
people to change the world.

in fact, it is the only
thing that ever has.

- Margaret Mead





Smith
(e/her),
Head of Lived
Experience and Co-
production, The
National
Collaborating Centre
for Mental Health

Jill Corbyn
(they/them),
Director of
Neurodiverse
Connection

Brendan Stone
(he/him),
Associate Non-
Executive Director
of Sheffield Health
and Social Care
and Professor of
Social
Engagement and
Communities

Jacqui Dyer
(she/her),
Director of Black
Thrive Global

ure
Care



Showcasing work from Culture of Care



**Sophie
Bagge**

Lived Experience
Advisor



**Adele Denvir-
de Bono**

Senior Quality
Improvement Coach



**Caitlin
Cockcroft**

QI Coach



**Megan
McKee**

QI Coach

Humber Teaching NHS Foundation Trust

Nikki Gratton

Lived Experience Lead for Adult
Mental Health Services



My journey: From service user to lived experience leadership

Nikki Gratton, Lived Experience and Co-production Lead



Humber Teaching
NHS Foundation Trust



Caring, Learning
& Growing Together



Cygnnet Healthcare

Julie Johnson

Team Leader



Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Amy Wood

Occupational Therapist / Project Lead

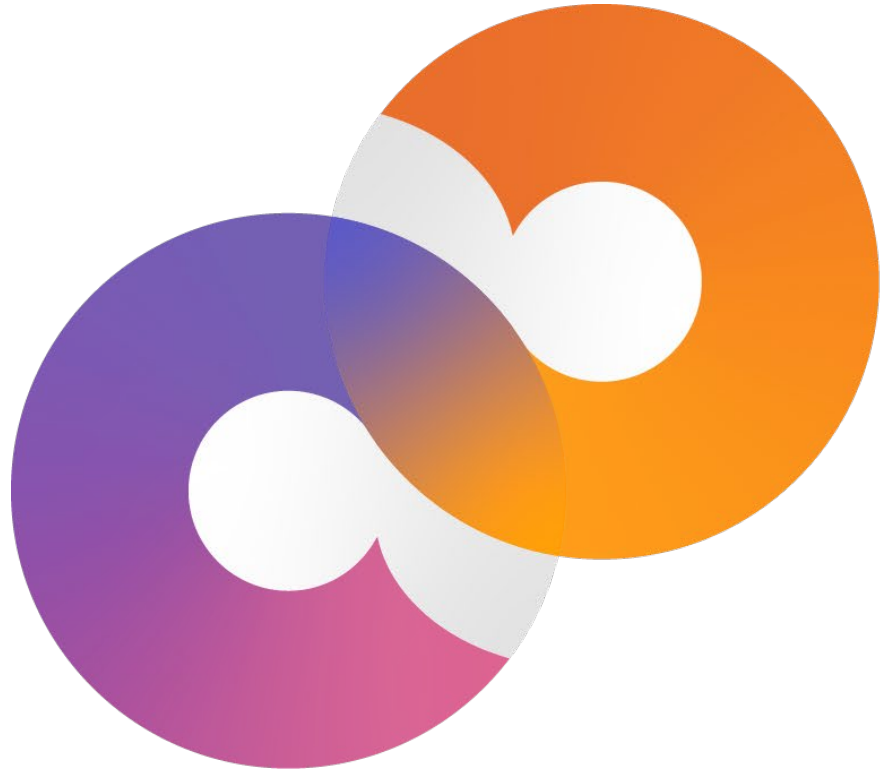
Cat Allen

Peer Support Worker

Lauren Pirt

Service User and Carer Lead





Culture of Care

**Beckfield's critical friend
panel**

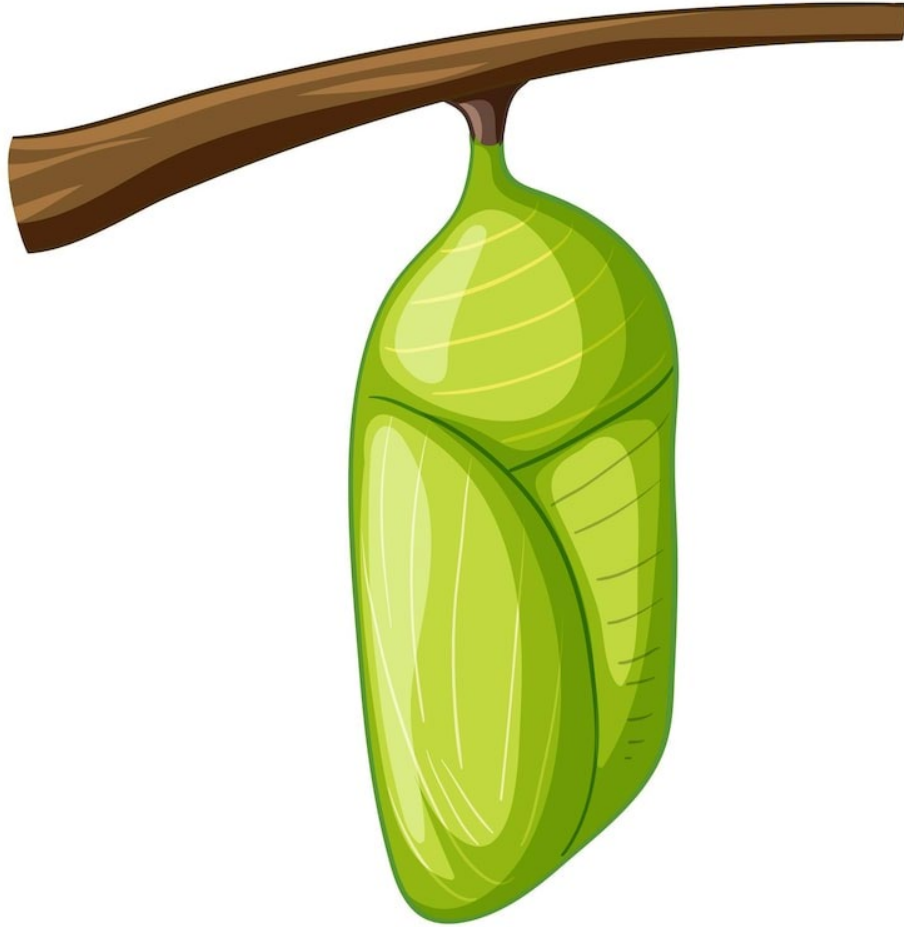


It started as a little grub ...

We didn't feel we could judge the culture when we were part of the ward team.

We invited external specialists to be our critical friends – to tell us how they view our culture – the good, the bad and the ugly. We knew as a ward we were far from perfect; we wanted to be better; we asked for help and feedback

- Scrutiny
- Transparency
- Challenge positively
- Advise us through their specialist lens



The grub morphed into a chrysalis

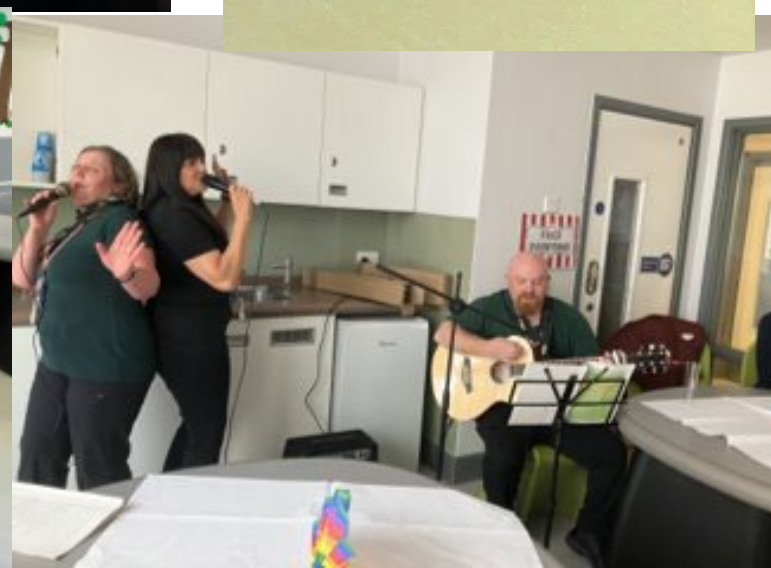
- The critical friends wanted to spend time listening to patient's experiences. Patients valued the space and were open and honest (cuppa & cake sessions)
- We added more lenses and invited a representative from our cultural diversity staff network
- We took problems to the panel
- Critical friends came to our events
- We received positive and constructive feedback
- We created a newsletter to keep our critical friends and other interested people updated

It has transformed into a butterfly and continues to change to meet patient's wishes



“It feels like you must do what you are told to get out” patient quote from cuppa & cake session.

Critical friends create psychological safety for patients to speak up. Thank you from Beckfield community to our critical friends and culture of care team.



Cornwall Partnership Trust

Katie Ryan

Health Care Assistant

James Rann

Clinical Psychologist



Cornwall Foundation Trust Culture of Care Programme

through Royal College of Psychiatrists



Improving Care Together!



Reflective Practice



Table Reflections

At your table and using the prompts below, please reflect on the following:

- 1. What are you proud of / what are one of your change ideas and why?**
- 2. From your learning throughout and presentations, what change would you like to make but are yet to make?**



Comfort break



15 minutes

11:20 – 11:35

Catering will be served in the 1882 Suite

Showcasing work from Culture of Care contd.

Emily Daly

National Advisor



Cambridgeshire and Peterborough NHS Foundation Trust

Mike Seaman

Deputy Chief Nurse

Naomi Rose

Lived Experience Worker PSP





UNIVERSITY OF
CAMBRIDGE

Teaching
Hospital



Cambridgeshire and
Peterborough
NHS Foundation Trust

Culture of Care: Transition from National Programme to CPFT QI Collaborative

Naomi Rose – Patient Safety Partner EbE
Mike Seaman – Deputy Chief Nurse

www.cpft.nhs.uk



Why we are transitioning



The national Culture of Care programme concludes in March 2026



CPFT intention is to sustain and continue with the Culture of Care standards & Principles at the core reflected in our Strategy



Expand what we have learnt to other parts of the Trust – what it's meant to Naomi



A vehicle to embed Culture, Quality Improvement, PCREF, Coproduction – what it's meant to Mike

What stays the same - what changes

Stays the same: Culture of Care standards/principles as the core framework

Stays the same: co-production as a central element (service users and carers as partners)

Stays the same: teams generate their own change ideas through co-production

Changes: delivery/coaching moves from national to CPFT-led

Changes: expand to up to 12-team - QI collaborative approach

Cohort selection, engagement and readiness

Principle: teams self-select to maximise engagement and avoid assigned participation



Approach: online 'taster session' so teams understand expectations and opt in



Current position: 8 Expressions of Interest received (March 2026)



Cohort: includes inpatient and community teams across mental and physical health



Engagement: Recruiting Experts by Experience (March/April 2026)

How we will deliver it

May 2026: training package (Standards & Principles; Co-production; QI methodology; Measurement)

June 2026: teams commence improvement work with coaching support

Fortnightly online QI coaching sessions with individual teams (1 hour)

Monthly face-to-face sessions with individual teams

Bi-monthly QI collaborative workshops bringing all teams together (6 events across 12 months)

Governance & roles (how we make it work)



Core delivery team: Project Lead (Deputy Chief Nurse) and SRO (Chief Nurse)



Core delivery team: QI advisors; Patient & Carer / Patient Safety Partners; Directorate reps (PDL); EDI; Safe Staffing; Medical/AHP; Psychology input



Each participating team: named QI lead with strong MDT representation

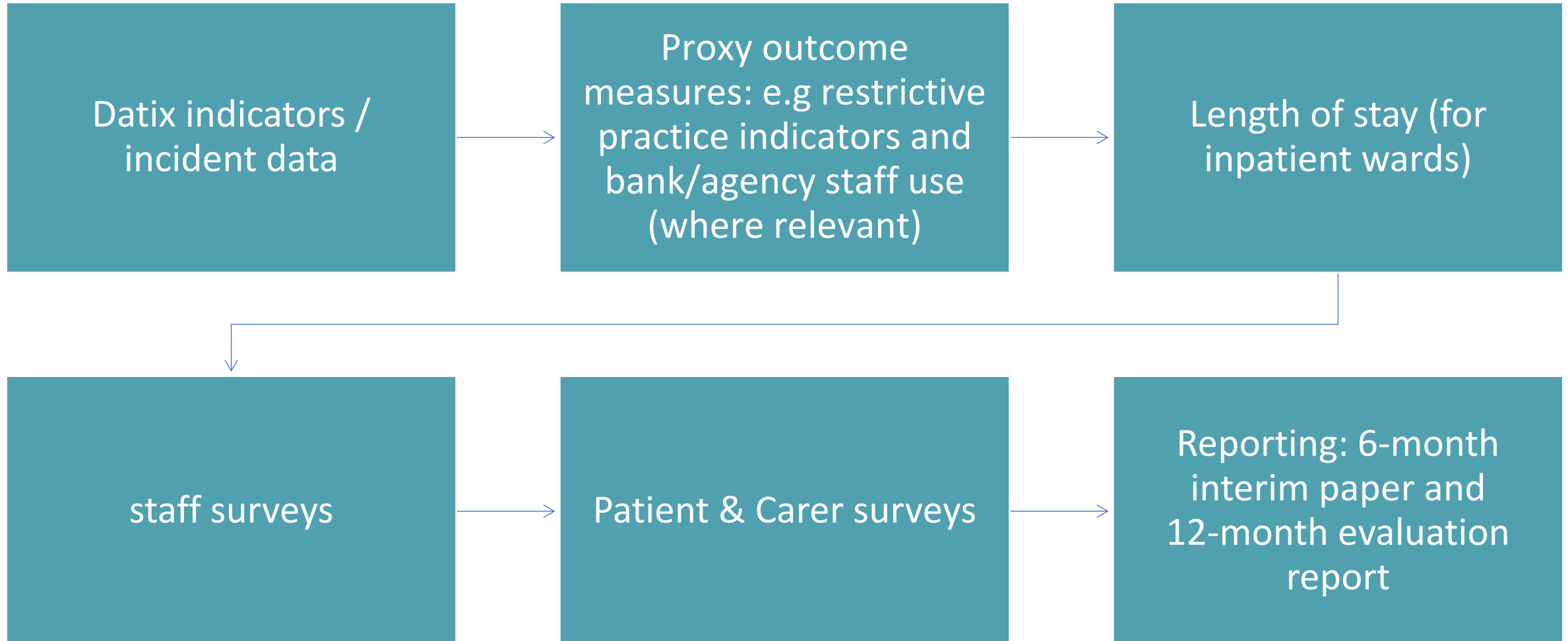


Each participating team: minimum 2 service user/carers partners



Each participating team: service sponsor + Quality Matron and Practice Development support

How we will measure impact



Resourcing, risks and mitigation



Key enablers: protected time for training/coaching; venue/admin support; BI/Quality support for dashboards

**COMMUNITY/PHYSICAL HEALTH
OUTCOME MEASURES**



Co-production budget to reimburse participation (e.g., travel/vouchers)



Risks: capacity pressures; variable engagement; inconsistent data; limited co-production participation



Mitigation: senior sponsorship, flexible schedule, standard dashboards, active recruitment and ongoing support

North East London NHS Foundation Trust

Kate Lorrimer

Strategic Director of Relational Care

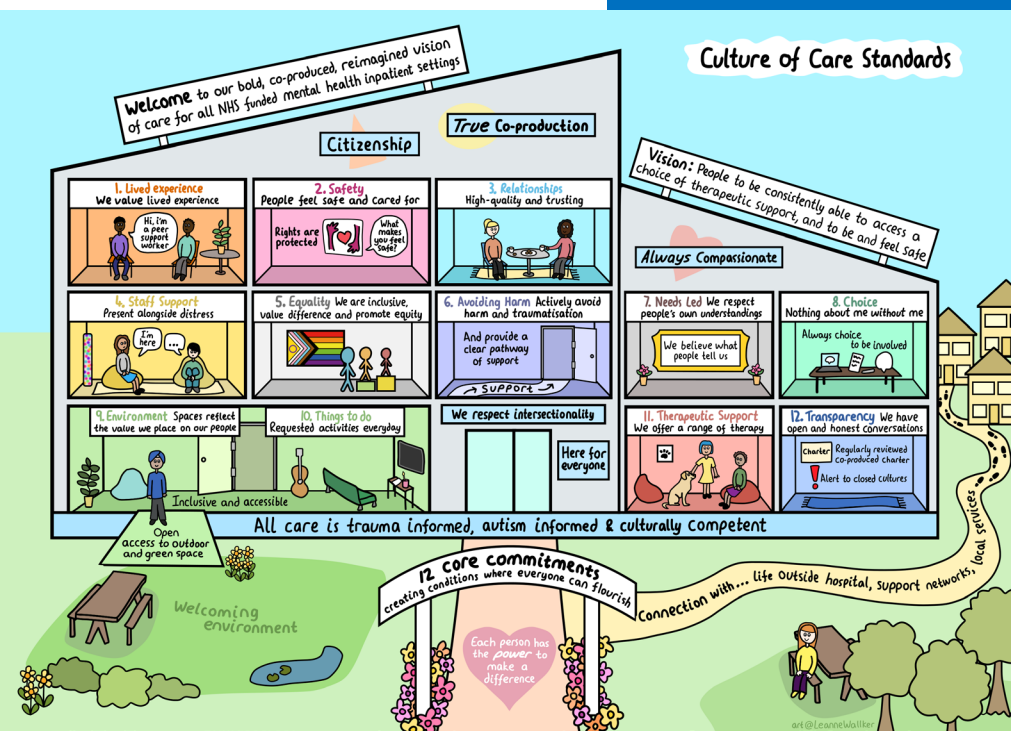
Pea Meyer Higgins

Lived Experience Lead – Relational Care



ARD Mental Health Inpatient Improvement Collaborative (MHIIC)

