Culture of Care

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Organisational support:
Resource for providers

Introduction

Organisational leadership, alignment and sustained action are fundamental to achieving and embedding meaningful culture change within inpatient services.

When NHS England commissioned the Culture of Care support offer, there was clear recognition that improving ward culture requires not only frontline change but also co-ordinated, organisation-wide engagement. This is reflected in the cross-organisational work led by the National Collaborating Centre for Mental Health (NCCMH), and in the focus of this resource on the critical role of leaders and corporate services in enabling lasting improvement.

This document has been developed to share key learning, insights and practical approaches emerging from this cross-organisational work. It is intended to support organisational leaders and corporate teams to embed, sustain and scale the Culture of Care standards across their organisations and services.

The 12 Culture of Care standards set out a vision for inpatient settings where people feel safe, respected and valued, and where they can access meaningful therapeutic support and choice. The accompanying illustration (on page 3) developed by Leanne Walker, provides a representation of this vision.

Through quality improvement coaching delivered to over 200 wards, thousands of change ideas have been developed, tested and implemented. These have provided valuable insight into what supports the effective application of the standards in practice, and where organisational enablers are critical.

Culture of Care

Introduction	**p2**
Culture of Care standards: exploring organisational change ideas	p5
1. Lived experience	p6
2. Safety	p8
3. Relationships	p10
4. Staff support	p12
5. Equity	p14
6. Avoiding harm	p16
7. Needs led	p18
8. Choice	p20
9. Environment	p22
10. Things to do	p24
11. Therapeutic support	p25
12. Transparency	p27
The guiding principles: Scenarios to support reflection across organisations	p29
Co-production and lived experience leadership	p31
Trauma-informed approaches	p37
Autism-informed approaches	p41
Racial equity	p45

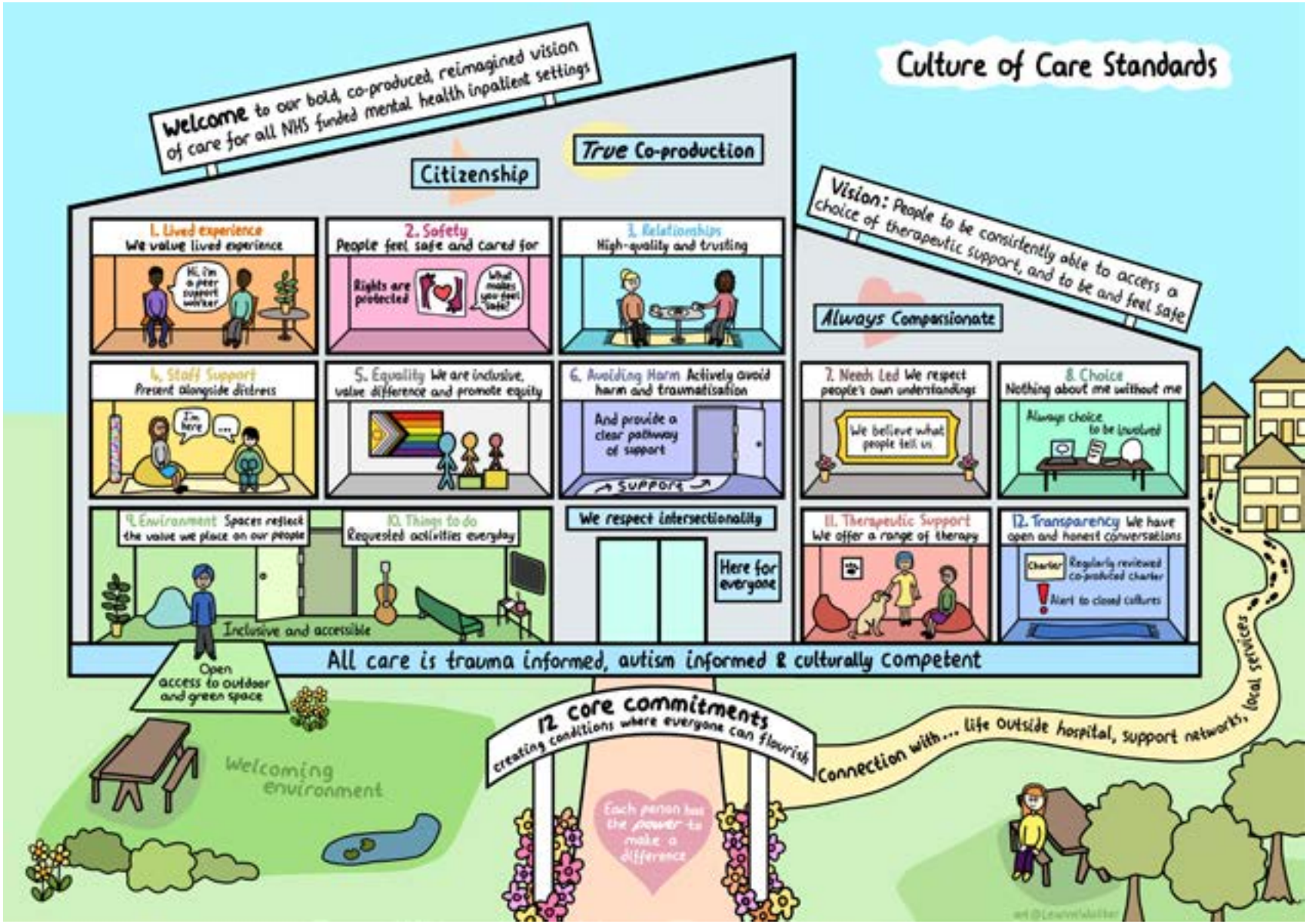

Figure 1: NHS England Culture of Care standards. By Leanne Walker

Culture of Care

Introduction	**p2**
Culture of Care standards: exploring organisational change ideas	p5
1. Lived experience	p6
2. Safety	p8
3. Relationships	p10
4. Staff support	p12
5. Equity	p14
6. Avoiding harm	p16
7. Needs led	p18
8. Choice	p20
9. Environment	p22
10. Things to do	p24
11. Therapeutic support	p25
12. Transparency	p27
The guiding principles: Scenarios to support reflection across organisations	p29
Co-production and lived experience leadership	p31
Trauma-informed approaches	p37
Autism-informed approaches	p41
Racial equity	p45

This document is structured in two parts:

Culture of Care standards: Exploring organisational change ideas:
Provides practical tools and prompts to support leaders in identifying and implementing organisation-wide changes aligned to the 12 standards.

The guiding principles: Scenarios to support reflection across organisations:
Presents a series of scenarios and reflective prompts designed to support leaders and teams to consider how equity is experienced and enacted across services, with a focus on relevant NCCMH key approaches:

- Co-production and lived experience
- A trauma-informed approach
- Autism-informed care
- Racial equity and an approach based on anti-racism.

See also the annexes to the NHS Culture of Care standards, with which our approaches align. Note that co-production is built into those annexes, and that at the NCCMH we have emphasised it as an overarching approach.

Together, the sections below are intended to support organisations to move from isolated improvement efforts toward a coherent, system-wide approach to culture, safety and equity.

Culture of Care

Introduction	**p2**
Culture of Care standards: exploring organisational change ideas	p5
1. Lived experience	p6
2. Safety	p8
3. Relationships	p10
4. Staff support	p12
5. Equity	p14
6. Avoiding harm	p16
7. Needs led	p18
8. Choice	p20
9. Environment	p22
10. Things to do	p24
11. Therapeutic support	p25
12. Transparency	p27
The guiding principles: Scenarios to support reflection across organisations	p29
Co-production and lived experience leadership	p31
Trauma-informed approaches	p37
Autism-informed approaches	p41
Racial equity	p45

Culture of Care standards: Exploring organisational change ideas

Presented across the 12 sections below are prompts and provocations to support organisational reflection and action in relation to each standard.

