Culture of Care

Organisational Support

Lived Experience and Coproduction

Virtual Learning Session 2

Friday 14 November 2025, 13:00-15:00

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Neurodiverse Connection

Global Black Thrive

NCISH

Welcome from our team!

Matt

Jess

Mark F

Megan

Gbenga

Molly

Mark A

Emily

Rachael

Ros

Housekeeping

- Please mute your microphone unless you are speaking.
- Cameras on or off, whatever is comfortable.
- We will be recording today's session and sharing with colleagues who weren't able to attend.
- If you would like to ask a question or leave a comment, please use the chat function within the meeting or the mentimeter.
- If you experience any technical difficulties, please email: cultureofcare@rcpsych.ac.uk

How we want to work together

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

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

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

Diversity of views – *respecting different viewpoints and experiences and being okay with sometimes disagreeing.*

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

Be kind to yourself – *take breaks if needed, use our quiet space*

Who’s in the room?

Please kindly scan the QR Code, or click on the link available in the chat, to add your details to today's register.

It will really help us to understand who has attended today and from which departments – thank you!

Registration: Org Support Virtual Learning Session 2: Lived Experience & Coproduction

https://forms.office.com/e/Uf6C0SnSEn

Support Space

On-Call Support Space Facilitator: Ros Warby

Join at any time:

Join the meeting now

Meeting ID: 397 139 624 117 7

Passcode: sn39aj6R

The link to the support space will also be available in the chat.

Q&A

As we go through the session on coproduction, please feel free to share your thoughts, questions and reflections by using the QR code below.

QR Code link:
https://www.menti.com/alyc4jcroxc9

Schedule of Events

Time	Event
13:00 – 13.10	**Welcome, Introductions and Shared Principles** Matt will introduce the session and share some information about how we hope to work together.
13:10 - 13:25	**Overview of the Culture of Care Programme** Matt will give an overview of the whole programme and explain the organisational support element
13:25 - 13:40	**Overview of the Culture of Care Standards** Emily and Molly will share the standards and what they mean from a lived experience perspective.
13:40 - 14:05	**Introduction to Coproduction and Lived Experience** Jess and Molly will introduce coproduction and share ideas around good practice as well as doing some myth busting.
14:05 - 14:10	**Break**
14:10 - 14:25	**Exploring Lived Experience Leadership** Jess and Emily will share some ideas on the value of lived experience leadership.
14:25 - 14:55	**Growing the Peer Support workforce** Mark Allan will give an overview of peer support, what it is, why it's needed and ideas on how to grow and sustain a peer workforce.
14:55 - 15:00	**Next Steps and wrap up** Matt will finish the event with some information about next steps.