Sustaining and scaling up a culture of continuous improvement



Striving to provide the best care by the best people

The MHIIC delivery team



KATE LORRIMER

Strategic Director of Relational
Care

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PATRICK ONYEMA

Senior QI Advisor for ARD

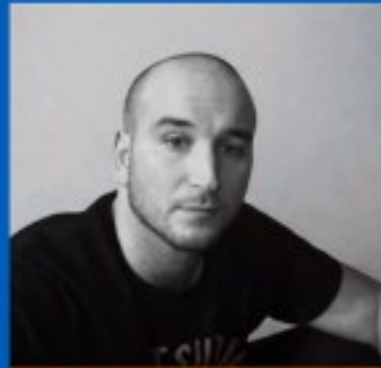
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PEA MEYER HIGGINS

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CLAIRE ALLEN

Project Support

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Rationale for the ARD MHIIC



Build on and sustain progress for ARD's mental health improvement approach, including the Culture of Care Programme



Enhance quality of care, patient safety and staff wellbeing/career progression



Embed the relational care approach and support the prioritisation of positive relationships between staff and those we care for



Enable changes to be made from the ground up/to be owned by the directorate rather than coming from external sources



Positive and proactive response to the trial verdict - supporting staff with associated fears about patient safety and staff accountability



Promote equitable access across all wards to improvement opportunities and support



Respond to difficulties in prioritising improvement work in the face of system pressures (demand, capacity, flow, financial constraints, staffing, etc)

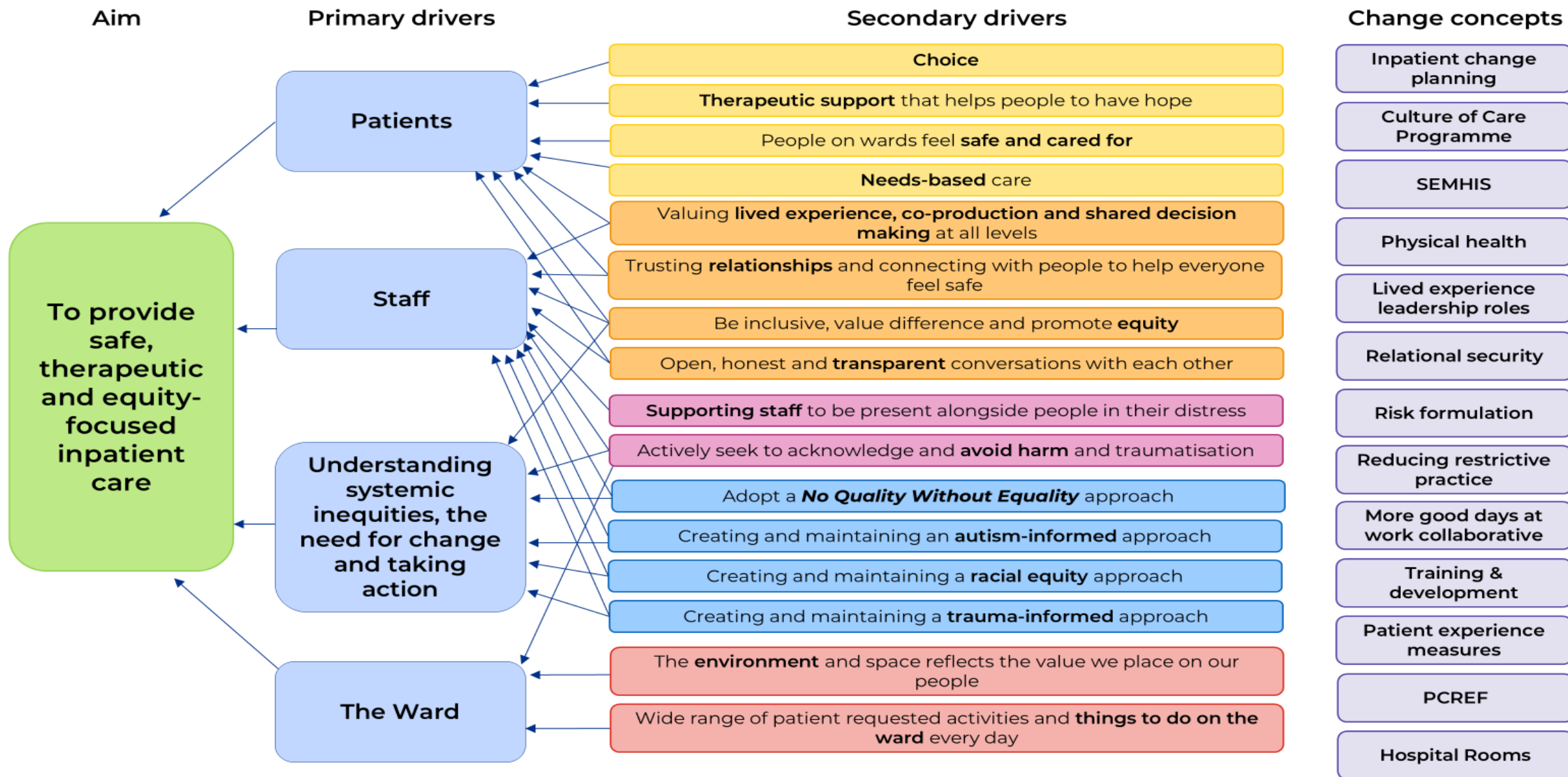


Build a system of shared learning, collective responsibility and continuous improvement

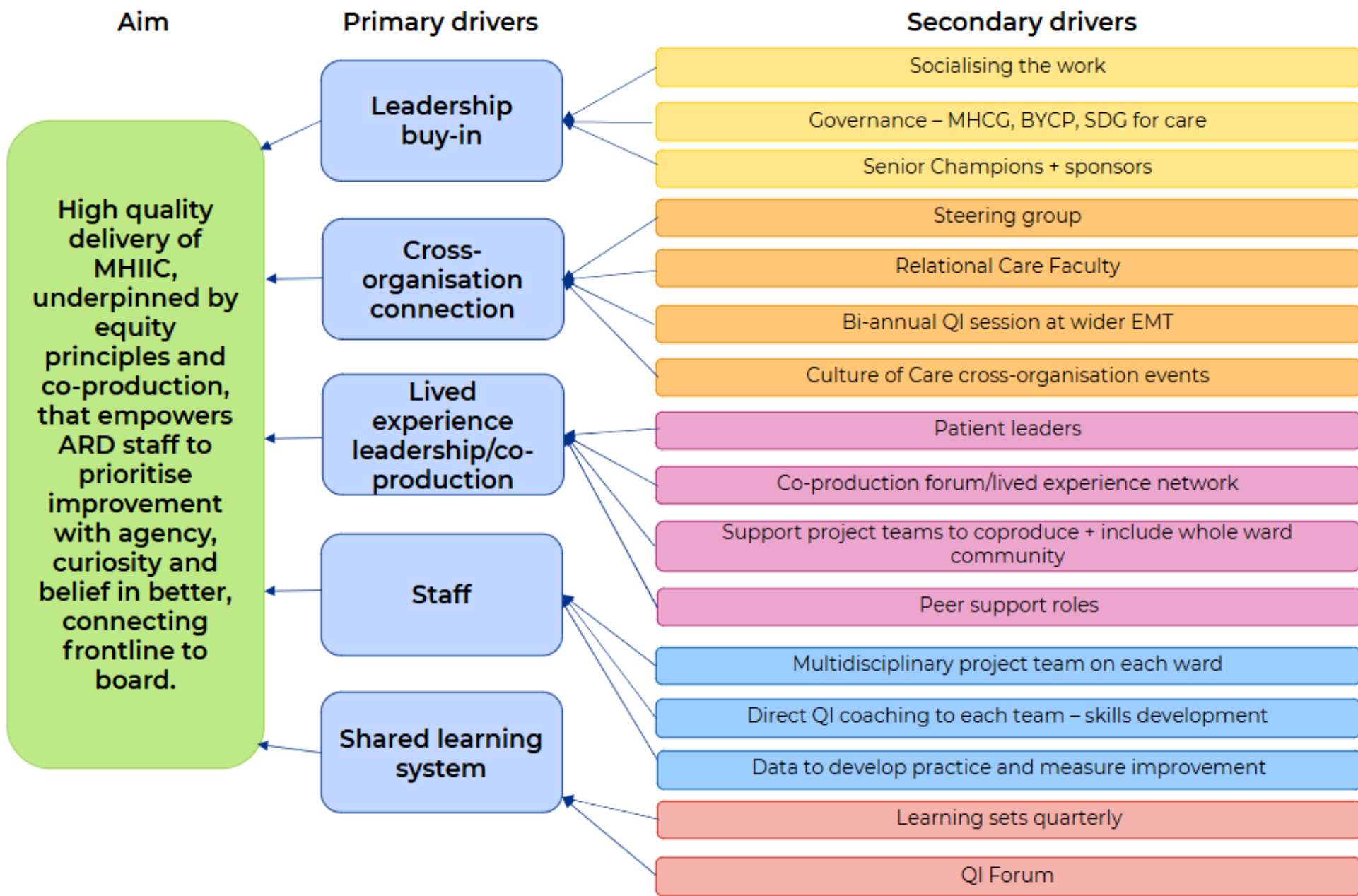


Align with NELFT values and strategy and NHS England's Culture of Care Standards

ARD MHIIC – theory of change



ARD MHIIC – programme delivery driver diagram



The Relational Care Faculty



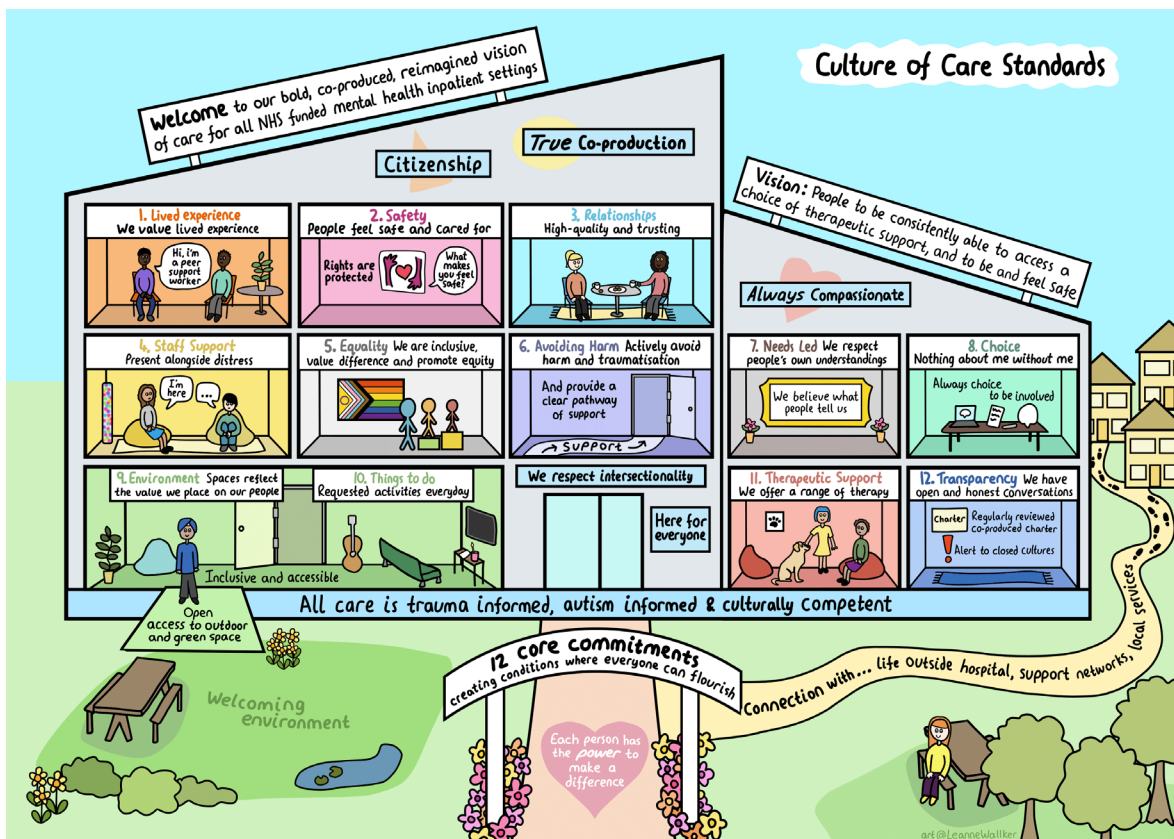
- The Relational Care Faculty officially launched in early 2025. It is values driven and role models and champions the relational ways of working NELFT strives towards.
- It connects and aligns various workstreams across NELFT that specialise in delivering relational change and individuals who champion this approach, providing a coherent organisational infrastructure that creates a link from frontline to board and between each area of work.
- It provides a supportive, safe space to maximise collective responsibility for achieving change. It also looks beyond organisational boundaries to maximise learning and sharing of good practice by including key external stakeholders who are also leading on relational change in other organisations and nationally.
- It takes a co-produced reflective approach to innovating and identifying opportunities and problem solving/addressing challenges together.
- The RCF is underpinned by dialogical practice and encompasses the following areas of work (not an exhaustive list, and will iterate over time):
 - The national Culture of Care Programme
 - The Adult Mental Health Clinical Strategy
 - Peer-supported Open Dialogue
 - Patient safety
 - PCREF
 - Peer support and co-production
 - The work within the Trust to move away from Closed Cultures
 - Reducing restrictive practice
 - Risk formulation
 - Relational security
 - Enhanced care and engagement
 - The work to improve/integrate the whole pathway of care
 - Personalised Care Framework
 - Triangle of Care
 - Commissioning of new crisis services (incl. Redbridge Well House; Waltham Forest Community Mental Health Hub & Crisis House; and 24/7 MH Crisis Assessment Hub).

Birmingham and Solihull

Lisa Stalley-Green

CNO, Executive Director of Quality and Safety





Culture of Care Excellence Framework

BSMHFT Quality Improvement Framework



Purpose and Strategic Intent

Accreditation is both a maturity model and assurance mechanism.

AIM	DESCRIPTION
Recognition	Celebrate teams embedding all 12 Culture of Care Standards
Assurance	Provide structured reporting into governance committees
Improvement	Drive measurable change using Model for Improvement
Co-production	Embed EBE leadership in culture and decision-making
Standardisation	Create a shared Trust-wide culture maturity language
Accountability	Establish mandatory quality expectations across services

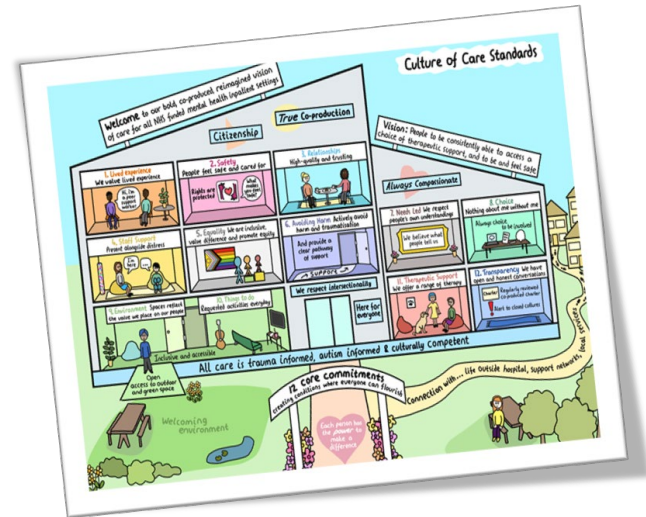
Accreditation Structure Overview

Validity: 2 years. Annual light-touch review required. All wards/services must achieve minimum Bronze within phased rollout.