Key questions to consider throughout are:

- What might need to change at an organisational level to enable each standard to be consistently embedded across all wards?
- Which elements fall beyond the decision-making authority or resources available to ward teams alone, and therefore require organisational leadership, coordination or investment?
- How are you involving the ideas and voices of people with lived and living experience in each level of decision-making?

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Standard 1. Lived experience

1. Lived experience: Prompts and provocations	Decision-makers
Investment in lived experience and peer roles including leadership positions	Finance
What is our organisation's vision for lived experience and peer roles?	Operations
How might we invest to achieve having peer workers in every ward of every hospital?	Clinical leaders
How might we fund and support leadership positions?	
How might we bring lived experience roles into corporate services?	
Development of a robust payment policy for co-production and involvement activities	Finance Involvement and engagement team
How do we pay and reimburse people with lived experience, involvement members and experts by experience who are not contracted employees?	
Do we have a policy fit for purpose?	
Trauma-informed human resources (HR) policies to support lived experience and peer roles to thrive	HR
Do our HR policies support people with a serious mental illness, Autistic people and people with a learning disability to be able to access and thrive in our organisation? For example, policies for: • recruitment • sickness • staff support.	

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

1. Lived experience: Prompts and provocations	Decision-makers
Meaningful training for lived experience/peer roles Do we provide meaningful, relevant training for peer workers and lived experience leaders? For example, training in: • human rights • trauma-informed care • mad studies • alternative approaches to suicide and self-harm, hearing voices and so on.	HR – education and training Involvement and engagement team Peer leaders
Meaningful support and supervision for lived experience/peer roles Do staff in lived experience and peer roles have access to lived experience supervision?	HR

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6

2. Safety p8

3. Relationships p10

4. Staff support p12

5. Equity p14

6. Avoiding harm p16

7. Needs led p18

8. Choice p20

9. Environment p22

10. Things to do p24

11. Therapeutic support p25

12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Standard 2. Safety

2. Safety: Prompts and provocations	Decision-makers
Risk assessment policy aligned to the Safety standard Is our organisational risk policy aligned with the Culture of Care Safety standard? Does our risk policy promote or rely on tools that stratify risk, and what are the implications of this? To what extent do we prioritise relational safety and personalised approaches to managing risk?	Nursing and governance
Ward environments that promote relational safety Does the layout and design of our ward environments support connection, engagement and relational safety? Do our ward spaces feel like environments that facilitate care and trusted relationships, rather than restriction, control and coercion? What organisational decisions have been made regarding ward offices, and how do these impact visibility, accessibility and relational practice?	Estates
Compassionate responses to distress How does our organisation prioritise compassion within recruitment processes? How are compassionate, trauma-informed responses to distress developed through training and ongoing professional development? Do all staff have access to, and actively participate in, high-quality reflective practice?	HR – education and training Clinical leadership

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

2. Safety: Prompts and provocations	Decision-makers
Aligned approaches to responding to incidents	Nursing and governance
Does our organisational approach to serious incidents align with the Culture of Care Safety standard?	Executive team
Is our messaging to staff consistent with a relational, person-centred approach to safety?	
Do incident responses prioritise understanding the person's experience, supporting therapeutic relationships, personalised approaches to risk assessment and identifying what would help them feel safe?	
Leadership culture and development	Executive team
Across the organisation, do we model consistently positive, humane and relational language about people using our services?	HR
How do executive leaders demonstrate that patient experience and safety are central to organisational priorities?	
Do we consistently model compassionate, non-judgemental responses in our leadership behaviours?	
Does our leadership development approach explicitly centre the patient experience and relational safety in how leaders lead?	

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 3. Relationships

3. Relationships: Prompts and provocations	Decision-makers
Measuring what matters How are we collecting patient, carer and staff experience in ways that are meaningful and inform action? How is the data used to identify and address inequities in experience and outcomes? How do we ensure that we are prioritising measures that reflect what matters most, and reducing or stopping measures that do not add value? How are the voices of people using services and staff used to identify and respond to risks of closed cultures?	Data IT Nursing and governance
Staff recognition and accountability What schemes or approaches are in place to recognise staff who build and sustain trusted, therapeutic relationships? How do we proactively support improvement in staff–patient relationships? How are staff supported and held accountable when relational care is not prioritised or delivered effectively?	Executive
Aligning policies How do we identify and review organisational policies that may inadvertently hinder staff from building and maintaining trusted relationships with people using services? What mechanisms are in place to ensure policies actively support relational, person-centred care?	HR Policy teams

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

3. Relationships: Prompts and provocations	Decision-makers
Stability of staff team How does our organisational approach to safe staffing recognise and prioritise the importance of relational continuity? How do staffing models support consistent, trusting relationships between staff and people using services?	Nursing and governance – safe staffing
Staff training and development Are all staff equipped and trained to work alongside people in distress in a compassionate and relational way? How do we ensure staff feel confident and supported to respond to people experiencing extreme distress?	HR – education and training
Compassionate and relational leadership How do we recruit and develop leaders who understand, model and promote relational approaches to care? In what ways does the executive team consistently model relational, compassionate leadership in practice?	HR Executive
Continuity of care How do our models of care support continuity, including in-reach from community teams, so that relationships are maintained during inpatient stays? How do organisational structures enable continuity across care pathways?	Clinical leaders Operations
Reducing non-value-added activity How do we critically review ward-based paperwork, audits and checks to ensure they add value to care and do not detract from relational time? What processes are in place to stop or streamline activities that do not contribute to experience or outcomes of care?	Quality improvement Data IT Clinical leadership
Ward size and design How are decisions about ward size and bed numbers informed by their impact on relational care and patient safety? If building and sustaining trusted relationships were the priority, how might this influence decisions about ward size and capacity?	Executive Finance

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 4. Staff support

4. Staff support: Prompts and provocations	Decision-makers
Reviewing shift patterns To what extent do current shift patterns support staff to remain emotionally available, compassionate and relational throughout their working day? Where this is challenging, how might we review 12-hour shift models and consider alternative approaches that balance staff wellbeing, continuity and service needs? How are workforce, financial and patient experience considerations brought together in decision-making about shift patterns??	Nursing and governance HR Finance
Organisational modelling of compassionate responses to staff Do our HR policies and practices reflect a trauma-informed, inclusive and compassionate approach to supporting staff? Do staff feel cared for, respected and valued by the organisation in ways that enable them to provide compassionate care to people using services their and families/carers? How well do staff wellbeing, sickness and support policies align with trauma-informed, autism-informed and anti-racism principles?	HR Executive

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

4. Staff support: Prompts and provocations	Decision-makers
Enabling reflective practice and development	Nursing and governance
Do workforce models and rota planning enable staff to access regular, high-quality reflective practice?	Psychology
How do we ensure staff have protected and paid time for training, development and reflective spaces?	
Is reflective practice embedded as a core component of all clinical roles?	
How do we ensure there is appropriate access to both management supervision and clinical supervision?	
Staff recognition and reward	Executive
How do we recognise and celebrate the delivery of compassionate, high-quality care?	
To what extent is patient experience and feedback used to inform how staff are recognised and valued?	
Maximising relational opportunities through mealtimes	Finance
How might organisational approaches to food and mealtimes support relational care for both staff and people using services?	Executive
What consideration has been given to enabling staff to share mealtimes with people staying on the ward (for example, through funded meals and protected time), and what are the potential benefits and implications of this?	

