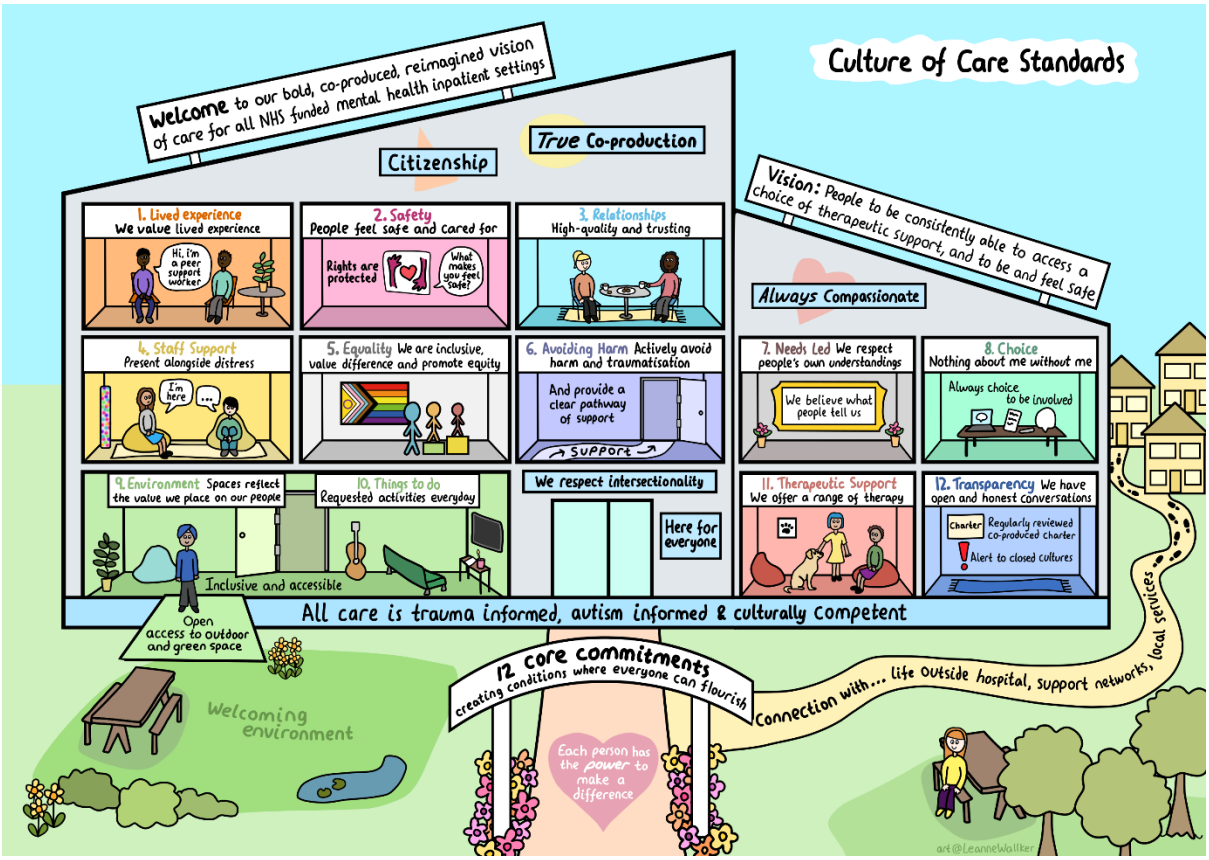
Culture of Care National Learning Session: List of change ideas from the Teams chat

07 July 2025, 10:00 – 13:00 || Microsoft Teams

Please see below the change ideas that are being tested and/or suggested by the attendees of the National Learning Session in the Teams chat during the event. The change ideas are listed under the relevant Culture of Care standard.

Thank you to everybody who shared their wonderful work/ideas/thoughts in the chat on the day 😊



Standard 1. Lived Experience

- A Culture of Care volunteer post
  (We advise that lived experience posts are remunerated fairly and in a way that reflects the responsibilities and skills required. However, we acknowledge that having some volunteer posts alongside paid opportunities can help some people to access the roles)
- Lived Experience roles have to be flexible, authentic and well paid.
- A Lived Experience Lead paid position.
- Lived experience leadership roles within the organisation.
- In-reach work with community groups who can come onto the wards to meet patients and hopefully break down the stigma of attending a support network outside of the hospital.
- Increase the banding of lived experience roles.
- How is lived experience understood and valued in Agenda for Change and when banding roles.
- Co-producing all policies with people with lived experience.
- A thought: we DO have nursing staff with lived experience, but they are discouraged from sharing this. I wonder what type of effect that supporting these staff to share this with colleagues and patients would continue to raise the currency of the value of lived experience and our lived experience ambassadors, and improve mental health support for our staff as well?
- Peer support workers are not to be seen as extra clinical/support staff- they bring something different.
- Peer support workers are not to be included in the staffing matrix or 'numbers,' so should not be expected to do 12-hour shifts and get involved in restraint or restrictive practise or invasive treatments.

Standard 2. Safety

- The Trust involves lay representatives in their patient safety work. Patient safety partners.
- Make seclusion as therapeutic as it can be e.g. adding sensory boxes, religious items, phone to make calls, or a radio.

Standard 3. Relationships

- Reduce the time staff need to spend filling out forms.
- Move away from assurance driven observations, when appropriate.