Level	Focus	Descriptor	Expected Maturity
Bronze	Foundation	Baseline complete; improvement underway	Awareness & Engagement
Silver	Embedded	Measurable improvements demonstrated	Consistency
Gold	Exemplar	Sustained impact; influences wider system	Leadership

Service Accreditation Methods

- Self-Assessment (and peer reviews)
- PREOMs
- PLACE Scores
- Staff Survey & Service User Surveys
- Safe-Care Metrics
- Delivery Plan
- Compliance Review
- Award Panel Presentation
- Accreditation & Celebration



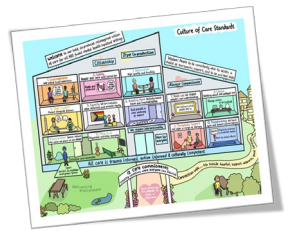


The 12 Culture of Care Standards – Accreditation Evidence Map

Standard	Core Evidence Areas	Governance Link	Agenda item	Lead
1. Lived Experience	PREOMs, Patient Councils, EBE roles at all levels, QI Big I & Little I	SULAG	Patient Experience Report/PREOMS data	Kirstie
2. Safety	Safe Care Dashboard, PSIRF learning, safeguarding	CGC/LFD/SMB	PSIRF, Learning From Deaths, Safeguarding	Mel
3. Relationships	Reduction in restrictive practice, Think Family	RRP / CEAG/QAG	Data/IPR	Sophia
4. Staff Support	Staff survey trends, retention, assault reduction	SSC	Safer Staffing	Katie
5. Equality	Outcome monitoring by ethnicity, anti-racist practice	PCREF	PCREF Report	Jas
6. Avoiding Harm	Trauma-informed care, reduction in prone restraint	QAG / RRP/CGC	Data/IPR	Sophia
7. Needs Led	Physical health data, autism-informed care	CEAG / PHC	Data, Physical Health	Sophia
8. Choice	MHA compliance, consent, faith & food	MHLC/SULAG	MHAct, PREOMs	Mel
9. Environment	Ward environment standards, H&S compliance	H&S / CGC	Regulation update	Natassia
10. Things To Do	20 hrs activity offer (inpatient), daily plan	SULAG/CEAG	Activities report	Kirstie
11. Therapeutic Support	5 hrs therapy/week (where applicable), psychology	RRP/SULAG	Activity report	Sunny
12. Transparency	FTSU, open governance, supervision	CEAG/QPESC	Data/FTSUG	Kirstie

- All 12 must be evidenced at every accreditation level
- Minimum harm-reduction targets and core evidence types to be finalised following consultation

Service Accreditation Evidence details



Lived experience: EBE roles, at all levels, Big I and Little I QI training, Patient Councils, PREOMS, staff surveys

Safety: People on our wards feel safe and cared for: Safe Care Dashboard, PSIRF, Sexual Safety, Safeguarding, safety and incident reporting, whistleblowing

Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe: Reducing restrictive practice, reduce prone restraint, ETOC, Dialog+, think family & carers

Staff support: We support all staff so that they can be present alongside people in their distress, staff survey, recruitment retention, skill and knowledge training, reduce assaults, reasonable adjustments and wellness support, staff safety strategy, staff networks, peer networks

Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes: monitor outcome data by ethnicity and race, professional anti-racist practice

Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs: open patient safety panels with clear governance and escalation, Evidence based treatments only NICE/RCPSYCH, Nigel's Plan

Needs led: We respect people's own understanding of their distress: Prioritise based on need for admission to provision of care, Dialog+, physical health and ward meetings, trauma and autism informed

Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care: Mental Health Act and framework for personalised care, MCA/DoLS, Consent, Faith & Food, Dialog+

Environment: Our inpatient spaces reflect the value we place on our people: Get the Buildings right now improve toilets, showers, furniture and patient care environment, access to outside space, time/clocks, discharge planning

Things to do on the ward: We have a wide range of patient requested activities every day: 20hrs of patient choice activity minimum, themed events and challenges, fund raising, Night Care, published plan for the day

Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better: 5hrs of therapy/ week which leads, improved health, to risk reduction and discharge, psychology and art therapy, 7 days a week

Transparency: We have open and honest conversations with patients and each other, and name the difficult things: Open patient safety and clinical Governance structure which are inclusive of patients, carers and Staff where open discussion can occur with clear escalation, clinical supervision, team & ward meetings, psychological safe reflective spaces, freedom to speak up



Core Accreditation Process

Stage	Description	Responsibility	Key Outputs
1. Registration	Mandatory enrolment; SRO Sponsor assigned	Division	Baseline dashboard
2. Self-Assessment	≥75% staff completion; EBE co-review	Local Team	12-standard heatmap
3. Improvement Phase	2–3 priority standards; QI charter; PDSA cycles	Team + QI Coach	Run charts, reflection log
4. Evidence Submission	Structured pack across data, stories & governance	Local Lead	Accreditation dossier
5. Panel Review	Quarterly review & scoring	Trust Panel	Bronze/Silver/Gold decision
6. Recognition	Certificates, event, digital badge	Comms + Exec	Public recognition
7. Sustain & Review	Annual review; 2-year revalidation	Division	Continuous improvement plan

Evidence Requirements

Evidence Type	Bronze	Silver	Gold
Quantitative Data	Baseline established	Demonstrated trend/shift	Sustained ≥12 months
Patient Experience	PREOMs reviewed	Positive measurable change	Sustained excellence
Staff Experience	Engagement evidence	≥2 indicators improved	Sustained improvement
Co-production	EBE involved	EBE co-leads element	Embedded in governance
Governance	Divisional reporting	Committee-level reporting	Influences Trust policy
QI Method	QI tools used	Sustained measurable change	Continuous improvement culture



Scoring Model

Each of the 12 standards scored 1–5:

Score	Definition
1	Emerging
2	Developing
3	Embedded
4	Strong
5	Exemplar

Thresholds:

Level	Minimum Average Score
Bronze	≥2.5
Silver	≥3.5
Gold	≥4.2 + sustained outcomes

Failure to achieve Bronze triggers:

- Divisional support plan
- QI coaching escalation
- SRO Sponsor review

SRO Sponsorship Model

Component	Requirement
SRO Sponsor	Assigned to each accredited service
Role	Remove barriers; support local leadership; attend review; champion at executive level
Accountability	Escalation if Bronze not achieved, service support plan
Visibility	Recognition locally and at Trust events

Recognition & Incentives

Level	Recognition
Bronze	Divisional certificate & intranet feature
Silver	Trust celebration event & digital badge
Gold	Executive Board presentation; eligibility for innovation funding (subject to availability); mentorship role



Leadership & Governance

Standard	Lead	Group/Committee	Agenda Item
Lived Experience	Kirstie	SULAG	Patient Experience Report/PREOMS data
Safety	Mel	CGC/LFD/SMB	PSIRF, Learning From Deaths, Safeguarding
Relationships	Sophia	RRP/CEAG/QAG	Data/IPR
Staff Support	Katie	SSC	Safer Staffing
Equality	Jas	PCREF	PCREF Report
Avoiding Harm	Sophia	QAG/RRP/CGC	Data/IPR
Needs Led	Sophia	CEAG/PHC	Data, Physical Health
Choice	Mel	MHLC/SULAG	MHAct, PREOMs
Environment	Natassia	H&S/CGC	Regulation update
Requested Activities	Kirstie	SULAG/CEAG	Activities report
Therapeutic Support	Sunny	RRP/SULAG	Activity report
Transparency	Kirstie	CEAG/QPESC	Data/FTSUG

Culture of Care Standards

12 Core Commitments

Creating conditions where everyone can flourish



True Co-production

Citizenship

1. Lived Experience We value lived experience

Expert By Experience
Involvement
PREOMS
Patient Councils
Daily Ward Meetings

2. Safety People feel safe and cared for

Safe Care Dashboards
PSIRF & Learning Culture
Sexual Safety
Safeguarding
Enhanced Observations

3. Relationships High-quality and trusting

Reduce Restrictive Practice
Staff training
15 Steps
Think Family & Carers
Optimum staffing

4. Staff Support Present alongside distress

Staff safety strategy
Health & Wellbeing Offer
Post incident support
Reducing assaults/AVERTS

5. Equality We are inclusive, value difference and promote equality

Anti-racist practice
Staff networks
PCREF
Reduce health inequalities

6. Avoiding Harm Actively avoid harm and trans formation

Reduce prone restraint
Seclusion practice
Nigel's Plan
Physical health strategy

9. Environment Spaces reflect the value we place on our people

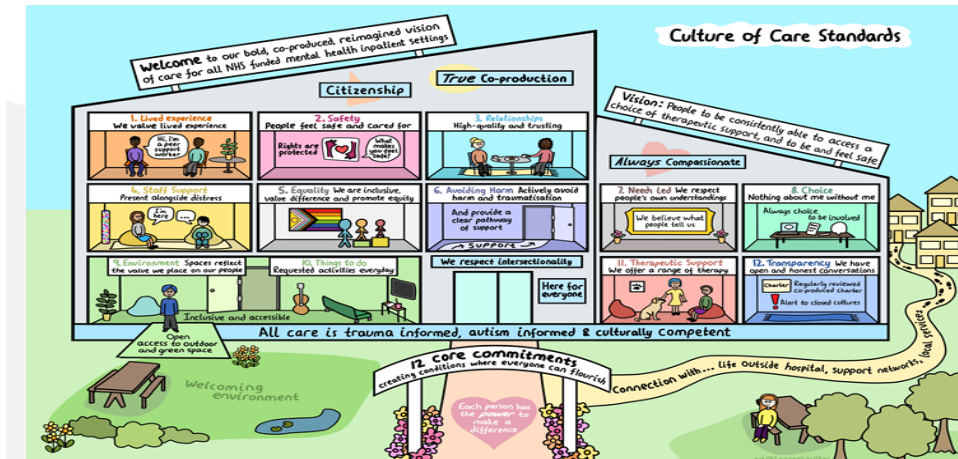
PLACE assurance
Health & Safety
ERA/LRA
Outside Space
Fire & water safety

10. Things to do Requested activities everyday

Plan for the Day & Night
Activities
Events & themes
Night Care

We respect intersectionality

Here for everyone



Always Compassionate

7. Needs Led We respect people's own understandings

Dialog+
Ward meetings
Accessibility standards

8. Choice Nothing about me without me

Mental Health Act
Discharge planning
Consent/MCA DoLs
Faith & Food

11. Therapeutic Support We offer a range of therapy

Psychological interventions
Recovery College
Access & waiting times

12. Transparency We have open and honest conversations

Safety Huddles
RMS & Clinical Supervision
Team Meetings
Clinical Governance
Chairing Skills

All care is trauma informed, autism informed and culturally competent

Table Reflections

At your table and using the prompts below, please reflect on the following:

- 1. What has your organisation / trust done that you're proud of?**
- 2. What would you like to do now, and who do you need to connect with to make this happen?**



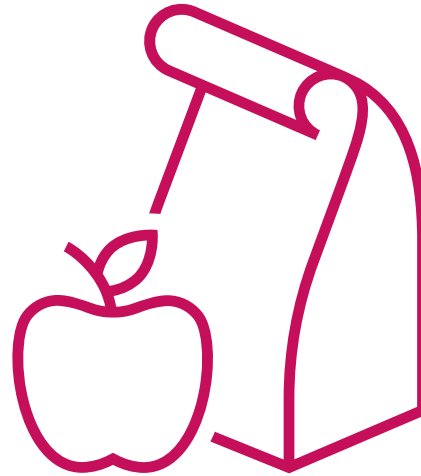
Wrap up and reflections

Tom Ayers

Director



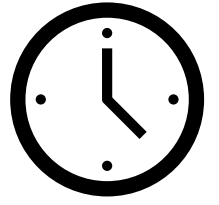
Lunch



12:25 – 13:25

Lunch will be served in the 1882 Suite

Post-lunch energiser



10 minutes

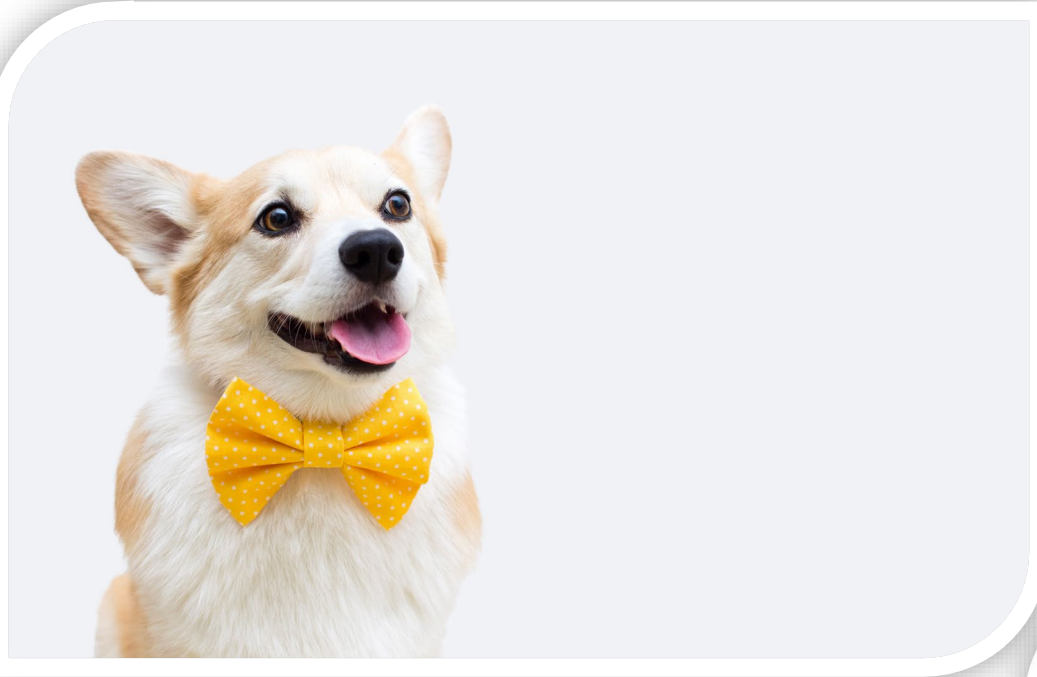
quiz?



Rianna Herbert
Quality Improvement
Coach



Bethan Warner
Quality Improvement
Coach



quiz?

Dog...

Or

Mushroom?





How we will play...

This is a fun and friendly quiz 😊

We are playing for pride, **try not to use phones**

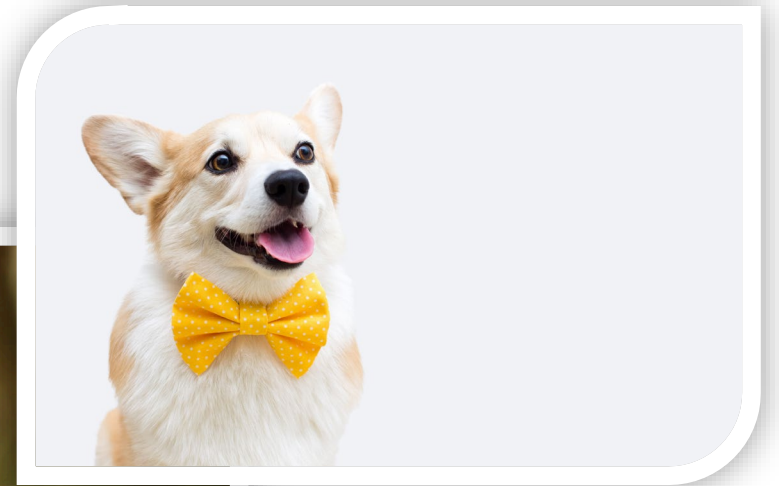
Take part in **whatever way works best for you.**

There are 10 words. For each one: is it a **dog or a mushroom?**

On your table are two sheets — hold up the one that matches your answer.

Dog *or* Mushroom?

1. Morel



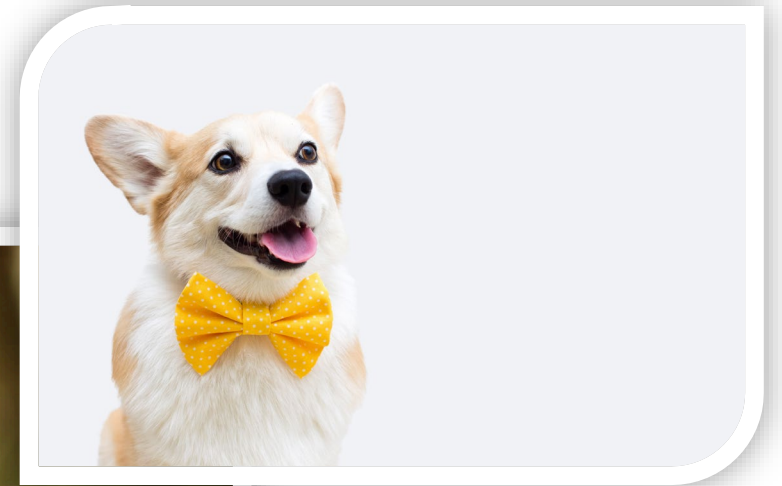
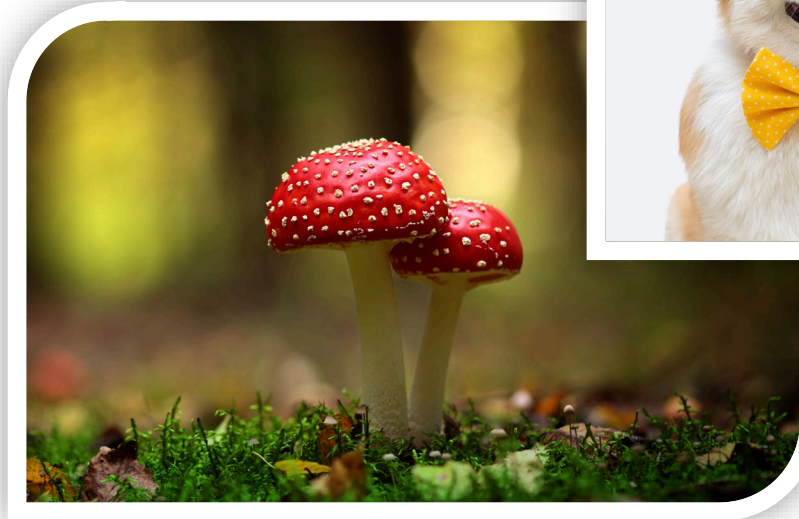
Dog *or* Mushroom?