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Standard 5. Equity

5. Equity: Prompts and provocations	Decision-makers
Workforce diversity and representation How are we taking a deliberate and systematic approach to improving diversity across all protected characteristics within our workforce? To what extent does our leadership reflect a range of perspectives, experiences and backgrounds? How well does our workforce represent the communities we serve, and how is this monitored and acted upon?	Executive HR – recruitment
Embedding the Patient and Carer Race Equality Framework (PCREF) Do we have a clear, resourced and accountable plan to implement and sustain PCREF? How is leadership oversight ensuring that PCREF is embedded into routine practice, rather than operating as a standalone initiative?	Operations
Equity-focused data and insight Do we collect and use data in ways that enable meaningful analysis across access, experience and outcomes, including from an equity perspective? Which groups are under-represented in our services, and what actions are being taken in response? Which groups have poorer outcomes and experience or higher levels of restrictive practice, and how are these disparities being addressed?	IT – data teams

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

5. Equity: Prompts and provocations	Decision-makers
Investment in community and user-led organisations	Finance
How do procurement and contracting processes enable equitable access to culturally appropriate advocacy, peer support and community-based provision?	Procurement
Equity across care pathways	PCREF lead
Where within the clinical pathway are there risks of bias, inequity or differential treatment?	Equality and diversity leads
Which parts of the pathway may be less accessible or less effective for particular groups, and what organisational changes are required?	Clinical leaders
Communications engagement with under-served communities	Comms
How does our organisation proactively listen to and engage with communities that are under-served or less frequently heard?	
How is communication tailored to meet the needs, preferences and cultural contexts of different groups?	

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 6. Avoiding harm

6. Avoiding harm: Prompts and provocations	Decision-makers
Pathways for people harmed by care What organisational responsibility do we hold to recognise and respond to iatrogenic harm within our services? How might we develop pathways of support for people who are unable or unwilling to re-engage due to previous harm?	Executive Finance ICB (integrated care board) colleagues
Independent routes for raising concerns What mechanisms are in place to ensure that people and their families or carers can raise concerns safely, independently and in a timely way? How might roles similar to a Freedom to Speak Up Guardian be adapted or extended to support the voice of people and their family or carers? How do we ensure these routes lead to meaningful action and improvement?	Executive HR
Embedding lived experience in complaints processes How are lived experience perspectives embedded within the investigation and response to complaints? How do we ensure that complaints processes prioritise learning, accountability and repair, rather than defensiveness or procedural responses?	Complaints team

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

6. Avoiding harm: Prompts and provocations	Decision-makers
Enabling patient-reported incidents How might digital systems enable people using services to report incidents or concerns directly, alongside staff-recorded accounts?	IT
Alignment with commissioning standards Which services or wards may be operating outside agreed commissioning frameworks or expected standards? What leadership actions are required to address this, including improvement, redesign or decommissioning where necessary?	Executive
Access to specialist support services How do we work with partner organisations, such as local authorities and voluntary, community and social enterprise (VCSE) sector providers, to ensure people using services have access to specialist advocacy and support services (for example, domestic abuse support)? What organisational barriers exist to accessing these services, and how might they be addressed?	Partnership lead

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 7. Needs led

7. Needs led: Prompts and provocations	Decision-maker
Workforce implications of therapeutic provision How does the organisation assess and plan for the workforce required to deliver a range of evidence-based and needs-led therapeutic interventions?	HR Psychological therapies
Partnership working for holistic care How do we strengthen partnerships with primary care and other acute services to better meet people's physical health needs alongside mental health care?	Operations
Continuity across care pathways How do current service models (for example, functional split between inpatient and community services) impact continuity of care and relationships? What organisational changes could improve continuity, coordination and patient experience across transitions?	Operations
Co-produced training and lived experience input How can we commission and embed training delivered by VCSE and user-led organisations to strengthen staff understanding of patient experience (for example, Hearing Voices Network training)? How do we ensure this input is sustained, valued and integrated into organisational learning?	HR – training and development Finance

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

7. Needs led: Prompts and provocations	Decision-maker
Culturally responsive support	Operations
How might we commission or partner with VCSE organisations to provide culturally specific and responsive support within inpatient settings?	Finance
Food, nutrition and cultural needs	Finance
How do catering contracts support the provision of nutritious, high-quality food that meets diverse needs?	
How can contracts enable flexibility to meet cultural, religious and individual preferences (for example, access to culturally familiar food)?	

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. **Needs led p18**
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Standard 8. Choice

8. Choice: Prompts and provocations	Decision-maker
Staffing models To what extent does our staffing mix support a range of treatment and support options for people? How are workforce and operational decisions informed by the need to maximise patient choice and access to different approaches?	HR – workforce Operations
Embedding co-produced care in policy and practice Do our organisational policies clearly set expectations around co-production (such as, 'nothing about me without me')? How consistently are these principles enacted in practice across services? What steps are required at an organisational level to move towards people being meaningfully involved in all decisions about their care?	Clinical leaders
Access to information and care plans Do people and families/carers have appropriate, timely access to care records and care plans? How do our systems support transparency, shared understanding and involvement in care?	IT and data

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

8. Choice: Prompts and provocations	Decision-maker
Staff capability to support choice Are staff trained and supported in approaches that enable choice and shared decision-making (such as Open Dialogue and collaborative care planning)? How is this training reinforced through supervision, leadership and organisational expectations?	HR – training and education
Advocacy and independent support Do we commission equitable and high-quality advocacy provision, including culturally appropriate advocacy and peer advocacy? How do we ensure people are aware of, and able to access, advocacy to support informed choice and involvement?	Finance

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 9. Environment

9. Environment: Prompts and provocations	Decision-maker
Sensory-informed environments What organisational changes are required to support ward environments that are sensory-aware and responsive to diverse needs? How are environmental decisions informed by patient experience, including neurodivergent and trauma-related sensory sensitivities?	Estates
Clarity of environmental constraints and flexibility How do we ensure clarity across the organisation about what aspects of the ward environment can and cannot be changed? How are regulatory requirements (such as CQC and infection prevention and control) interpreted and applied, and where is there flexibility to create more comfortable, personalised and homely environments? What processes are in place to support proportionate, case-by-case decision-making?	CQC Infection prevention and control
Investment in therapeutic environments How does the organisation prioritise and resource investment in ward environments that promote wellbeing, dignity and recovery? What capital and operational decisions are required to support meaningful environmental improvements?	Finance

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

9. Environment: Prompts and provocations	Decision-maker
Alternatives to traditional ward offices What alternatives to traditional nursing office models could better support visibility, accessibility and relational practice (for example, open workspaces, mobile or 'walking' office approaches)? How can environmental design support staff presence within shared spaces, rather than separation from people staying on the ward?	Estates
Leadership visibility and modelling How do organisational leaders model relational engagement within ward environments (for example, spending time in shared spaces, engaging directly with people and staff)? What expectations are set for leadership visibility, and how does this influence culture and patient experience?	Executive

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Standard 10. Things to do on the ward