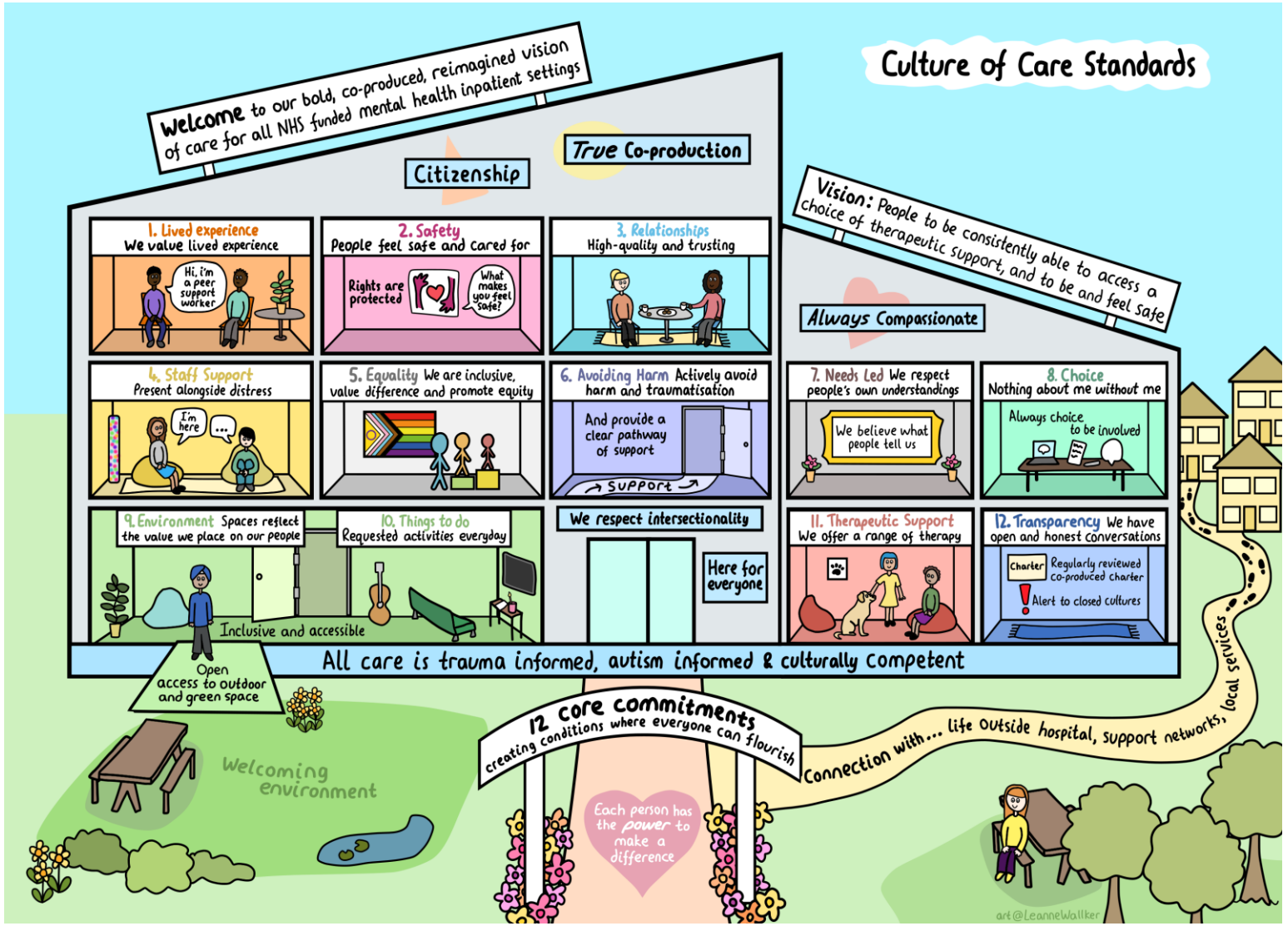
Culture of Care Programme Overview

Matthew Milarski
Head of Quality Improvement, NCCMH

Culture of Care

Culture of Care Standards

Illustration by Leanne Walker



Culture of Care – programme overview

NHS England's standards

Coproduced standards for inpatient care
Evidence-based standards to ensure a safe, compasionate, needs-based culture of care

Guiding principles

Our approaches — Anti racism, trauma-informed, autism-informed

Lived experience
Leadership, mentoring, coaching, support and challenge

Programme elements

Programme element icons and acronymns

Our approach

Bringing together our collective expertise in:

- Lived experience leadership
- Quality improvement collaboratives
- Autism-informed care
- Race equity
- Trauma-informed care
- Leadership and organisational development
- The evidence-base around safety

To support wards and organisations to develop their culture in line with NHS England's Culture of Care standards

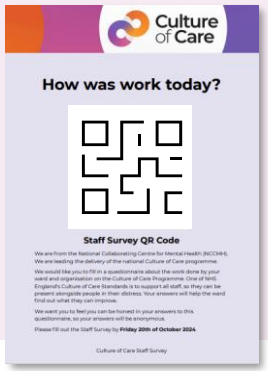
Culture of care measurement

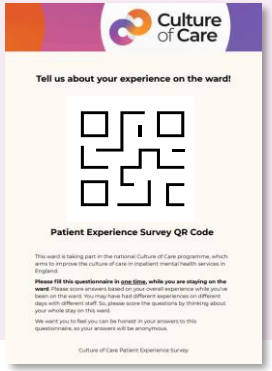
Proxy measures

- Episodes of restrictive practice
- Incidents of sexual harm
- Number of days since absence without leave (AWOL)
- Use of bank and agency staff