1. Morel



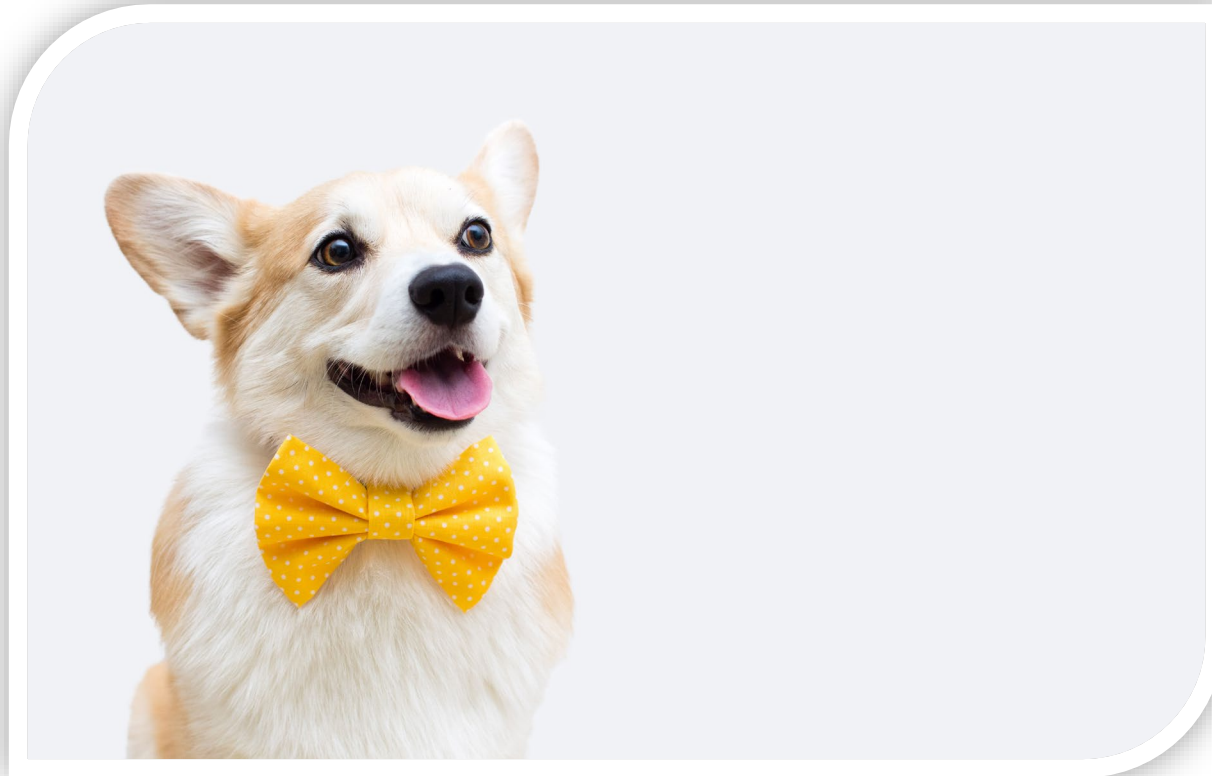
Dog *or* Mushroom?

2. Leonberger



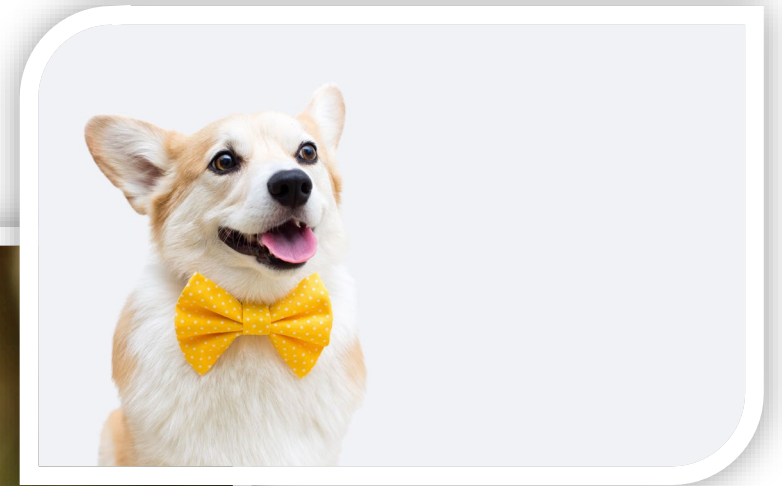
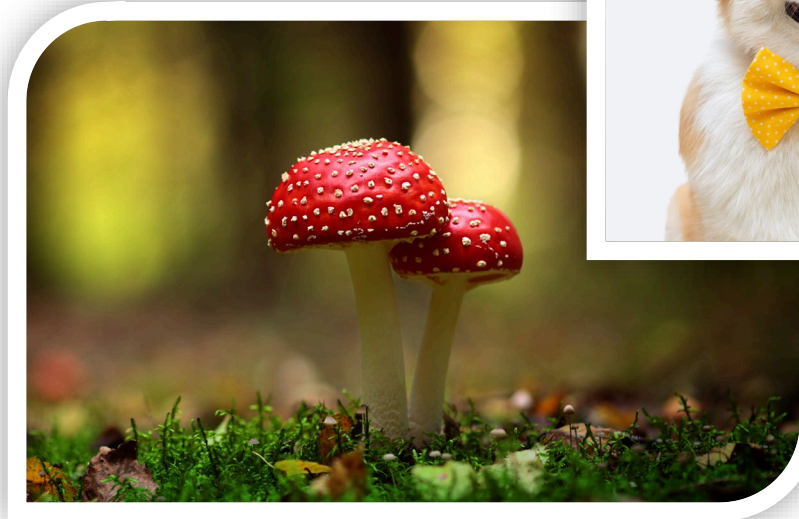
Dog *Or* Mushroom?

2. Leonberger



Dog *or* Mushroom?

3. Enoki



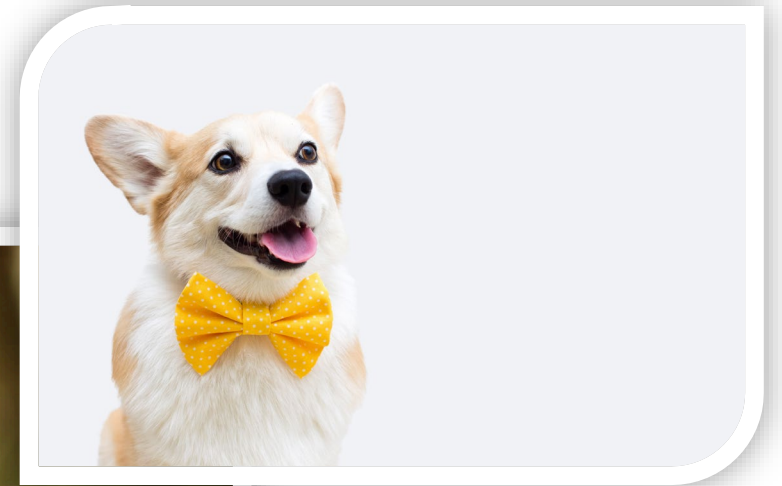
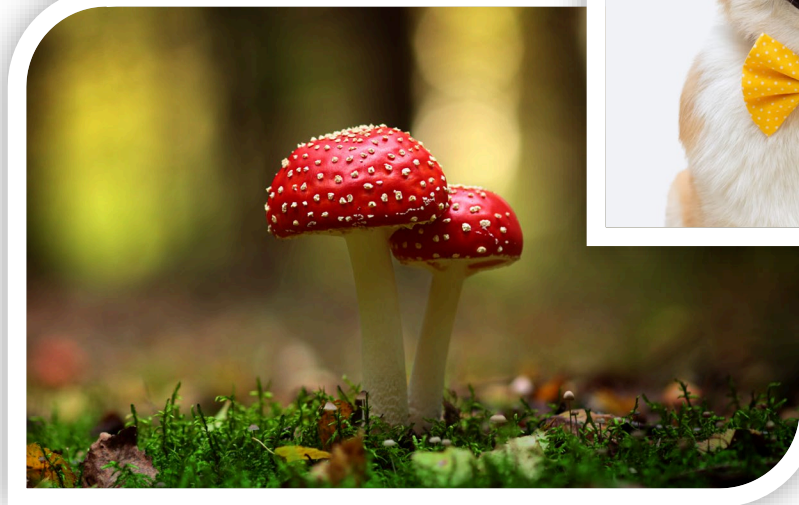
Dog *or* Mushroom?

3. Enoki



Dog *or* Mushroom?

4. Tremella



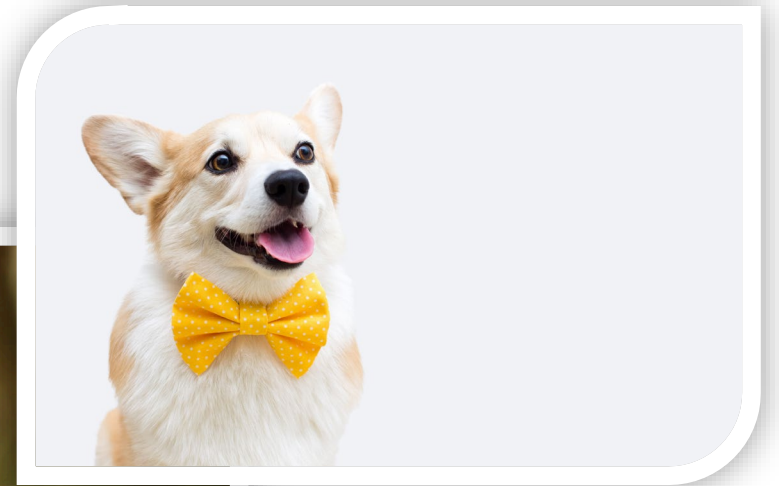
Dog **or** Mushroom?

4. Tremella



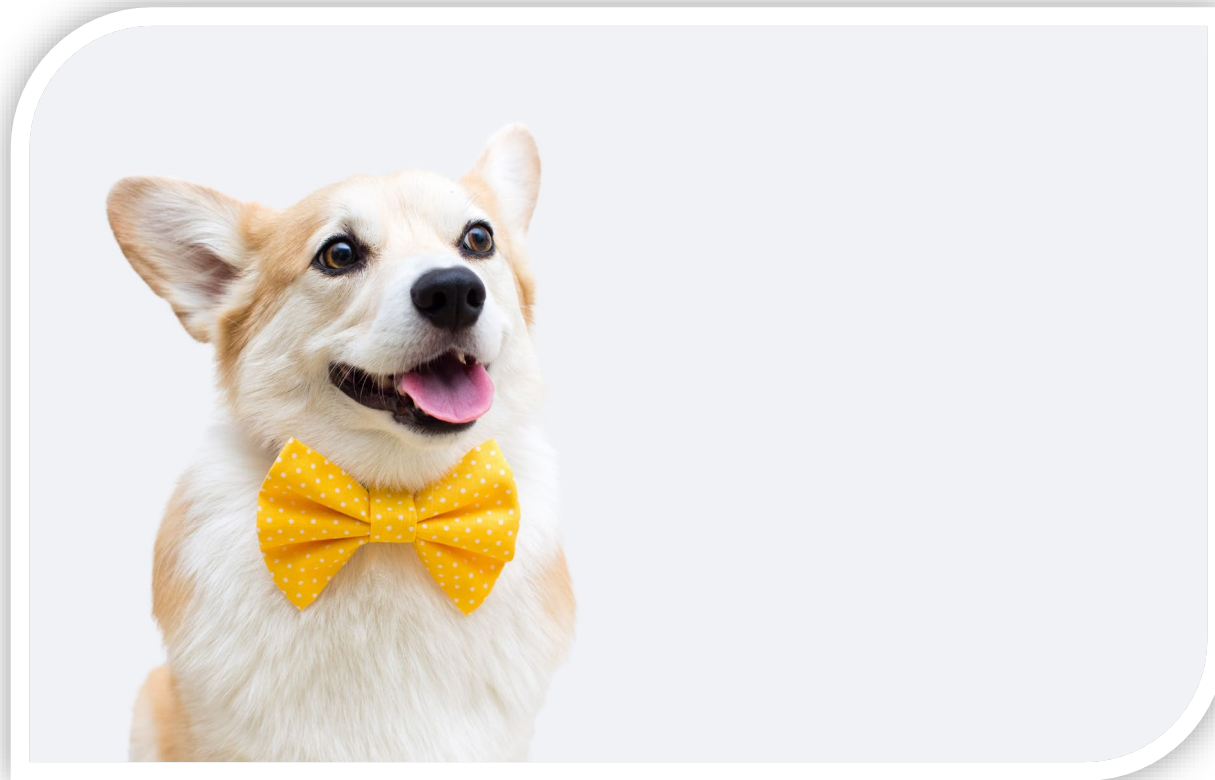
Dog *or* Mushroom?

5. Lagotto



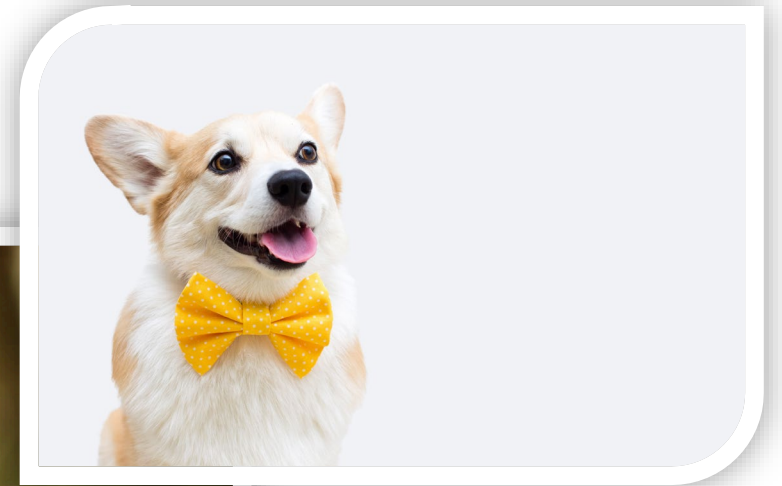
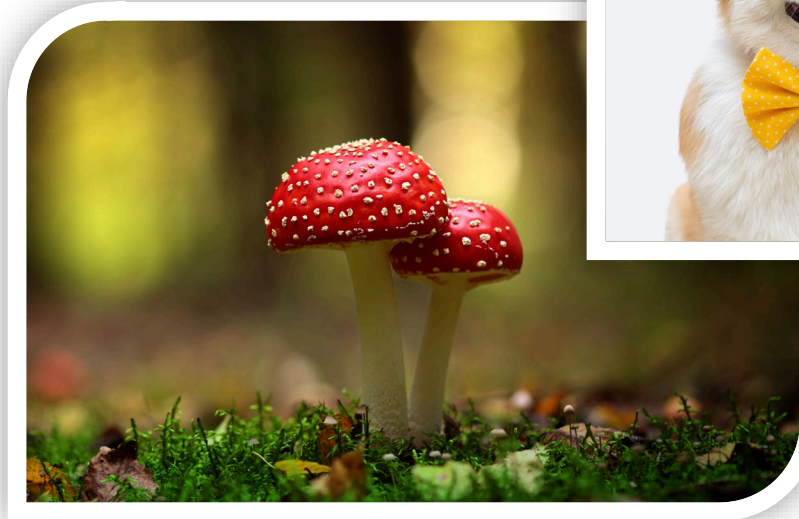
Dog *Or* Mushroom?