10. Things to do on the ward: Prompts and provocations	Decision-maker
Partnerships to support meaningful activities Do we have commissioning arrangements in place with VCSE organisations to provide meaningful, needs-led activities for people? How do we ensure these partnerships are equitable, sustainable and responsive to people's preferences?	Finance
Flexible funding for patient-led activity How do we enable access to flexible budgets that allow people and their families/carers to identify and engage in activities that matter to them? What governance arrangements are needed to support this flexibility while maintaining accountability?	Finance
Targeted charitable funding How does the trust charity work in partnership with ward teams and experts by experience to target funding toward activities and support that people find meaningful?	Trust charity
Partnership working to support access to community support and activities How do we work with local VCSE and community organisations to best enable access to community activities and assets for inpatients? How is the voice of people using our services embedded in decisions about charitable spending?	Executive Director of partnerships

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 11. Therapeutic support

11. Therapeutic support: Prompts and provocations	Decision-makers
Staffing mix to enable therapeutic vision Do we have the appropriate staff mix to provide a range of therapeutic interventions that meet people's diverse needs? How are workforce and funding decisions aligned to ensure equitable and consistent access to therapeutic support?	Finance Operational leadership
Equity of access and experience of therapy Do we collect and use data to understand access to, and experience of, therapy across different groups (including racialised experience)? How are identified disparities addressed at an organisational level?	IT Data team
Values-based recruitment and progression To what extent are recruitment processes grounded in values aligned with compassionate, relational care? How are probationary reviews and ongoing appraisal processes used to reinforce these values in practice?	HR
Compassionate responses to distress How do we ensure staff are trained and supported to respond to distress in compassionate, non-punitive ways?	HR – training and education

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

11. Therapeutic support: Prompts and provocations	Decision-makers
Review of behavioural approaches How do we critically review the use of approaches such as Positive Behaviour Support (PBS) and other behavioural models within inpatient settings? What alternative approaches better align with trauma-informed, person-centred and relational care principles?	Clinical leadership
Access to trauma-specific services How do we commission or partner with specialist services (for example, women's centres, rape crisis services and other trauma-informed provision) to provide in-reach support to wards? What organisational barriers exist to accessing these services, and how might they be addressed?	Finance Operational leadership
Therapy across care pathways How do we ensure continuity and access to therapeutic support across inpatient and community pathways? What organisational changes are required to reduce fragmentation and improve consistency of care?	Community services Operational leadership

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Standard 12. Transparency

12. Transparency: Prompts and provocations	Decision-makers
Organisation modelling of openness and learning How do we acknowledge mistakes openly and ensure that learning is embedded across the organisation? How are experts by experience and lived experience leaders involved in shaping how we respond to incidents, complaints and feedback? How do leaders consistently model humane, compassionate and non-defensive responses to all people using services, including those who raise repeated concerns or complaints?	Executive
Improve complaints processes How are complaints processes co-produced with people, families and carers to ensure they are accessible, fair and focused on learning? How are principles such as Duty of Candour embedded and applied in practice?	Complaints team
Addressing risks of closed cultures How are known risk factors for closed cultures identified, monitored and addressed across services? How is this understanding embedded within reporting processes, governance structures and staff training?	Nursing and governance

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

12. Transparency: Prompts and provocations	Decision-makers
Co-producing incident and investigation processes To what extent are people, families and carers meaningfully involved in serious incident reviews and investigations? How are their perspectives used to shape organisational learning and improvement?	Nursing and governance
Speaking up and psychological safety How robust and accessible are Freedom to Speak Up and whistleblowing processes for staff? How might these approaches be extended or adapted to support the voice of people and their families or carers? What investment and leadership oversight are required to ensure these systems are trusted and effective?	Finance HR
Real-time feedback and transparency How can digital systems enable people and families to provide feedback in real time? How is this feedback used proactively to inform care, identify risks early and support continuous improvement?	IT

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

The guiding principles: Scenarios to support reflection across organisations

Alongside the standards, Culture of Care also sets out the following key guiding principles:

- Co-production and lived experience
- A trauma-informed approach
- Autism-informed care
- Racial equity and an approach based on anti-racism.

Videos that introduce each of those principles can be found under 'Our approaches', on the Culture of Care Design of the programme web page.

Co-production and lived experience

Members of the delivery team with lived experience developed guidance for wards, on co-production and lived experience leadership, which can be found here:

Supporting co-production and lived experience leadership across the Culture of Care work: Guidance for wards (v2, 2025)

Autism-informed approaches

The Neurodiverse Connection team created a resource that summarises what it means to be autism-informed, and outlines the key principles of autism-informed care:

Culture of Care: Resources and Reflective Questions to Consider

Race equity

This race equity learning pack introduces key concepts, frameworks and lived realities related to race and racism particularly as they intersect with mental health and psychiatry:

Org Level: Race Equity. Reading document

The NHS Patient and Carer Race Equality Framework is designed to reduce inequalities in mental health services by involving people from racialised communities in improving care, through actions involving strong leadership, improved ethnicity data and feedback.

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Trauma-informed care

This guidance from NHS England supports people working in mental health, learning disability and autism inpatient settings to make services more trauma-informed and harm-aware:

Trauma-informed and harm-aware inpatient care

Scenarios

The following scenarios, prompts and reflective questions were designed to support our organisational sessions. We are sharing them here for any organisations that would like to use them with their executive team or corporate teams.

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Co-production and lived experience leadership

Scenario 1 (organisational): New lived experience role

We have secured funding to introduce a new lived experience role within our corporate service, as part of our organisation's broader co-production strategy (for example, peer researcher within research and development, a lived experience lead within communications, a patient safety partner within nursing and governance or a lived experience lead within complaints management).

This represents a strategic opportunity to embed lived experience perspectives within core organisational functions and decision-making processes.

Reflective prompts

- What value and insight might this lived experience role bring to our service, particularly in strengthening co-production and improving quality, safety and experience of care?
- In what ways might this role contribute differently from existing professional roles within the team?
- What organisational, cultural and practical considerations will be necessary to support the role to be effective and sustainable? For example, recruitment processes, role clarity and boundaries, team readiness, supervision, training, psychological safety and ongoing support
- What potential risks or challenges might we anticipate in introducing this role (for example, role tokenism, unclear expectations, staff resistance, emotional burden), and how could these be proactively addressed?

Scenario 2 (organisational): Co-producing a policy

Following a serious incident, you have been asked to lead a review of the organisation's Policy for Communicating with Service Users.

The associated learning report indicates that a person left a voicemail for their care coordinator, which wasn't accessed due to the care coordinator being on annual leave. This has led to concerns about clinical risk and continuity of communication. As a result, some stakeholders have suggested introducing more restrictive measures, such as removing the access of people using services (and their family or carers) to direct staff contact details (for example, mobile numbers or email addresses).

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

You are required to co-produce the revised policy with people and families. You are aware, through engagement and feedback, that many service users value flexible and responsive communication options. For example, children and young people have expressed interest in using platforms such as messaging or social media, and neurodivergence service user groups have highlighted the importance of adaptable, needs-led communication approaches.

Reflective prompts

- How might we design and lead a co-production process that meaningfully incorporates the perspectives of people, their families and carers, and staff in reviewing this policy?
- What are the potential risks and unintended consequences of introducing blanket restrictions (such as limiting access to email or direct contact with staff), particularly in relation to safety, accessibility, equity and therapeutic relationships?
- Can we identify other examples of blanket restrictions in practice, and how these may impact different patient groups?
- In what ways might the preferences of people, families and carers conflict with existing organisational policies or risk frameworks, and how could these tensions be constructively addressed?
- How would we balance the diverse needs or different service user groups (for example, children and young people, neurodivergent individuals, those in crisis) when developing a consistent but flexible policy?
- What does 'relational safety' mean in this context, and how can it be prioritised alongside clinical and organisational risk management?