Patient and staff experience

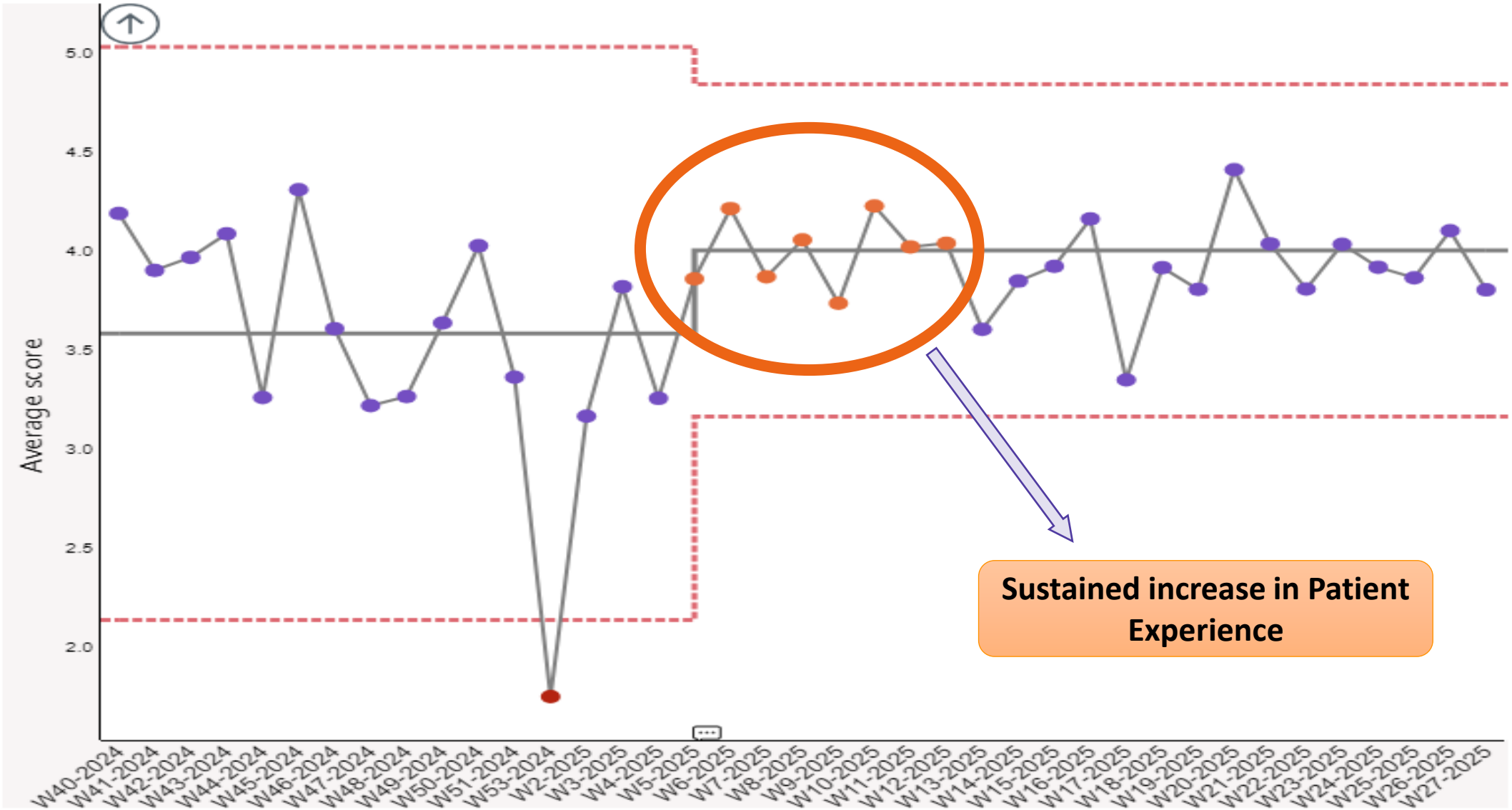
- Patient CARE survey
- Patient experience survey
- Staff survey
- Carer survey