5. Lagotto



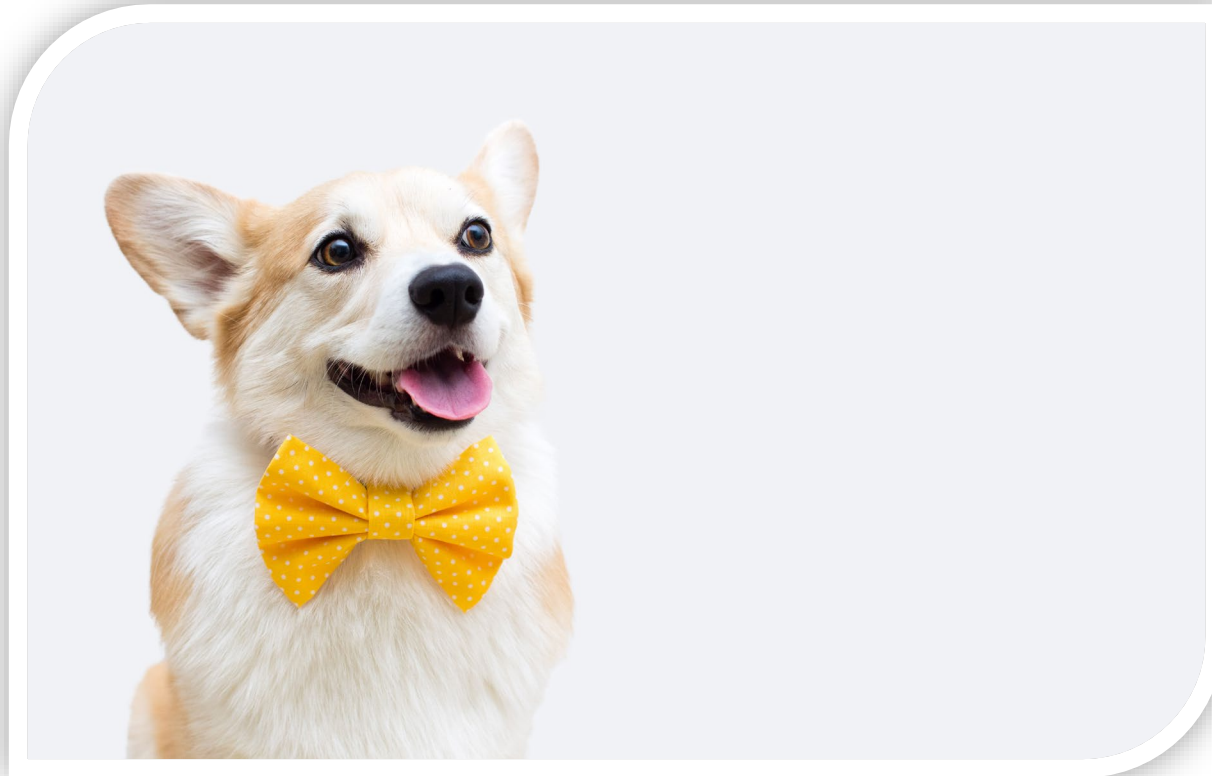
Dog *or* Mushroom?

6. Affenpinscher



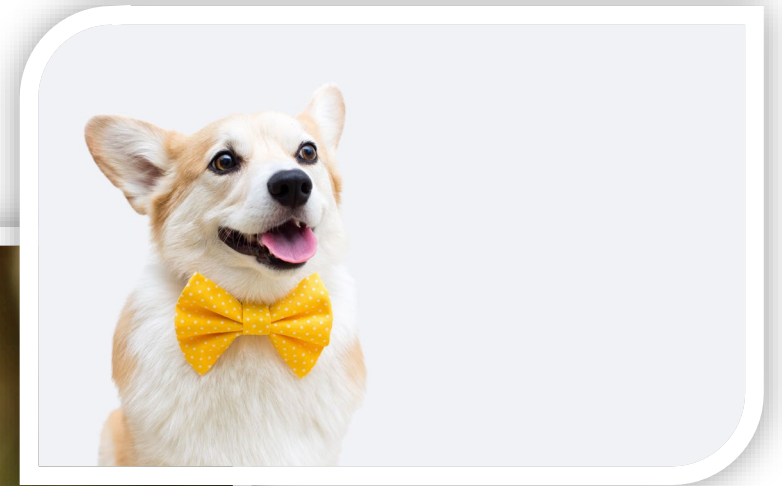
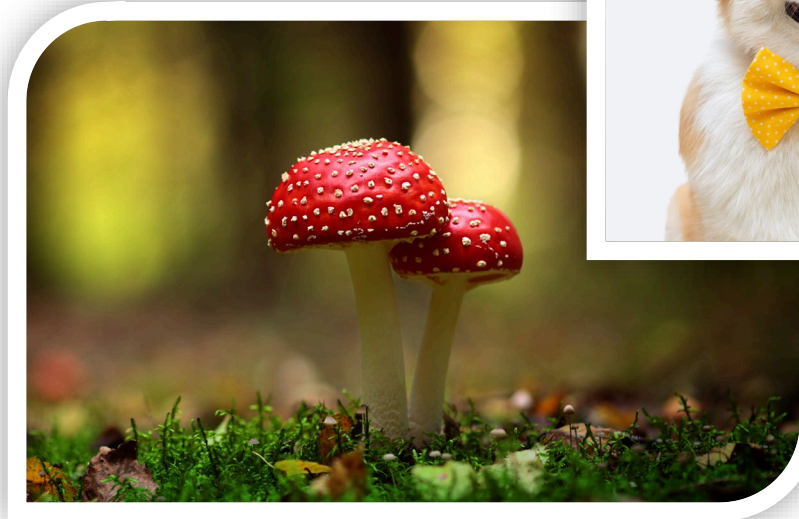
Dog *or* Mushroom?

6. Affenpinscher



Dog **or** Mushroom?

7. Chanterelle



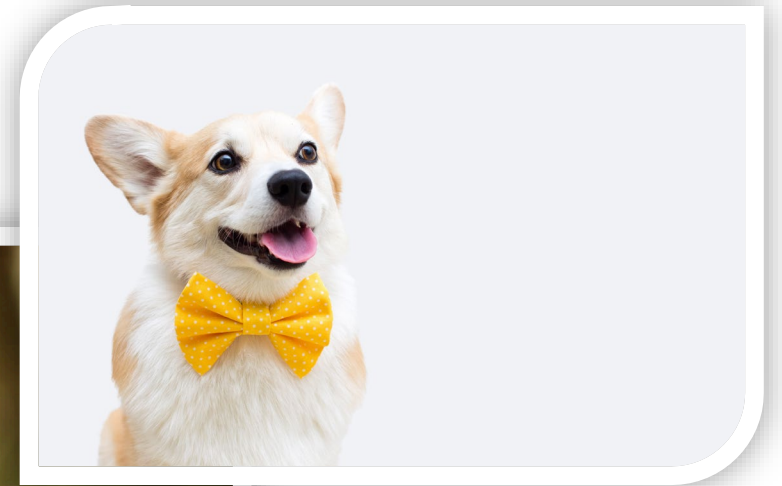
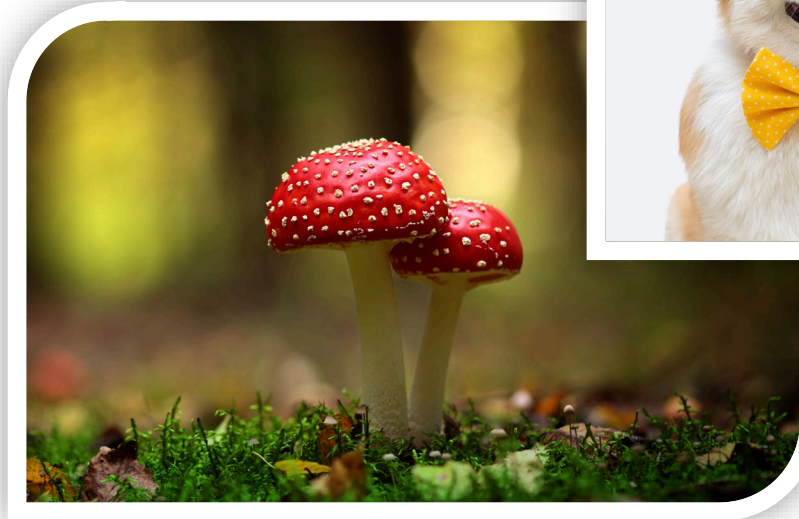
Dog **or** Mushroom?

7. Chanterelle



Dog *or* Mushroom?

8. Russula



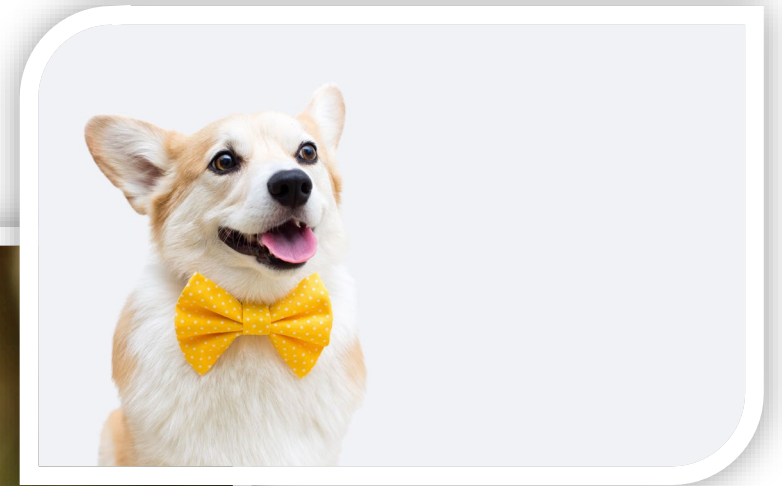
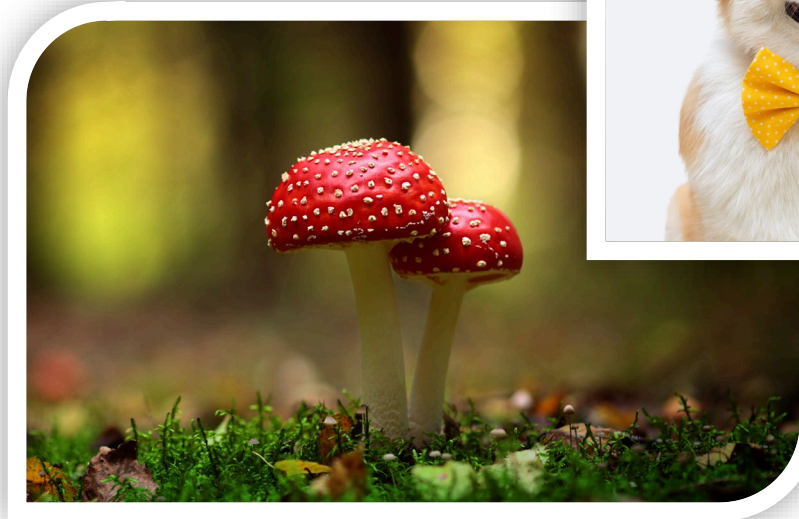
Dog *or* Mushroom?

8. Russula



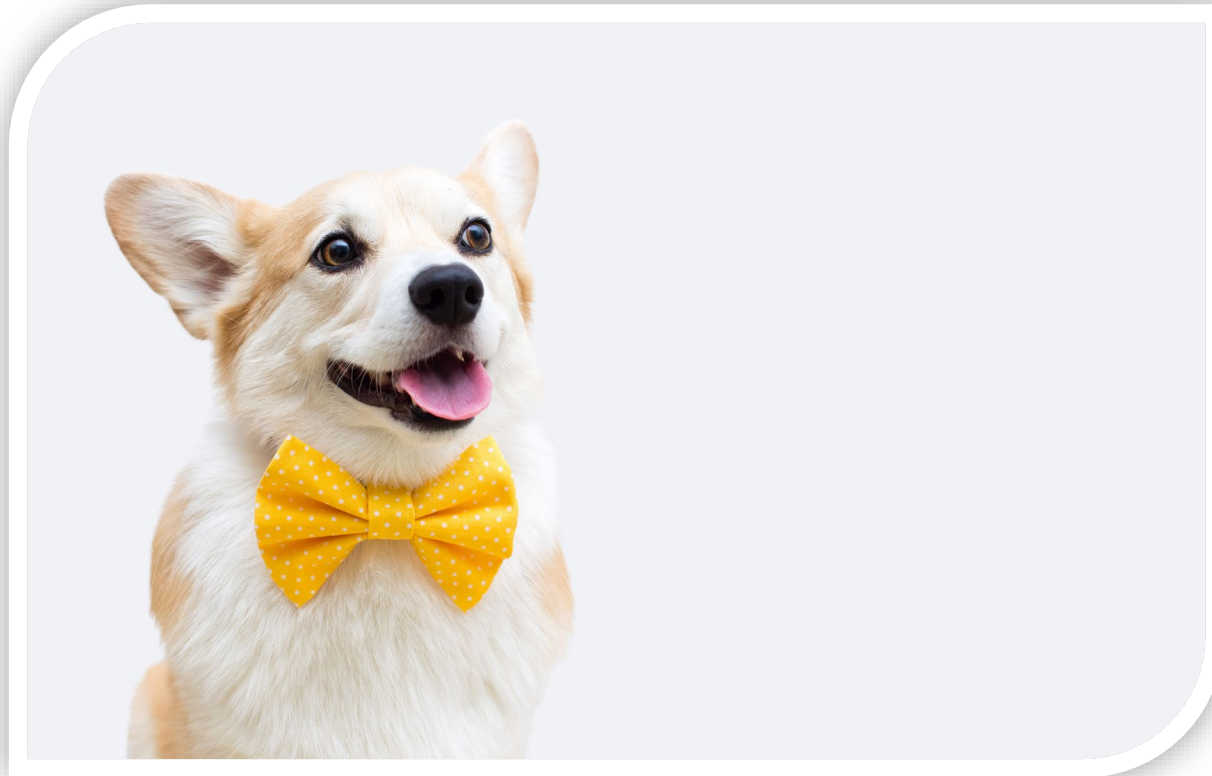
Dog *or* Mushroom?

9. Azawakh



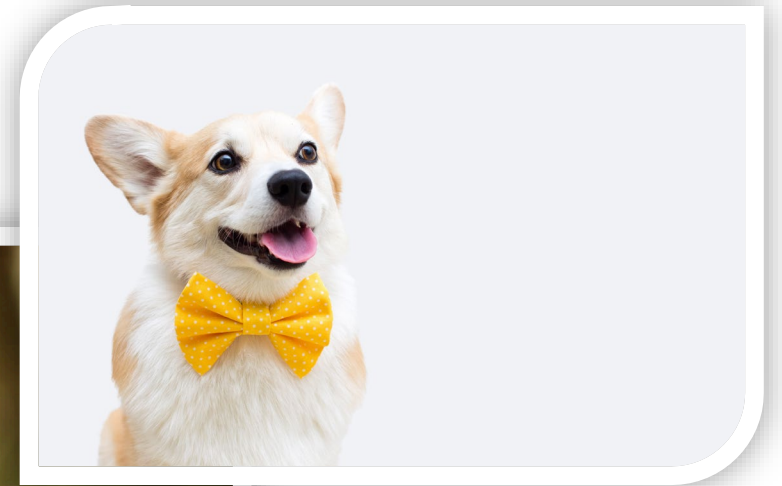
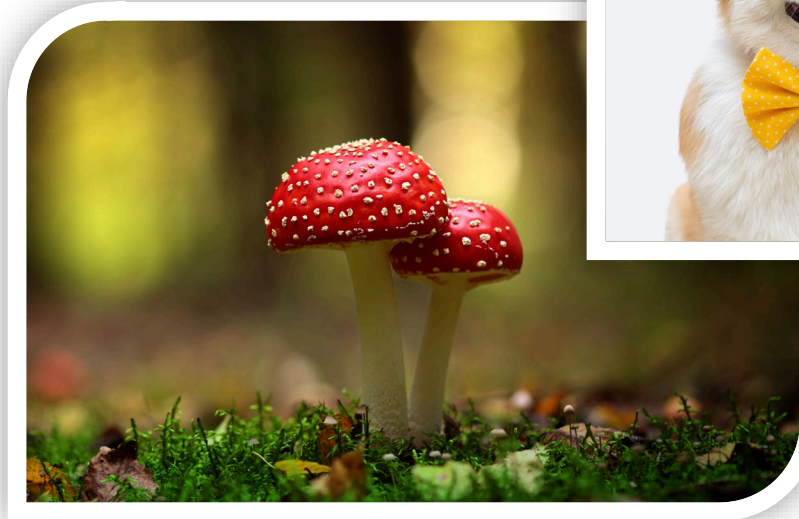
Dog *or* Mushroom?