Scenario 3 (ward-based): Ward round – 'nothing about me without me'

Sam is a 27-year-old female currently detained under Section 2 of the Mental Health Act. She has been known to mental health services since the age of 14 and presents with a significant history of childhood trauma including experiences of powerlessness. She also reports previous adverse and harmful experiences of inpatient admissions.

Sam has an advance directive stating that she should be involved in all discussions about her care from the outset, with no decisions made without her participation. This reflects a strong emphasis on autonomy and trauma-informed practice.

The current clinical team reports difficulty in understanding and engaging Sam. She presents as highly distressed, with multiple attempts to end her life occurring during this admission. Interpersonally, she is often withdrawn, spending prolonged periods isolated in her room, which has further challenged staff's ability to form a therapeutic alliance.

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Over the past 2 weeks, the multidisciplinary team has been using the initial 20 minutes of their meetings to formulate an understanding of Sam's presentation before inviting her to join. While this approach was intended to support clinical coherence, it is inconsistent with her documented preferences.

As a result, Sam is increasingly distressed and perceives that her expressed wishes and advance directive are not being respected. This is contributing to a deterioration in her trust in the team and may be compounding her sense of disempowerment and risk.

Reflective prompts

- What organisational conditions, leadership behaviours and resources are required to enable teams to meaningfully co-produce Sam's care in line with her advance directive, ensuring her involvement from the outset of decision-making?

Scenario 4 (ward-based): Family involvement

You are the ward manager caring for Ado, a young man currently admitted to an acute ward for his third episode of drug-induced psychosis. Outside of acute episodes, Ado identifies as very family-oriented and maintains close, positive relationships with his parents and siblings. He lives with them and regularly spends time engaging in shared activities, such as fishing and sailing with his father.

However, during periods of acute mental ill health, Ado consistently declines family involvement. On the ward, he has refused consent for family visits and becomes visibly distressed and agitated when the topic of family engagement is raised.

Ado's mother contacts the ward daily, expressing significant concern and a strong need to understand his care and progress. She asks detailed questions and appears highly anxious. There is some concern that members of the team may be relying on confidentiality as a means of limiting engagement with her, particularly given the emotional intensity and time demands of these interactions.

Reflective prompts

- What clinical, ethical and legal considerations do organisational leaders hold in balancing Ado's expressed wishes with the needs and distress of his family?
- How might the team recognise and work with the dynamics at play when a person's preferences differ significantly during periods of wellness versus acute illness?
- What organisational factors (for example, workload, culture, training, governance expectations) may be influencing how staff respond?
- What leadership approaches and structures could support the team to engage more confidently, compassionately and consistently with both Ado and his family, while remaining aligned with best practice and organisational values?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Scenario 5 (ward-based): Co-producing a change on a secure ward

There have been a high volume of complaints about food quality and experience across secure wards. Estates colleagues are seeking to work collaboratively with ward teams, people and families to co-produce the procurement of a new catering contract.

This presents a significant opportunity to improve patient experience, particularly given the length of stay in secure settings and the importance of food in supporting wellbeing, dignity and a sense of autonomy.

However, the current ward environment presents challenges. There are complex interpersonal dynamics, including a small number of long-stay patients who are highly influential within the ward community, alongside several recent admissions whose arrival has shifted established group dynamics. There is concern that these factors may limit equitable participation, with more dominant individuals potentially shaping outcomes in ways that may not reflect the wider group.

Reflective prompts

- How might we design a co-production approach that enables meaningful, inclusive and psychologically safe participation from a diverse range of people on the ward?
- What practical and relational factors would we need to consider in managing group dynamics and power imbalances during this process?
- How could we ensure that individuals who are newer, less confident or more marginalised are able to contribute safely and meaningfully?
- What safeguards or facilitation approaches might help prevent disproportionate influence from more dominant participants?
- How might we work in partnership with estates and procurement colleagues to balance experiential input with organisational and contractual requirements?

General prompt questions: Strengthening co-production practices

Co-production maturity and current practice

- What examples of effective co-production are already in place across wards, and how can these be built upon or shared?
- How are people using services, families and carers currently engaged across different levels of involvement (for example, feedback, consultation, partnership, shared decision-making)?

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

Use of experience and insight

- How effectively are patient experience data sources being used to inform improvement (for example, complaints, compliments, Friends and Family Test, qualitative feedback)?
- How is learning from these data translated into tangible changes in care delivery?

Infrastructure and support

- Are there clear, fair and flexible reimbursement processes to enable participation in co-production?
- What infrastructure is in place to support experts by experience (for example, training supervision, psychological support, role clarity)?
- How are staff supported to develop skills in co-production and facilitation?

Equity, diversity and inclusion

- How are diverse perspectives actively sought and included, particularly from those who may be less visible, less confident or more marginalised?
- What proactive approaches are in place to ensure representation reflects the full population of people using services, rather than a small number of voices?

Lived experience leadership

- What lived experience leadership roles currently exist within the organisation, and how are people in these roles meaningfully included in strategic conversations and decision-making forums?
- To what extent are there clear and accessible pathways for career progression for people in lived experience roles?
- What training, development and leadership opportunities are available to support people with lived experience to succeed and progress?
- Do organisational HR policies and practices enable people in lived experience roles to thrive (for example, through trauma-informed approaches, flexible working and appropriate support structures)?
- Where does lived experience leadership currently have the most impact, and where are there further opportunities to embed and expand its influence across the organisation?

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Peer support

- What peer support roles are currently in place across the organisation, and how consistently are they embedded within teams and care pathways?
- Are peer support workers employed directly by the trust or delivered through partner organisations, and what are the implications of this for integration, support and governance?
- Are there established peer leadership roles or structures that provide strategic direction and representation?
- How are people in peer support roles included in team processes, decision-making and wider organisational conversations?
- Is there a clear strategic plan or commitment to grow and sustain investment in peer support roles?
- What training, supervision and wellbeing support are in place to ensure peer workers can practice safely and effectively?
- How is the impact of peer support measured and evaluated (for example, outcomes, experience, cultural change)?
- To what extent is fidelity to peer support principles maintained, and how is this monitored and protected as roles expand?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Trauma-informed approaches: Organisational scenarios

Scenario 1: Trends in risk and restrictive practice

A data report has identified an increase in incidents involving non-fixed ligature points across all four female acute wards over the past year. As part of your organisation's Patient Safety Incident Response Framework, you are leading a review of the protocol relating to non-fixed ligature points.

Engagement with staff indicates a strong preference for the removal of additional items perceived as being of risk, alongside concerns about staffing capacity to maintain safety. Family feedback similarly reflects a desire for more proactive risk reduction measures.

However, patient engagement highlights a different perspective. Some people report that the removal of personal items can increase feelings of distress, loss of control and reduced sense of safety – potentially exacerbating risk.

Reflective prompts

- How can a trauma-informed approach support both physical and psychological safety in this context, particularly where perspectives on risk differ?
- What responsibilities do organisational leaders have in ensuring policies balance physical safety with psychological and relational safety?
- What factors should be considered in reviewing the ligature risk protocol (for example, proportionality, least restrictive practice, individualised risk assessment, environmental design, staffing levels)?
- How can differing stakeholder perspectives (people, families and carers, staff) be meaningfully integrated into decision-making?
- What approaches could strengthen relational safety, in line with Culture of Care standards, alongside environmental and procedural safety?
- What organisational signals (such as KPIs [key performance indicators], policies, leadership messaging) currently prioritise procedural safety, and how might these be rebalanced?