- Allocated staff to patients, and they are all expected to spend quality time with these patients and understand how they are.
- Add uniform colours, so patients know the role of each staff member.
- Addressing admission welcome packs for patients and carers. E.g. condensing a large amount of information to a more manageable amount for ease of access and adding in the names of a "named nurse and healthcare assistant" specific to each patient.
- We welcomed our newest patient onto our ward with a welcome card and a set of toiletries 😊 It made a huge difference during the period of change which can be anxiety provoking for many.
- Mandatory training and role modelling around proactive engagement by all staff.
- One to one work with patients can be effective and valued and the first steps to engagement and building or relationships.
- 'About me' posters with a photo of staff and just little information about us so the patients can read and then recognise us when we do come onto the wards.
- A "know your staff team" booklet available with one-page profiles.

Standard 4. Staff Support

- Clinical teams could complete aspects of the Peer Training for peer support workers – it could aid with improving compassion and understanding especially if it was delivered by those with lived experience, and it would also show clinical staff how peer support workers manage distress and support. Peer support workers have training to help them stay connected, compassionate and empathetic but also how to safely offload the day, so they do not go home to ruminate on the day. This may be helpful for clinical staff.
- Teach DBT techniques and safe ward skills widely and to support our staff to understand the benefit and the confidence in using these (for staff and patients alike) and to be engaging proactively.
- Encourage staff members that training is to assist them to provide and deliver more efficient care that is safe for both staff and service users, which is also evidence based, rather than the organisation ticking boxes that training is provided.
- Open door supervision can be an amazing thing for staff support and choice.

- Offer staff training for group facilitation and therapeutic activity, such as florists doing workshops, and yoga instructors doing morning yoga.

Standard 5. Equality

- Everyone should be offered the opportunity to meet with a chaplain if they wish.
- Patients to have access to a VR headset that supports service users to have virtual faith experiences such as Jummah Prayers or Sunday services if they cannot access the community.
- Incorporating translation into day-to-day interactions, not just key meetings. This is being supported by a digital translation system.

Standard 6. Avoiding Harm

- Safeguard ‘freedom to speak up’ from fizzling away.
- Everyone, including staff at the top, can "face up" to how things are going wrong. Only then will they really be open to HEAR. When people are courageous enough to speak up, their concern should not be met with incredulity or a desire to 'explain away'. We need to foster a 'Speak Up' culture and this needs to be supported at EVERY level.
- Consider the content of what the ward has on display on the walls.

Standard 7. Needs Led

- Discharge packs for patients, full of personalised information and breakdowns of what happens next when leaving care.
- An outreach handover happening between a ward representative, community representative, supported housing representative, patient and a loved one, in their discharge place - both pre-discharge and on discharge.
- Support patients with things to do during their time on leave/how to use their time on leave, especially if they are admitted out of area, away from their local community.
- Providing visiting friends and family with information about the local area, especially is they are unfamiliar with the area, to make their opportunity to see someone off the ward as positive as possible.

Standard 8. Choice

- Activity schedules with two options for each timeslot (so patients can vote for the activities each day)

Standard 9. Environment

- Hot drinks machine available on the ward
- A toaster available on the ward
- Silent alarms
- Creating ‘social hubs’ – e.g.: Social Hubs - Cygnet

Standard 10. Things to do

- Co-produced activity schedule weekly.
- Activity coordinator roles.
- All staff to support activities as a core part of their role.
- Protected engagement time for activities shared across staff not just Activity Coordinators.
- Activities available over the weekend.
- Twilight scheduled Activity Coordinators on shift (at times where there's often a lull in activity and increase in incidents)
- A movie night with popcorn.
- Cultural days and activities such as cooking sessions of specific cultures dishes.
- Creating ‘social hubs’ (as above) could enable patients to meet other patients from other wards, and ‘expand the walls’ of the ward.
- Flex Fridays - one day / afternoon on the ward where as many staff as possible join the patients on the ward for a few hours with unstructured time to socialise with activities / materials available to start conversations or engage people together.
- A 'snack and chat' daily in the evenings, as an informal debrief on the day (alongside the regular community meetings), but also a way of socialising / thinking of activity ideas for following days.
- We have moved away from 'timetabled' class like activities, and have done umbrella activities, such a 'Men’s Club' - 'Cook with me' - 'Nature time.’ Under these umbrella groups we have varied activities for maybe a 2–3-hour period where the patients can pop in and out. This creates a more social atmosphere, less expectation and pressure, and more flexibility, and allows staff to also pop in and out making it more achievable, the groups are designed and led by the patients and reviewed each week.

- A 'staff hobby interest database' – ask ward staff about their own hobbies and interests, and then build activities around this, asking the staff if they are happy to facilitate the group. If they don't want to, they can lead on the design of the activity and be the co-lead on the facilitation.

Standard 11. Therapeutic Support

- Create Autism/ADHD care plans. We have decided that patients do not need a formal diagnosis of Autism or ADHD to get one of those, as they may be only just aware that this may be the case. These can be used to support patients on their diagnosis journey and to include each person's specific needs.

Standard 12. Transparency

- Ideas and points raised by patients are listened to, used as a positive, and then actioned or feedback is speedily given.
- In ward rounds, use a projector to show the documents being discussed, so that the service user can see what is being written.