9. Azawakh



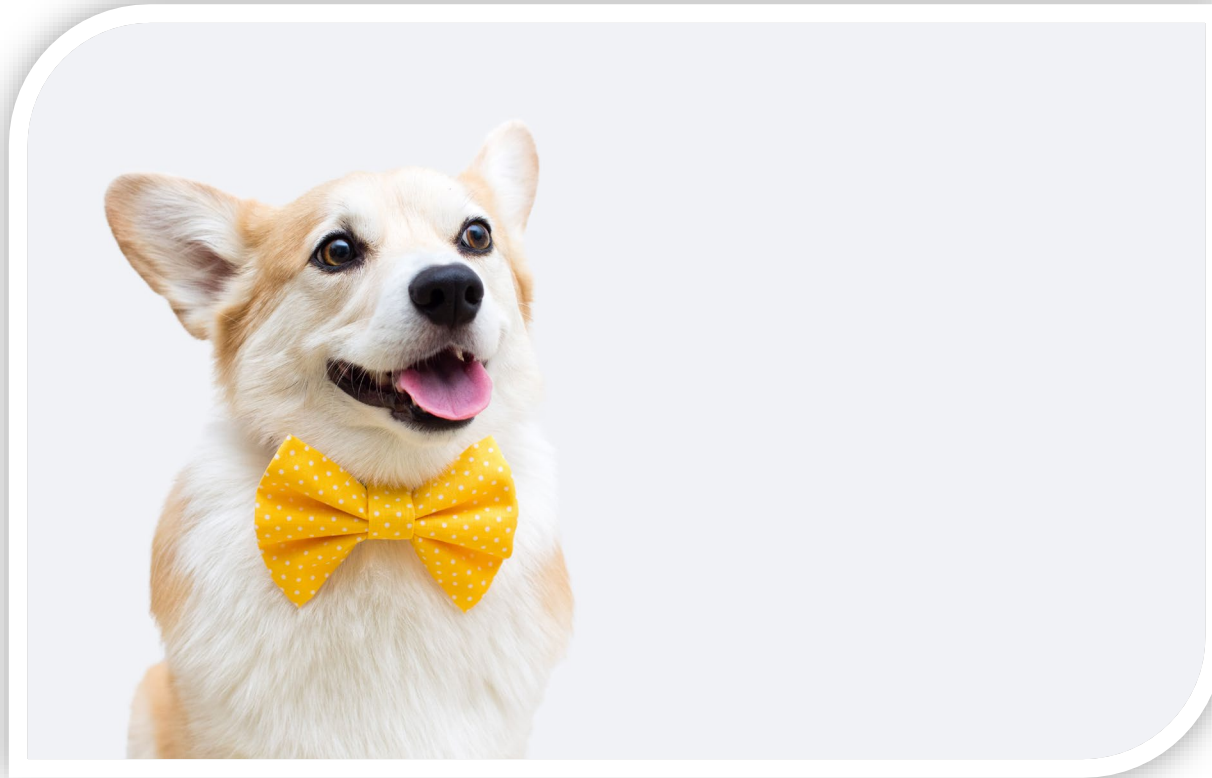
Dog *or* Mushroom?

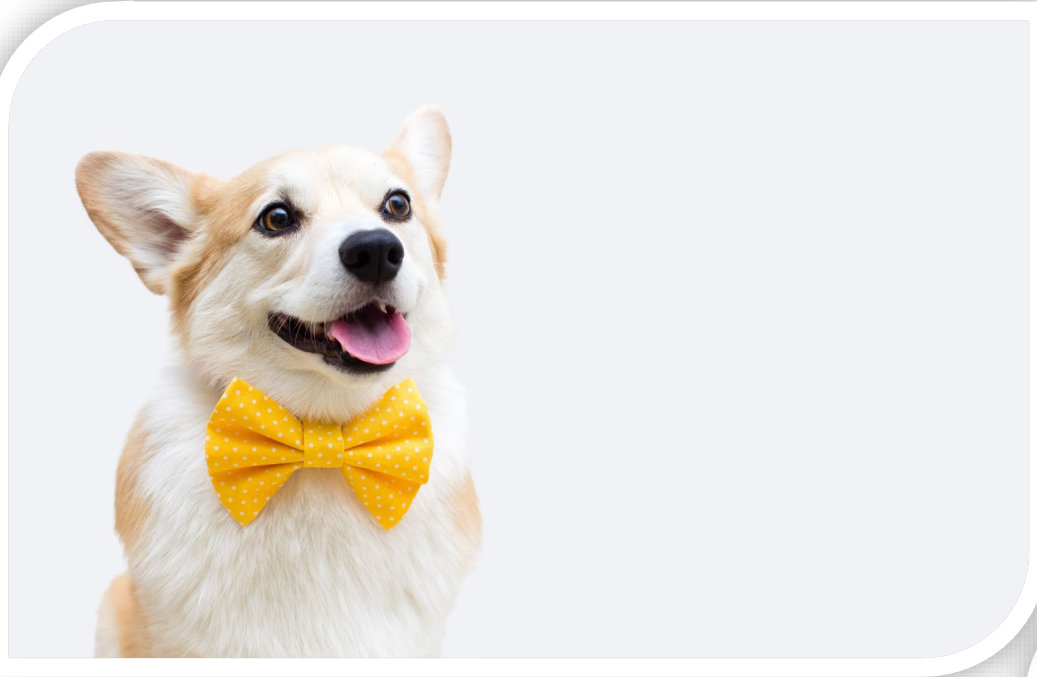
10. Xoloitzcuintli



Dog *Or* Mushroom?

10. Xoloitzcuintli





quiz?

Dog...

Or

Mushroom?



Focus on continuing the work



Tom Ayers
Director



Matt Milarski
Head of
Quality
Improvement



Sophie Bagge
Lived
Experience
Advisor

Personalised Approach to Risk

Nav Kapur

Subject Matter Expert

Leah Quinlivan

Subject Matter Expert

Pea Meyer-Higgins

Lived Experience Lead – Relational Care (PAR)

Dr Emma Nielsen

Researcher, Lived Experience PAR Lead



Importance of Lived Experience



Sal Smith

Head of Lived Experience



Mark Allan

Head of Peer Work



Eleanor O'Sullivan

Lived Experience Research Assistant



Jane McGrath

Lived Experience Consultant



Culture of Care

Lived Experience Evaluation

Sal Smith, Jane McGrath, Eleanor O'Sullivan

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CENTRE FOR
MENTAL HEALTH



Neurodiverse
Connection



NCISH

With fire in our belly
And flesh in the game
We shine light on places
There was once only shame.

The canary in mine,
The early warning sign for harm,
Lived Experience leaders;
Changing what services might
become.



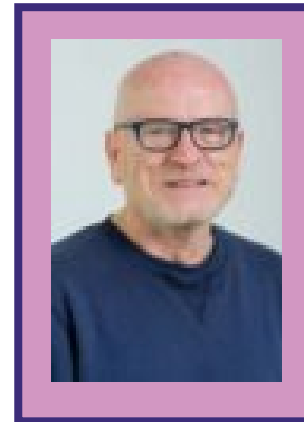
Artwork by Dolly Sen

The nuts and bolts

- Over 30 people in the delivery team in LE roles.
- More than half of our leadership team LE leaders.
- 200+ wards with patient and carer input.
- Co-developed materials and outputs including patient/carers experience measure.
- Safety delivery group for the PAR work
- Training for QI team from people with LE
- Aspiration for all training and events co-delivered or lived experience led
- Peer support implementation space
- Lived Experience Network for all people with LE involved in wards
- Lived Experience reference group to strengthen governance

Team

- Lived experience-led evaluation
- Small team of academics, researchers, lived experience leaders
- Collaborated on objectives, design and delivery



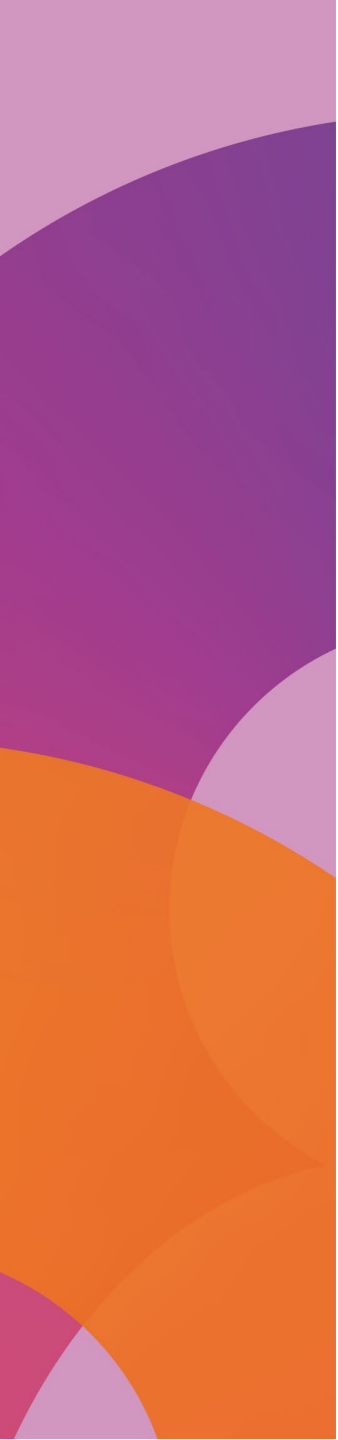
Methods:

For delivery team;

- 1 data gathering day: inc. found poetry, ripple mapping, focus groups
- 15 semi-structured focus groups
- 7 semi-structured one-on-one interviews
- 1 Likert-scale questionnaire (Strongly Agree – Strongly Disagree)

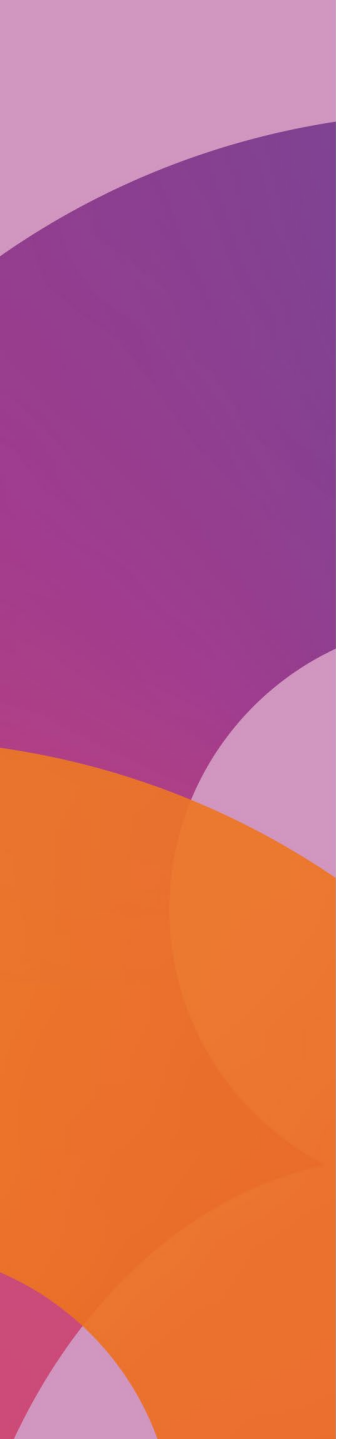
Site level;

- Questionnaire with multiple choices and free text boxes
- Secondary data analysis with CofC Dashboard data



Findings:

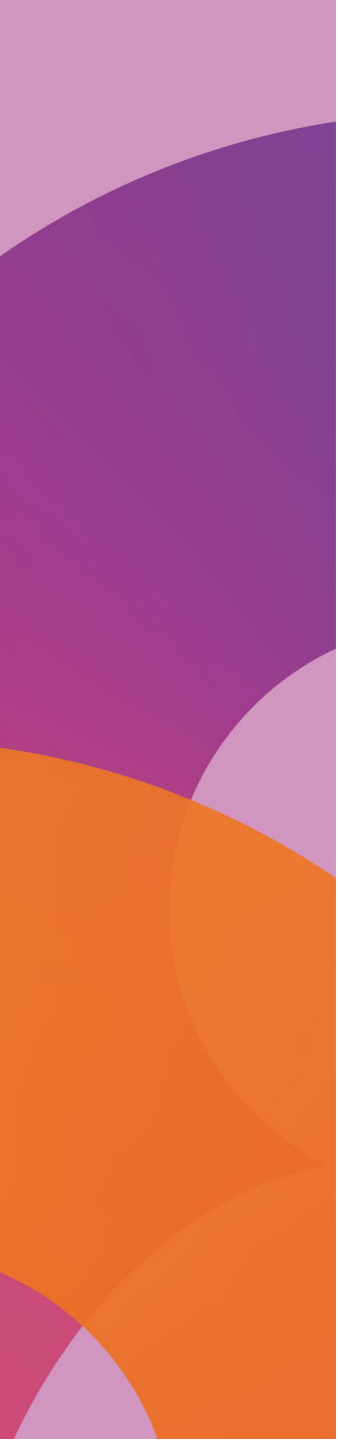
3 Key Learnings



Key Learning 1

Spotting harm:

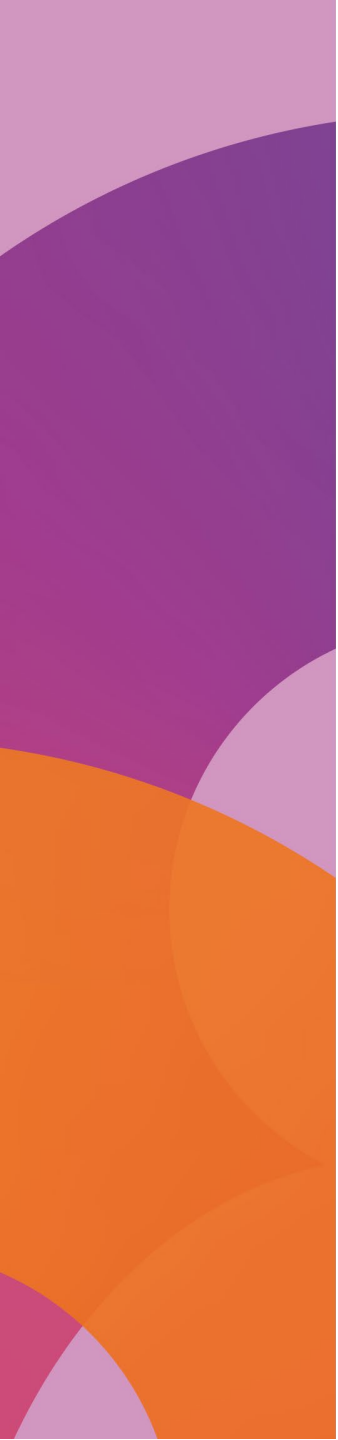
Collaboration reveals unexpected harm
the system would not otherwise see.



Key Learning 2

Speaking up:

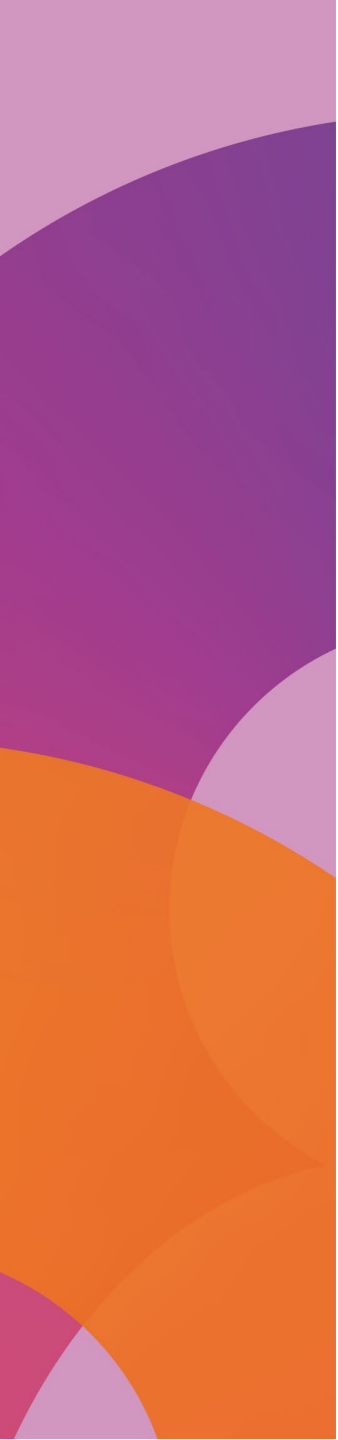
Professionals may hold back from challenging ideas from people with lived experience for fear of causing upset



Key Learning 3

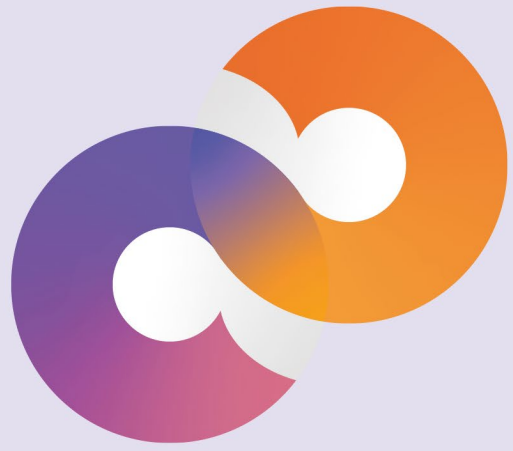
Support systems in place:

Build in time and space for reflection. This work has impact, and people need time to process and make sense of it



3 To-do's

- Listen actively for unexpected moments that reveal harm
- Be curious — are you holding back from disagreeing or challenging? All perspectives are needed
- Consider what support systems and reflective spaces are built into the work — are they sufficient?