Scenario 2: Managing a colleague back to work following an incident

A colleague you line manage was involved in a violent incident in the hospital café and has been off work for 3 weeks. You are due to meet them to discuss their potential return to work. They are relatively new in post, and you have limited knowledge of their previous professional experience, although they have referenced experiences of homophobia earlier in their life.

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Your manager informally minimised the severity of the incident in written communication and appears to be expecting a prompt return to the ward. You are aware of a possible team subculture in which staff who are perceived as 'tough' and able to continue working through adversity are particularly valued.

In recent communication, the colleague appears to be experiencing anger towards the person involved, expressing views that may reflect frustration or stigma (for example, questioning the legitimacy of the ward admission).

Reflective prompts

- What factors should be considered in taking a trauma-informed approach to supporting this colleague's return to work (for example, psychological impact, prior experiences, identity-related factors and workplace culture)?
- What support might the colleague need to process the incident, re-establish a sense of safety and return to work in a sustainable and supported way (for example, phased return, reflective space, supervision, occupational health)?
- What role does organisational and team culture play in shaping responses to staff wellbeing, and how might this need to be addressed?
- What organisational responsibilities and leadership behaviours are required to establish a trauma-informed approach to staff wellbeing following incidents?
- How can we mitigate the risk of this experience influencing the colleague's attitudes towards, or care given to, the person involved?
- How will we ensure team culture does not reinforce harmful expectations (such as 'toughness') that undermine psychological safety?
- To what extent do current HR policies and practices enable flexibility, psychological safety and a trauma-informed response in situations such as this?

Scenario 3: New safety initiative

You are a member of a governance committee responsible for overseeing quality and safety across the acute care pathway. A supplier is scheduled to present a digital technology reported to reduce incidents of violence and aggression on inpatient wards.

While full details are not yet available, you understand that the technology involves elements of surveillance and may invade people's privacy and autonomy. This raises potential considerations for its alignment with trauma-informed principles, particularly in settings where people may already experience heightened vulnerability, loss of control or mistrust.

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Reflective prompts

- What key questions should be asked to ensure that any proposed technology aligns with trauma-informed principles (for example, safety, choice, collaboration, trust and empowerment)?
- How might surveillance-based technology impact therapeutic relationships, trust and the ward environment?
- What potential unintended consequences should be considered, particularly for people with trauma histories or heightened sensitivity to monitoring and control?
- What constitutes robust due diligence in this context (for example, evidence of effectiveness, ethical review, data governance, equality impact assessment, patient and family involvement)?
- How can lived experience perspectives be meaningfully incorporated into decision making about technology adoption?
- How will we ensure lived experience input directly influences investment decisions?

Scenario 4: Shift patterns

Through Culture of Care engagement work, people using services and their families/carers have proposed moving away from the 12-hour shift patterns. People on the ward report that long shifts can result in extended periods without access to staff with whom they have established therapeutic relationships, sometimes for the whole waking day.

Staff have talked about challenges related to compassion fatigue and the acuity of ward environments. Ward managers have suggested that shorter (for example, 8-hour) shifts may better support access to training, clinical supervision and reflective practice.

However, many staff prefer 12-hour shifts, and there are operational and financial implications associated with changing working patterns.

Reflective prompts

- How might the organisation take a trauma-informed approach to reviewing the shift patterns, balancing patient experience, staff wellbeing and service sustainability?
- Who should be included in this conversation to ensure inclusive and informed decision making (for example, people using services, families and carers, multidisciplinary staff and workforce leads)?
- How can the organisation ensure that the perspectives of people using services, families and carers are given appropriate weight alongside staff preferences and operational constraints?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

- What evidence should inform this review (for example, relational continuity, patient experience, staff wellbeing, safety and incidence data)?
- How might different shift models influence therapeutic relationships, continuity of care and ward culture?

Scenario 5: Complaints

A person on the ward has put in a complaint about the use of a radio in the day room, and its impact on the sensory environment. In discussion with the complaints team, you learn that this person has made multiple previous complaints and is informally labelled as 'high frequency'. You note language in their records describing them as a 'vexatious complainer' and advising that they should not be seen alone.

The person is more widely known across the organisation, including at executive level, partly because of their use of social media to raise concerns. We have reason to believe that the quality of care they have received may not have consistently met expected standards. The person appears vulnerable and has limited family support.

We also recognise that there are strong emotional responses across the organisation in relation to this individual, alongside differing views about how best to respond.

Reflective prompts

- How can a trauma-informed approach shape the organisation's response to this person, particularly in acknowledging unmet needs, power dynamics and previous experiences of care?
- What might this person require to feel safe, heard and supported, and who is best placed to provide this (for example, clinical team, advocacy, senior review, complaints support)?
- What organisational support may be required to respond effectively (for example, leadership oversight, staff support, clear processes, reflective spaces)?
- How might Culture of Care Standard 6 (Avoiding harm) guide decision-making and interactions, particularly in reducing the risk of further distress, escalation or relational breakdown?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Autism-informed approaches

Scenario 1: A negative experience of ward rounds and involvement in care planning

Kieran is on a 12-bed male acute ward. He has been admitted for 3 weeks and, during this stay, was diagnosed as Autistic. Kieran has limited understanding of what this diagnosis means for him and does not relate to common media representations.

Kieran experiences difficulties identifying and expressing emotions, and describes a sense of disconnection from his body and a loss of control. He has identified that his own bedding plays an important role in self-soothing and sleep, but ward staff have informed him that organisational policy does not permit personal bedding, without clear explanation. Instead, Kieran has been prescribed sleep medication, which he reports as unhelpful.

At bedtime, Kieran has experienced significant distress linked to the ward bedding, leading to repeated incidents and the use of chemical restraint. His family have emphasised the importance of his bedding as a longstanding coping mechanism, but staff continue to cite organisational policy constraints.

During ward rounds, Kieran is asked multiple questions in quick succession and appears overwhelmed. Environmental factors (such as seating arrangements and expectations around eye contact) further increase his discomfort. The team express concern about their ability to meet his needs and suggest transfer to a specialist service. When Kieran asks for support in understanding his autism, he is told staff are not trained to provide this. Staff report uncertainty about where to access guidance within the organisation.

Reflective prompts

- How might organisational policies be adapted to allow proportionate, individualised decision-making?
- What is the potential impact on Kieran of not being able to access known coping strategies, and how might this relate to increased distress and risk?
- How might Kieran experience ward rounds in their current format, and what are the implications for involvement and consent?
- What practical adaptations could be made to ward rounds in their current format to support processing, communication and sensory needs?
- How can staff be supported to develop confidence and competence in autism-informed care (for example, training, specialist input, clinical guidance, access to expertise)?
- What organisational and team-level steps can be taken to prevent similar scenarios, and improve pathways for neurodivergent people?

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Scenario 2: A positive experience of workforce and lived experience involvement

A trust is recruiting three consultant psychiatrists for a new autism pathway. Priya, an Autistic peer-support lead, has been invited to chair the interview panel and co-produce the interview process. While she has some prior panel experience, this is her first time chairing.

Priya is supported by her line manager over several weeks to prepare. This includes identifying and implementing reasonable adjustments, reducing competing work demands and scheduling regular preparatory meetings with the interview panel. She is offered choice around the interview format, provided with candidate information in advance and given detailed insight into the environment (such as images, sensory considerations and access to a quiet space). Priya's line manager also offered a structured debrief.