Culture of Care

Peer Support Implementation Space

Mark Allan

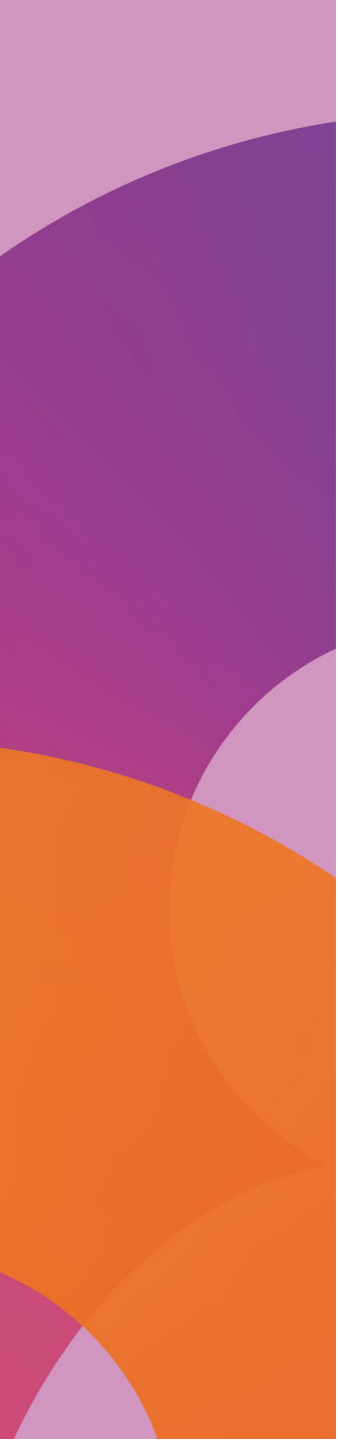
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MENTAL HEALTH



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Connection



NCISH



Why the Space Was Created

Trusts participating in Culture of Care were excited to develop peer roles.

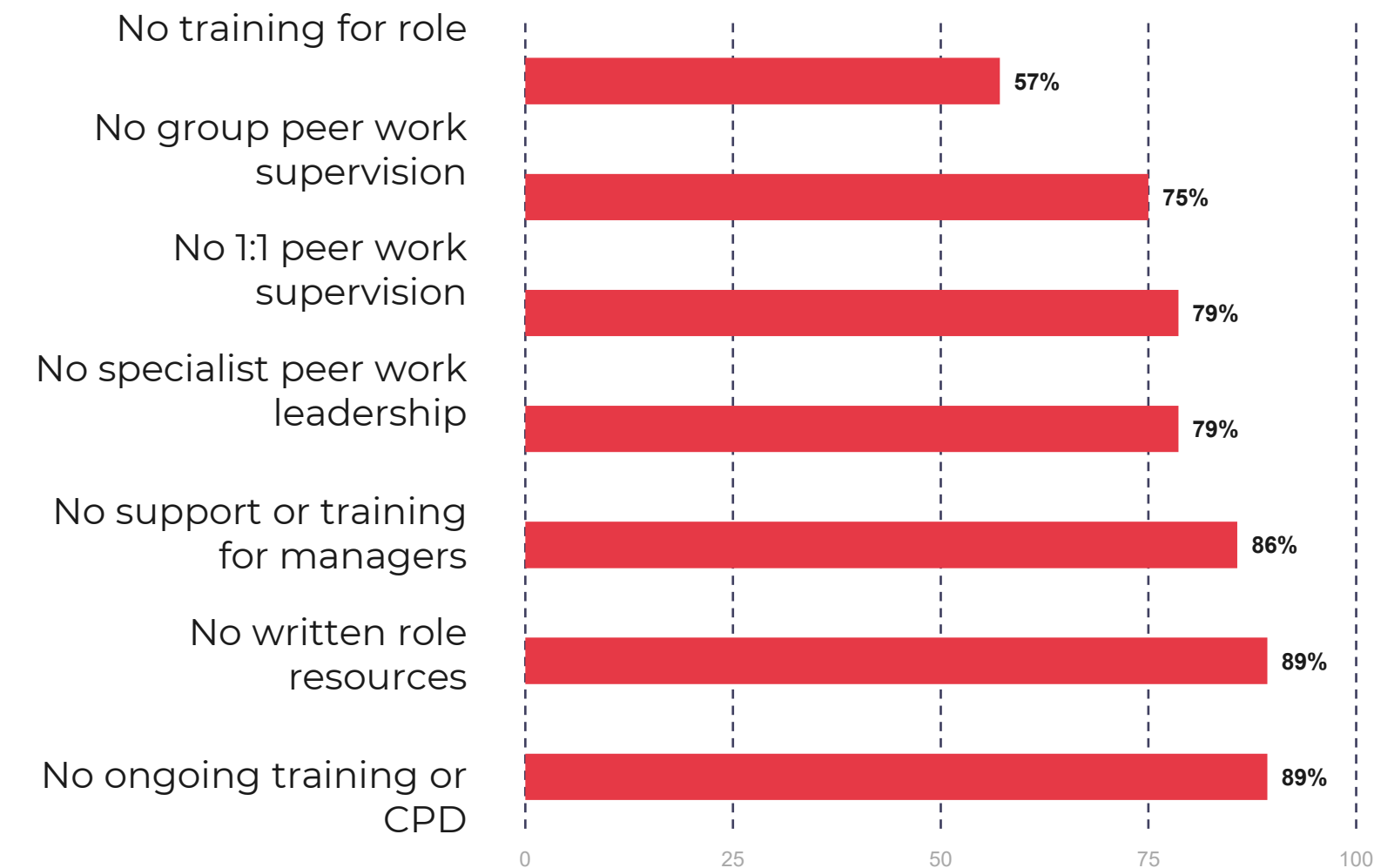
They wanted support with this because they understood:

- **Peer support workers are a key way to create lasting cultural change**
- **Ward peer support work is challenging - there is a responsibility to provide appropriate frameworks**
- **That the process of learning together & supporting each other is the best way to develop**

The Implementation Space was created so we could share learning, ask and answer the important questions together, and build a supportive community for everyone involved in implementing roles on wards

What Support Looks Like Across the Country

% OF NHS TRUSTS **NOT** PROVIDING EACH TYPE OF SUPPORT FOR PEER WORKERS



Key Context

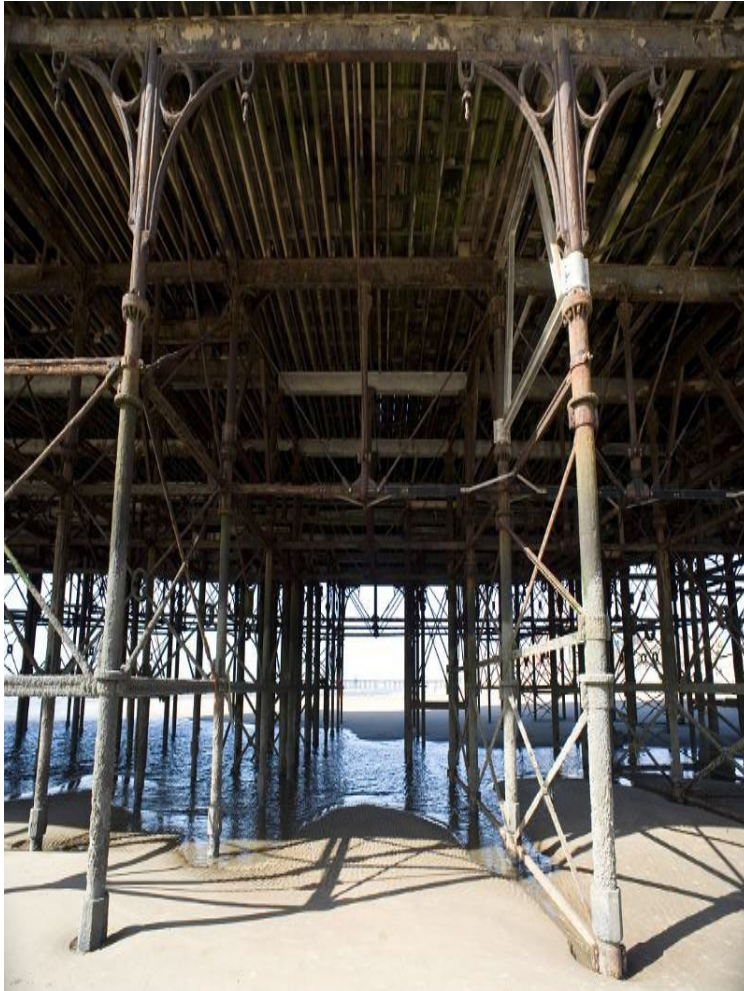
- PSWs use difficult personal experiences at work, face pre-existing mental health challenges plus stigma from colleagues.
- So support structures are as/more important as for other roles
- Providers with specialist support teams led by staff with lived experience tend to provide all recommended forms of support

Key Recommendation:

“Trusts seeking to employ PSWs on inpatient wards or improve their practice should obtain advice and support from the few Trusts excelling in this field”

[Source: Berry et al. \(2025\). Survey of 44/47 NHS Trusts delivering acute mental health care. Data based on 28 organisations with PSWs.](#)

Supporting Peers in TEWV: Creating Sustainable Roles



Robust Professional Governance & Support

- Peer-led professional structure
- Leadership & supervision roles
- Roles based on peer values
- Peers in pairs or linked roles
- Team preparation
- Peer-led recruitment
- Peer support training from day one
- 1:1 peer supervision

Strong Peer Community

- Monthly co-reflections
- Monthly social drop-in
- Monthly newsletter
- Bi-annual development days & directors forums
- Systemwide NHS + VCSE PSW networks
- Daily debrief availability

TEWV: Impact of Dedicated Professional Structures

Recruitment Data

- 2018: **217** applications for 6 Teesside roles
- 2021: **121** LE applications for 12 inpatient roles
- 2025: **236** applications for 6 SIS roles

Pilots: Service User Feedback

100%

of service users rated their experience of working with a PSW as 4/5 or 5/5

Pilots: Colleague Feedback

100%

of staff reported valuing having lived experience on the team

Service Retention Rates

- 1 year in: **98%** still in LE roles in Trust
- 2 years in: **88%** still in LE roles in Trust
- 3 years in: **81%** still in LE roles in Trust

Session 1: Opening Workshop

Our first session was all about listening. We wanted to understand where everyone was in their peer support journey and what they most needed from this space.

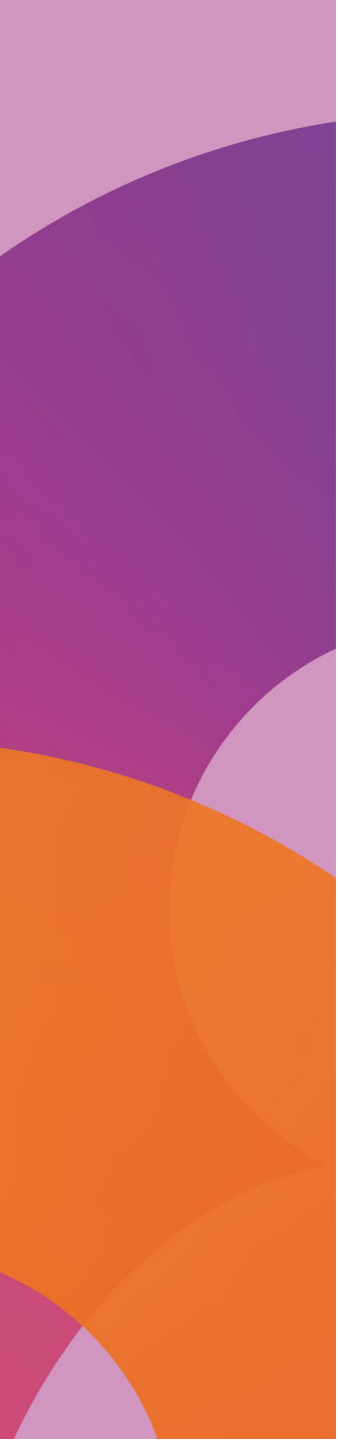
People told us they wanted:

- **Knowledge sharing** about practical issues and good practice, with a focus on inpatient settings.
- **Space for connection** and problem-solving discussions where people could support each other.

This shaped the structure of every session that followed:

- **First hour: Sharing best practice** – presentations from peer leaders with relevant experience.
- **Second hour: Problem-solving and sharing successes** – open discussion to reflect on challenges and celebrate progress together.

Together, the group collectively shaped the topics and schedule for the year ahead...

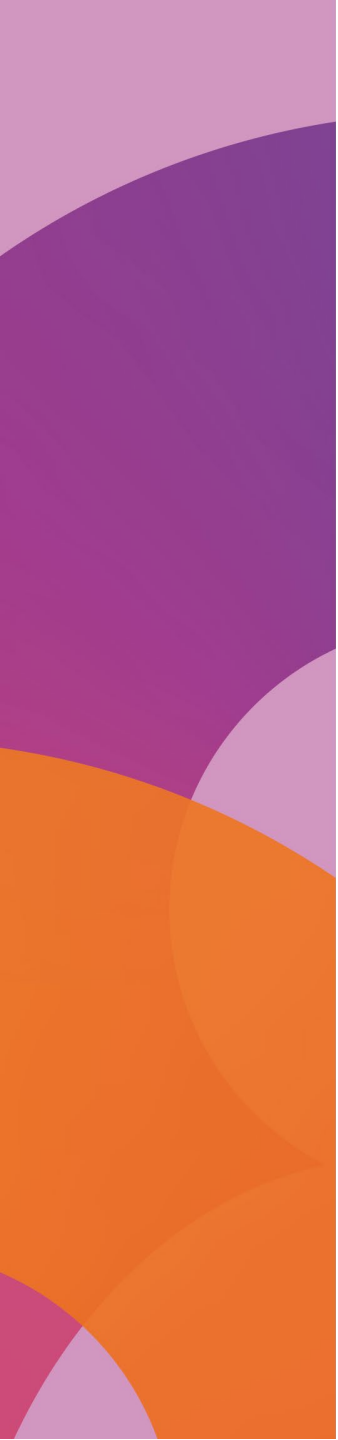


2. Preparation

- Peer leadership
- Organisational prep
- Team readiness
- Ensuring role fidelity

3. Recruitment

- Lived experience led
- Values-based approach
- Clear role remit
- Advertising roles
- Recruitment days & Interviews



4. Workforce Development

- Training & CPD
- Induction
- Peer supervision
- Addressing common challenges

5. Cultural Competency

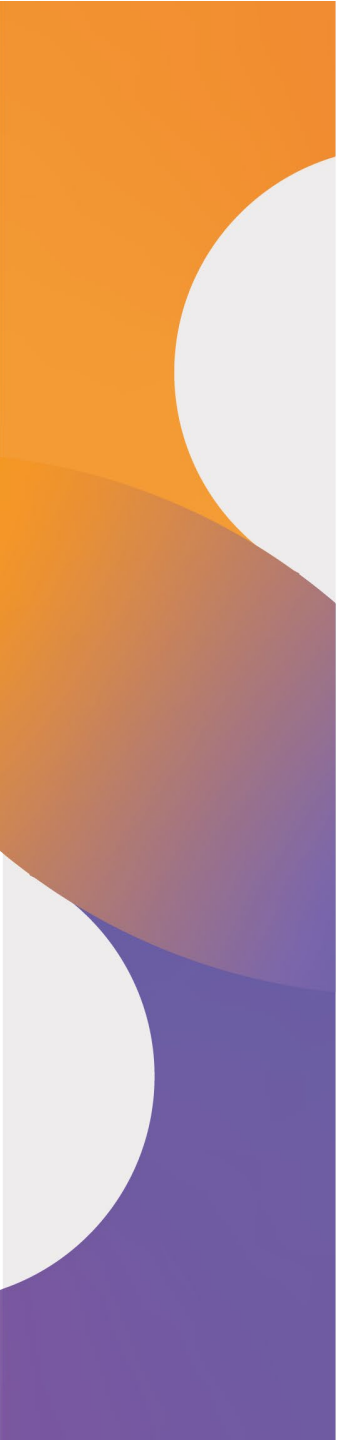
- VCSE partnerships
- CAPSA – Black Thrive Lambeth
- Robert spoke about the services focus on culturally appropriate peer support & peer advocacy

6. Career Structures

- MPFT - Lived Experience Framework
- Peers as leaders
- Full peer support/LE career structures
- Fair AfC banding
- Protect peer identity
- Shaping services as well as delivering

7. Evaluation

- Dr Simon Bradstreet & Ruth Lambley
- How do we measure what matters?
- Capture impact beyond narrow metrics
- Keep alignment with peer values
- Value of stories & data together
- Importance of learning as we go
- Recognising growing evidence base



Session 8: Peer Leadership and Networks

Peer Leadership

- Habitus Collective
- Importance of supporting peer leaders to develop peer support and influence how services develop
- Peer Leadership Self Development Tool by Habitus and TEWV Peer Support Team

Peer Networks

- Importance of networks across providers
- Facilitate sustainability and shared learning & collective growth
- Reflected on the space and what we would carry forward from it

Feedback

- "The format works brilliantly. It's really good to hear from the speakers and then have the space to discuss afterwards"
- "the space feel[s] safe ... people are heard and validated"
- "Yes [it was helpful], shared learning and problem solving, even just hearing how other people approach similar issues"
- "Extremely supportive, helpful and informative"
- "Amazingly helpful!"
- "It was very valuable being able to have open and honest discussions with others going through the same things or learning about how they have overcome some of the challenges"
- "I would love it if the main presentation part could be recorded and shared, to aid dissemination of such vital info in our organisation"
- "I am more grateful than anyone could imagine at being a part of this group and I am so keen to learn from everyone! Thank you so much!"
- "Vibrant & energetic, the power of peer support for us doing peer support!"

Looking Ahead ...



The Implementation Space continues!

We'll meet quarterly – next meeting is June 2026

Continuing our focus on implementing peer support

More sharing from within the group

Continue to explore the topics that matter most to the group

Thank you to everyone who has contributed, shared, and helped shape this space!

Welcome to anyone (peer or otherwise) providing leadership into the implementation of peer support - please do get in touch if you would like to join us!

Comfort break



15 minutes

14:25 – 14:40

Catering will be served in the 1882 Suite

Ward Review Findings



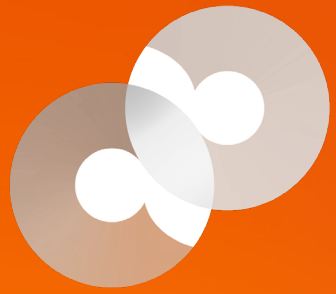
Jill Corbyn

Director and
Founder of
Neurodiverse
Connection



Jacqui Dyer

Director of
Black Thrive
Global



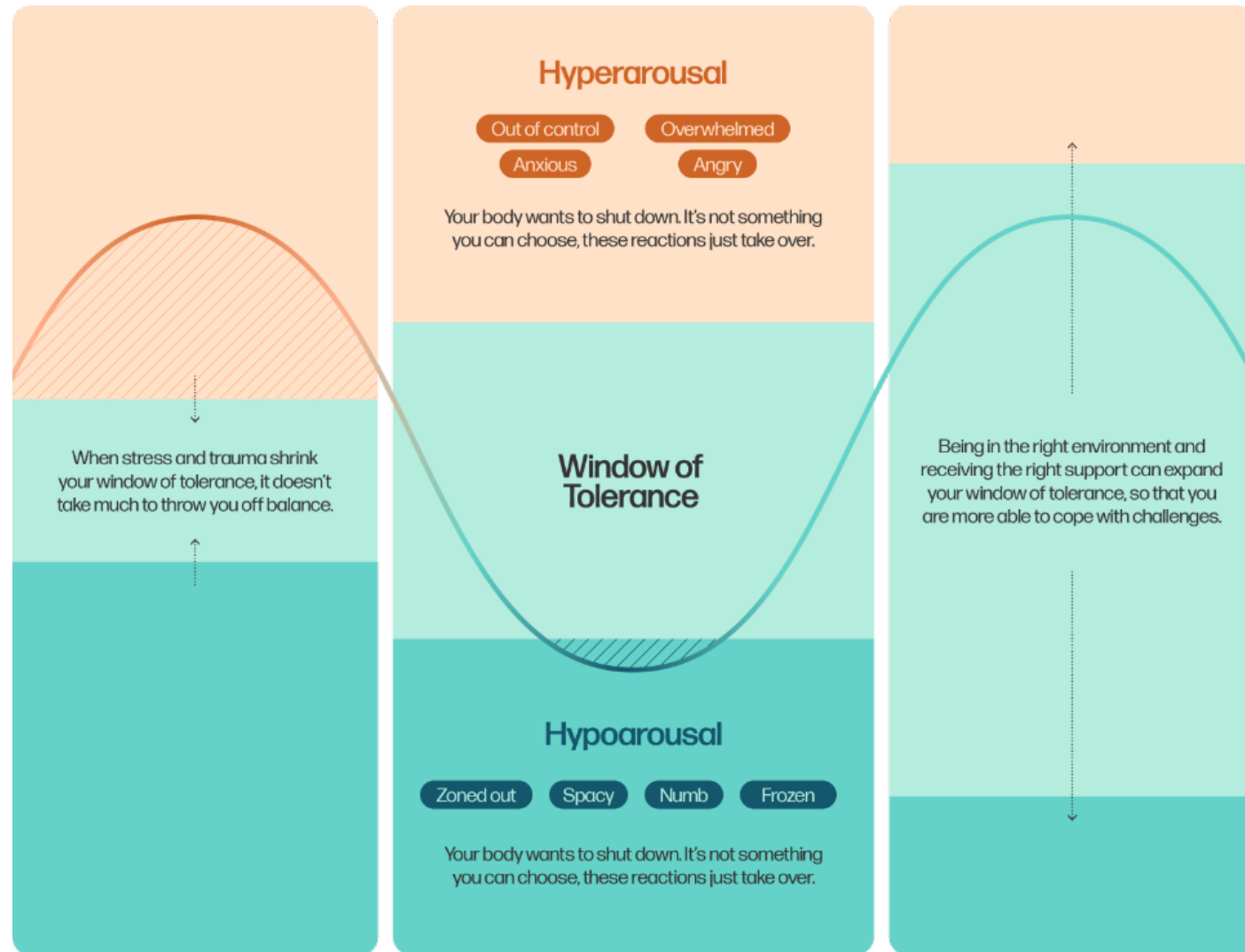
**Culture
of Care**

Autism and Trauma informed environments

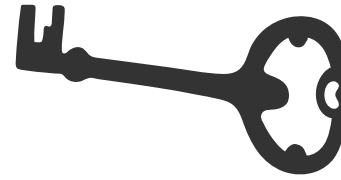
Jill Corbyn, Director, Neurodiverse Connection

Why environments matter

- Environments can soothe or harm.
- Environments can be powerful reminders of past traumatic experiences.
- Dysregulation happens when the nervous system is out of capacity and beyond the window of tolerance.
- This is an adaptive response and not chosen.
- Harmful environments can increase the likelihood of shutdown or meltdown.



Systemic themes

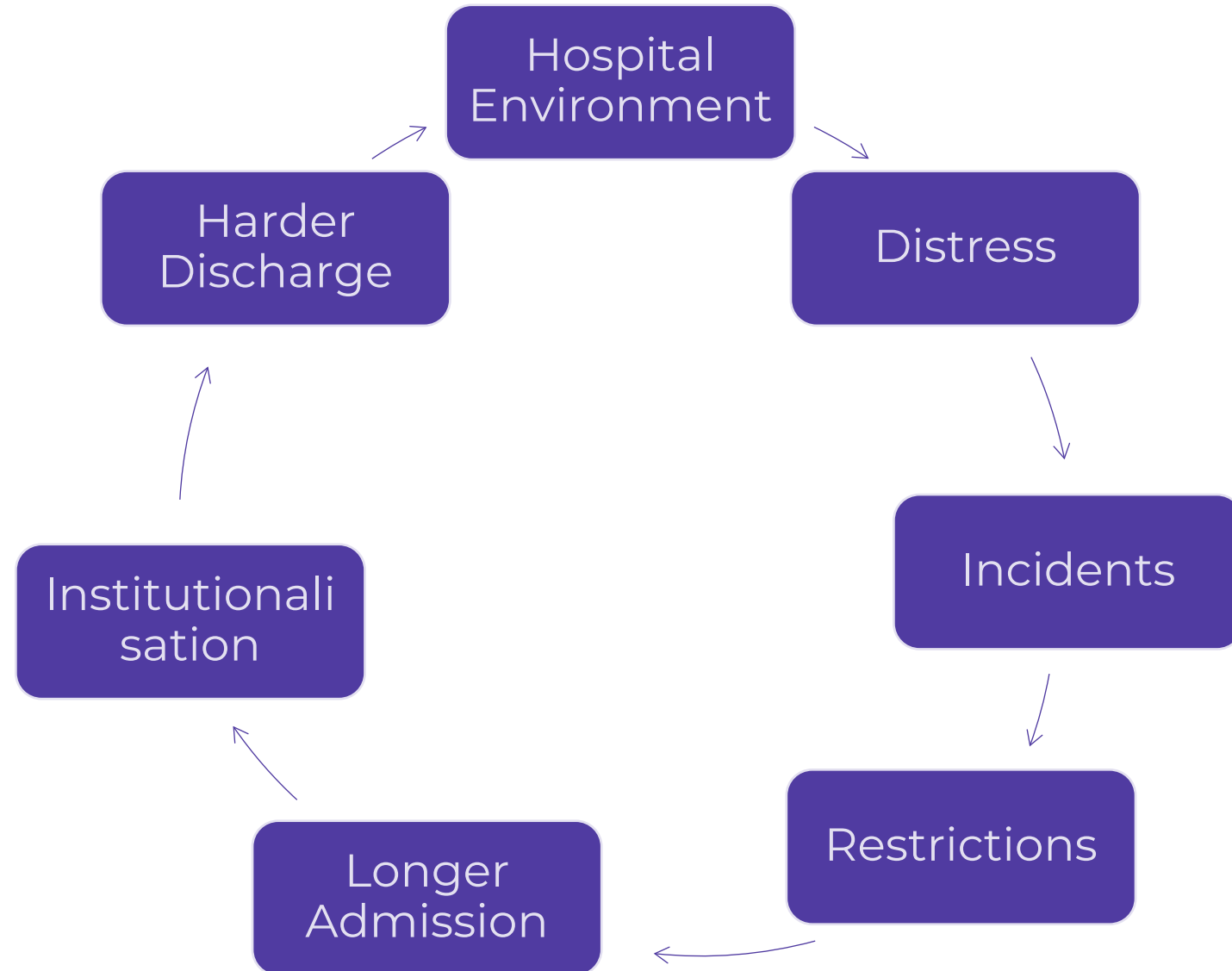


Across the 10 reviews we consistently saw:

- Environments designed around staff and risk, not around patients
- Environments not designed for autistic sensory needs
- High levels of noise, lighting and sensory overwhelm
- Limited control over space and routines
- Lack of quiet / recovery spaces
- Institutional features: alarms, locked doors, surveillance, offices
- Limited access to outdoors or meaningful activity
- Trauma triggers in the environment (noise, sudden entry, lack of privacy, restraint)



Impact: patients, staff and system





We need to move from:

- ‘watching’ environments
- Busy, bright, noisy wards
- Environment seen as estates issue
- Restrictive responses to distress (co-escalation vs co-regulation)

To:

- ‘Being with’ environments that support relationships and regulation
- Calm, predictable environments
- Environments that promote people feeling safe and prioritise dignity
- Sensory-informed design
- Environments understood as part of clinical care



Relationships are central to patient experience

“ The healing power of relationships is perhaps the single greatest leverage point to fundamentally re-wire a system’s behaviour and the outcomes it produces. ”

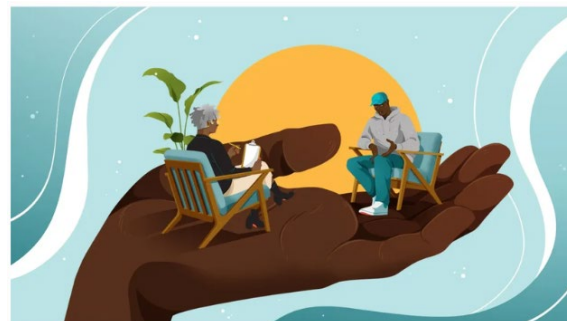
— Calderon de la Barca et al 2024



Thank you for listening

Race Equity in Inpatient Mental Health Care

- Cross-ward learning from Culture of Care programme
- Based on staff insight, lived experience input, and system data
- **Focus: How racism operates in real care environments**



How racism appears across settings

- **High-acuity / PICU:** frequent racist incidents, crisis-driven responses, staff exposure is constant
- **Acute wards:** quieter forms — hesitation, avoidance, uncertainty in naming racism
- **Recovery settings:** strong awareness but inconsistent translation into practice
- **Secure CAMHS:** structural patterns — custody pathways, longer stays, restricted discharge routes
- **Key point:** same issue, shaped by environment, pressure, and system design



Different environments produce different expressions of the same problem

The shared system pattern



1. **Racism** is recognised by staff
2. **Staff respond** professionally and often compassionately
3. **System follow-through** is inconsistent or unclear
4. **Learning** is not embedded into routine practice
5. **Patterns** repeat across time and settings
6. **Emotional impact** is carried by staff rather than systems

👉 **Result: coping replaces protection**

The shift we need



Current reality:

- Reactive responses after incidents
- Reliance on individual judgement and confidence
- Focus on single events rather than patterns

Future direction:

- Preventative, anticipatory practice
- System-level support and shared responsibility
- Pattern recognition across data, incidents, and experience



Race equity is a system design issue, not just a training issue

What strong systems look like

- Race-aware MDT discussions (including pathways, trauma, and context)
- Clear, visible support for staff after racist incidents
- Data that surfaces patterns (not just isolated events)
- Consistent access to culturally responsive and psychological care
- PCREF embedded into everyday ward practice, not separate
- Leadership able to explain: what is happening, what is changing, what is improving

 **Equity is built into how the system works, not added on**

What the data tells us

- 3,424 total change ideas generated across the programme
- Only 223 (6.5%) explicitly focused on race equity
- Race equity is present — but not prioritised at scale
- Improvement activity is happening, but not consistently focused on equity
- This gap reflects system prioritisation, not lack of awareness



👉 **What we prioritise shapes what changes**

What this means for us

- Staff are already doing a significant amount of equity work informally
- Current systems do not consistently support or sustain that work
- Variation between wards is driven by structure, not commitment
- Without system change, inequities will continue to repeat
- Opportunity: strengthen what already exists rather than start again

👉 **The task is to support the work staff are already trying to do**

What we take forward

- Staff are already doing important race equity work
- Current systems do not consistently support that work
- Variation reflects structure, not commitment
- **What the data shows:**
- Only 6.5% of change ideas focus on race equity
- Race equity is present — but not yet embedded

👉 **If race equity is not visible in our priorities, it will not be visible in our outcomes**



Table Reflections



Tom Ayers

Director, NCCMH

Table Reflections

At your table and using the prompts below, please reflect on the following:

- 1. What is something you have learnt or taken from the programme**
- 2. What is something you are proud of**
- 3. What is something you are going to share**



Close and thanks



Sal Smith

Head of
Lived
Experience



Jacqui Dyer

Director of
Black Thrive
Global



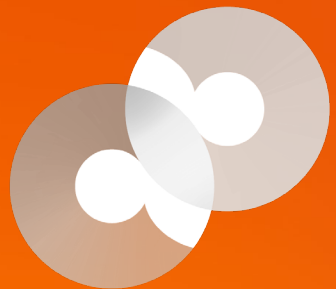
Jill Corbyn

Director and
Founder of
Neurodiverse
Connection



Brendan Stone

Leadership
Coach



Culture
of Care

End of day reflections

Jill Corbyn, Director, Neurodiverse Connection



 Neurodiverse
Connection

Interactive toolkit

A practical approach to neurodiversity-affirming care and support

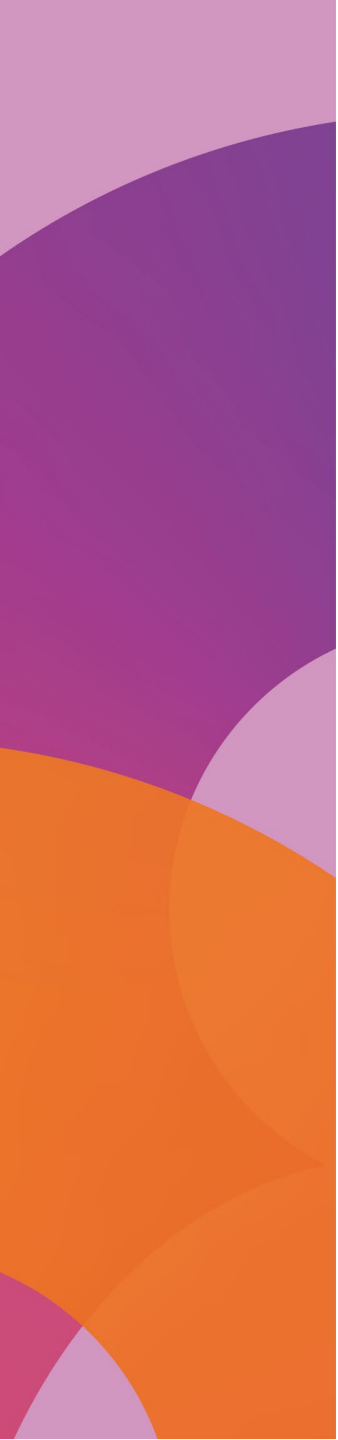
Created by Neurodiverse Connection

Based on the Autistic SPACE Framework created by
Doherty, McCowan and Shaw (2023)



**“The whole is
greater than the
sum of its parts”**





Thank you!

Before we say farewell, please
enjoy the following video