Priya experiences the process positively and reports feeling valued. She is subsequently to contribute to further panels across the trust, with similar support in place.

Reflective prompts

- What enabled Priya to participate fully and effectively in this process as an Autistic leader?
- What are the organisational benefits of embedding lived experience leadership within recruitment and service development?
- Which of the adaptations could be standardised or more widely implemented across the organisation?
- How were predictability, preparation and psychological safety facilitated for Priya?
- Which adaptations may benefit all staff, not only those who are neurodivergent?
- What organisational and team-level steps can be taken to ensure that Autistic lived experience workers are consistently supported to participate?

Scenario 3: A positive experience of ward admission

A collaborative approach is taken when planning an admission to an acute ward. The person, Shruti, is actively involved in decision-making, including ward selection leading to her admission to a local single-sex ward. She is provided with detailed pre-admission information (such as a virtual tour, staff photos, ward routines, maps and written materials).

Shruti is supported to communicate her needs in advance by email and collaborates with staff to identify reasonable adjustments, including environmental and sensory

Culture of Care

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

considerations. These are risk-assessed, agreed and implemented before admission.

The admission process is paced over Shruti's first few days, to allow time for adjustment, and information is provided in accessible formats. Shruti is informed of the few blanket restrictions in place and the reasons for them are clearly explained. Easy-read, condensed information about her rights and access to advocacy services is available.

Family involvement is facilitated, and practical steps are taken to meet her dietary and sensory needs (such as a loved one being able to help her unpack, arranging a family visit the following day, access to preferred foods from the day of admission).

Reflective prompts

- What aspects of this approach reflect autism-affirming and person-centred practice?
- How do providing information, predictability and choice influence patient experience and engagement offered?
- What impact might this have on Shruti's sense of safety, trust and engagement in relation to her care?
- How do different departments in the organisation (for example, clinical teams, estates, catering, administration) contribute to this experience?
- What policies or procedures might support or inhibit such flexibility (such as visiting, pre-personal items, budget access)?
- What organisational and team-level steps can be taken to embed these practices?

Scenario 4: A negative experience of ward activities and environment

Hamish is admitted during a busy period on the ward. He is exposed to multiple intense sensory stimuli (including smells, noise, visual activity) and is asked to wait in a high-stimulation area during admission.

He becomes increasingly overwhelmed, eventually losing the ability to communicate. PRN (pro re nata/as needed) medication is administered, and he withdraws to his room. Over subsequent hours, ongoing sensory stressors (such as alarms, noise, lack of clear information) and limited engagement contribute to increasing distress, confusion and isolation.

The following day, further challenges arise, including environmental discomfort (such as inadequate facilities, strong cleaning smells, crowded dining area). Accumulated distress leads to Hamish experiencing an Autistic meltdown, culminating in an incident recorded as aggression.

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Reflective prompts

- How might Hamish have experienced the admission environment, and what factors may have contributed to sensory overload and distress?
- What aspects of the ward environment and processes may be particularly challenging for Autistic people?
- What immediate and anticipatory adjustments could have supported Hamish on arrival?
- How could predictability and clear communication (such as orientation information, explanation of routines and alarms) have been improved?
- What role can corporate and support services (such as estates, facilities or procurement) play in reducing sensory burden?
- What 'quick wins' could improve the sensory environment (for example, quiet spaces, noise reduction strategies, clearer signage)?
- How might the lack of structured activity and engagement impact wellbeing, distress and risk?
- What organisational and team-level steps can be taken to prevent similar experiences and support more autism-informed wards?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Race equity: Organisational scenarios

Scenario 1: Systemic factors, bias and staff impact

Aaliyah, a young Black woman, has been admitted as an inpatient on an acute ward. During a period of escalating distress (for example, pacing, changes in breathing, raised voice while attempting to communicate difficult emotions), her presentation is interpreted by staff as aggression rather than distress.

The ward is operating under significant pressure, with staff shortages and competing demands limiting opportunities for relational engagement. Although supportive tools are available (such as visual communication aids, de-escalation prompts), they are not utilised in the moment.

As the situation escalates, staff responses become increasingly procedural and risk-focused.

A decision is made to administer rapid tranquilisation, without consideration of Aaliyah's individual context (for example, care plan, communication needs, cultural considerations, known triggers or preferences). Some staff later reflect that they felt uncertain or uncomfortable with the decision, but did not feel able to challenge it within the team dynamic.

Following the incident, Aaliyah becomes withdrawn (such as reduced communication, disengagement from care and diminished eye contact), indicating a loss of trust and psychological safety.

The incident is subsequently recorded in a brief, outcome-focused way ('Violent incident managed using rapid tranquillisation'), with limited capture of the antecedents, relational dynamics or emotional impact on people staying on the ward and on staff.

At a senior level, reporting focuses primarily on incident data and trends, with limited integration of lived experience, cultural context or reflective learning. This constrains opportunities for organisational insight, accountability and improvement.

Reflective prompts

- Where are there missed opportunities for culturally responsive understanding of the Aaliyah's distress, communication style and lived experience, and what organisational responsibility exists to ensure this is embedded in practice?
- How might applying PCREF's competency on Culturally Informed Practice have changed the outcome and how should organisational leaders ensure this competency is consistently developed, supported and monitored across services?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

- How have organisational pressures (for example, staffing, workload and culture) influenced staff responses, and what changes are required at system level to reduce reliance on assumptions, bias and reactive decision-making under pressure?
- How did perceptions of risk shape decision-making in this scenario, and what organisational structures (such as supervision, governance, reflective practice and anti-racist frameworks including PCREF's Anti-Racist Practice and Bias Reduction competency) are required to support a more proportionate and equitable response?
- Consider the breakdown in communication between frontline staff and executives.
    - What responsibilities do organisational leaders hold in ensuring transparent, bidirectional communication and learning between frontline care and governance structures?
    - Which PCREF competency on Transparent and Connected Leadership was not realised, and how should reporting and feedback processes be strengthened to support learning rather than blame or avoidance?
- Reflect on the person's disengagement after the incident.
    - What accountability do organisational leaders have for embedding trauma-informed and person-centred care across services?
    - How could the Trauma-informed and Person-centred Care competency have guided staff responses, both before and after the incident?
    - What organisational changes (such as training, culture, leadership oversight and measurable standards) are required to sustain trust, diginity and equitable care?

Scenario 2: The corridor complaint

Ama, an experienced estates technician, is working on a ward refurbishment project. The ward environment is busy, with multiple teams moving through shared spaces.

While walking with a contractor, Ama overhears a comment from ward staff implying distrust of unfamiliar individuals (for example, 'I don't know why they keep bringing in people we don't know. Things go missing when they do.'). Although not addressed directly to her, the comment carries potential racialised or bias-informed undertones.

Ama chooses not to respond in the moment and later raises the concern informally with her supervisor, who minimises the issue, attributing it to pressure

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

on clinical staff. Over time, additional subtle behaviours occur (for example, her leadership role being overlooked, assumptions about who holds responsibility and reduced direct engagement).

These cumulative experiences begin to affect Ama's sense of belonging and psychological safety. She becomes less visible in meetings and reduces informal engagement, while the wider team remains largely unaware of her experience.

Reflective prompts

- What behaviours or interactions in this scenario may signal exclusion, bias or undermining of professional credibility, and what responsibility do organisational leaders have to recognise and address these patterns systematically – not just as isolated incidents?
- What would an appropriate and culturally responsive response look like from a colleague who witnesses such behaviour, and how should organisations equip and expect staff to respond in real time?
- What organisational cultures, policies and leadership behaviours are required to ensure that all staff (including non-clinical teams and contractors) experience psychological safety, inclusion and respect across shared environments?
- What accountability sits with senior leaders and corporate functions to ensure that cross-department working does not reinforce hierarchies or exclusion (for example, clinical versus non-clinical staff), and how should this be monitored?
- How do subtle, cumulative experiences (for example, microaggressions, being overlooked, misdirected communication) impact staff wellbeing, confidence and retention, and what organisational mechanisms are needed to identify and respond to these early?
- How might the application of organisational competences in anti-racist practice, inclusive leadership and psychological safety have changed Ama's experience, and how will leaders ensure these are embedded, measured and held to account across services?
- What systems (such as reporting routes, supervision, staff networks and leadership visibility) are in place to ensure that concerns like Ama's are heard, validated and acted upon, rather than minimised?
- What actions can organisational leaders take to ensure that estates, facilities and other non-clinical teams are fully included as equal partners in delivering safe and high-quality care environments?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Scenario 3: Part of the team?

Andre has recently joined the Business Support department as a permanent member of staff. In his third week, he is still becoming familiar with the team and its ways of working.

During a busy morning, a colleague asks him to carry out a logistical task typically assigned to temporary or agency staff (for example, moving boxes to storage), without clarifying roles or responsibilities.

Later, when Andre contributes his knowledge about a system that he has been trained in his input is overlooked and redirected to another colleague. Similar patterns occur repeatedly:

- His role as lead is questioned or bypassed
- Decision-making conversations happen without his inclusion
- Communication is often indirect
- He is more frequently approached for lower-status or support tasks.

Andre becomes increasingly uncertain about how he is perceived within the team. As the only Black member of the department, he feels hesitant to raise concerns, worrying about how this may be received. Over time, these experiences affect his sense of belonging, confidence and inclusion, leaving him feeling peripheral rather than an established member of the team.

Reflective prompts

- What behaviours, assumptions, or patterns in this scenario may indicate bias, exclusion or undermining of professional credibility, and what responsibility do organisational leaders have to identify and address these consistently across teams?
- What assumptions are being made about Andre's role, authority or status, and how should organisations actively challenge and disrupt these through inclusive leadership and clear role governance?
- How do these dynamics influence whose knowledge is recognised and valued, and what organisational mechanisms are needed to ensure equitable recognition of expertise and contribution?
- What impact could these repeated interactions have on Andre's sense of belonging, psychological safety and willingness to contribute, and how should organisations monitor and respond to these early indicators of exclusion?
- What expectations should be placed on teams and managers to create inclusive working environments, and how should leaders ensure staff are equipped and held accountable to meet these expectations?

Culture of Care

Introduction p2
Culture of Care standards: exploring organisational change ideas p5
1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27
The guiding principles: Scenarios to support reflection across organisations p29
Co-production and lived experience leadership p31
Trauma-informed approaches p37
Autism-informed approaches p41
Racial equity p45

- How do organisational cultures, hierarchies or informal norms (for example, assumptions about seniority or permanence) reinforce exclusion, and what leadership actions are required to address these at a systems level?
- How might organisational competences in anti-racist practice, inclusive leadership and psychological safety have changed this experience, and how will leaders ensure these are embedded, measured and sustained across departments?
- What systems (such as onboarding processes, supervision, leadership visibility and safe routes for raising concerns) are in place to ensure that new staff – particularly those from underrepresented groups – are actively included, supported and able to raise concerns safely?

Scenario 4: Seeing the person not the breach

Asher is a 47-year-old Black British Caribbean man admitted to a medium secure forensic ward following recall due to a breach of conditional discharge (positive drug screening for cannabis). Prior to recall, Asher had been stable, engaging with services and adhering to medication.

On receiving the news of his recall, Asher displayed distress (such as shouting phrases linked to cultural and historical expressions of resistance). This response led to police involvement and admission.

Since admission, Asher has largely disengaged from ward-based activity and spends most of his time in his room listening to reggae music. Staff and people on the ward have raised concerns about volume levels; however, there appears to be inconsistency in how similar behaviours are managed across different people. These experiences appear to go unreported by Asher, possibly due to fear of further punitive or restrictive responses.

The ward workforce reflects a mix of staff backgrounds, but inclusive and psychologically safe practice is inconsistent. Notably, Asher appears more comfortable engaging with a non-clinical member of staff who shares aspects of visible cultural identity.

While Asher maintains positive engagement during the visits, he does not disclose his ward experiences, suggesting a disconnect between his external functioning and internal experience of care.

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Reflective prompts

- What environmental, cultural and relational factors on the ward may be impacting Asher's mental health, wellbeing and engagement, and what responsibility do organisational leaders hold in ensuring these factors are consistently identified and addressed?
- Where are there gaps in Asher's care (such as cultural understanding, response to racism, consistency of boundaries and engagement strategies), and how should organisations ensure that individualised, culturally informed care is the standard across services?
- How are assumptions about 'risk' and 'non-compliance' shaping responses to Asher, and what organisational structures are required to support more nuanced, equitable and trauma-informed decision-making?
- What does this scenario highlight about the organisation's approach to anti-racist practice, psychological safety and cultural responsiveness, and how should leaders ensure these are actively embedded, measured and acted upon?
- How should staff be supported and held accountable to recognise and respond to racism and discrimination in real time, and what systems are required to ensure this is consistently addressed rather than overlooked?
- What responsibility does the organisation have to ensure that spiritual, cultural and identity-related needs are recognised and incorporated into care planning, even where these are not formally documented?
- How can leaders ensure greater consistency and fairness in the application of ward rules and boundaries, and how might inconsistency contribute to inequity and disengagement?
- What organisational levers (for example, training, supervision, leadership visibility, incident review processes) are required to support staff to move from task-focused or procedural care toward relational, person-centred practice?
- How can organisations ensure that the patient voice (including unspoken or withheld concerns) is safely accessed, heard and acted upon, particularly for individuals who may fear repercussions?
- Thinking about your role, what actions can you take within your sphere of influence, and what escalation routes or organisational structures are needed to address issues beyond your remit?
- How might relevant frameworks (such as PCREF, Culture of Care standards) be used not only to analyse this scenario but to drive measurable improvement in access, experience and outcomes for people such as Asher?

Introduction p2

Culture of Care standards: exploring organisational change ideas p5

1. Lived experience p6
2. Safety p8
3. Relationships p10
4. Staff support p12
5. Equity p14
6. Avoiding harm p16
7. Needs led p18
8. Choice p20
9. Environment p22
10. Things to do p24
11. Therapeutic support p25
12. Transparency p27

The guiding principles: Scenarios to support reflection across organisations p29

Co-production and lived experience leadership p31

Trauma-informed approaches p37

Autism-informed approaches p41

Racial equity p45

Microsoft Copilot was used during the development of this resource to support structuring content, generating and refining draft text, developing organisational reflection questions and scenarios, and improving readability and consistency. All AI-generated outputs were reviewed, amended, verified and approved by NCCMH contributors. Decisions regarding content, interpretation, recommendations and final wording remained the responsibility of the development team, who retain full accountability for the published resource.

Cite as: Culture of Care Delivery Team Members. Organisational Support: Resource for providers. London: National Collaborating Centre for Mental Health; 2026.