Building a movement

Patient Experience Survey Data – National Aggregate



Sustained increase in Patient Experience

Organisation level support

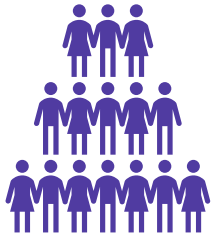
Organisational support aim:

Facilitate the opportunity for a diverse cross section of people across an organisation, including people with lived experience, families and carers to

- Connect
- Learn
- Reflect

To bring about systemic and sustainable change that supports anti-racism, autism informed and trauma informed approaches and a culture of care.

The offer



- All organisations were offered either a **light-touch** or **full programme** of support.

- Both offer **4 virtual learning sessions**:
  1. Anti-racism at organisational level
  2. Trauma-informed organisations
  3. Autism-informed organisations
  4. Embedding lived experience leadership and coproduction in an organisation.

Light-touch offer will follow up an **in-person reflective space**. With wards involved in Culture of Care and executives receiving coaching.

Full programme will follow up with **5 in-person reflective spaces** to embed the sessions above at an organisational-level, and an additional session to sustain and spread learning and successes.

Full support

1. Avon and Wiltshire Mental Health Trust
2. Birmingham and Solihull Mental Health NHS Foundation Trust
3. Black Country Health Care Foundation Trust
4. Bradford District Care Trust
5. Bramley Health
6. Cambridgeshire and Peterborough NHS Foundation Trust
7. Central and North West London NHS Foundation Trust
8. Cornwall Partnership NHS Foundation Trust
9. Coventry and Warwickshire Partnership NHS Trust
10. Devon Partnership NHS Trust
11. Essex University Partnership Trust
12. Gloucestershire Health and Care NHS Foundation Trust
13. Greater Manchester Mental Health Trust
14. Hampshire and IOW NHS Foundation Trust
15. Herefordshire and Worcestershire Health and Care Trust
16. Humber Teaching Foundation NHS Trust
17. Lancashire and south Cumbria foundation trust
18. Mersey Care NHS Foundation Trust
19. Norfolk and Suffolk NHS foundation trust
20. North East London Foundation Trust
21. Northamptonshire Healthcare NHS Foundation Trust
22. Nottinghamshire Healthcare Foundation Trust
23. Priory Woodbourne
24. Sheffield Health and Social Care
25. Somerset NHS Foundation Trust
26. South West Yorkshire Partnership Foundation Trust
27. Sussex Partnership NHS Foundation Trust
28. Tees Esk and Wear Valley NHS Foundation Trust

Light-touch support

1. Berkshire Healthcare Foundation Trust
2. Birmingham Women's and Children's NHS Foundation Trust
3. Cheshire and Wirral Partnership Foundation Trust
4. Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
5. Cygnet
6. Derbyshire Healthcare NHS Foundation Trust
7. Dorset Healthcare NHS Trust
8. Elysium Healthcare
9. Gateshead Trust
10. Hertfordshire Partnership Foundation NHS Trust
11. Kent and Medway NHS and Social Care Partnership Trust
12. Leeds and York Partnership Foundation Trust
13. Leicestershire Partnership NHS Trust
14. Lincolnshire Partnership Foundation Trust
15. Livewell Southwest
16. North London Foundation Trust
17. North Staffordshire Combined Healthcare Trust
18. Northumbria Healthcare NHS Foundation Trust
19. Oxford Health NHS Foundation Trust
20. South London and Maudsley NHS Foundation Trust
21. St Andrews Healthcare
22. Surrey and Borders Partnership Trust
23. West London NHS Trust

Who to get involved

We are aiming to bring together the following in each organisation:

- Wards receiving QI support on the programme
- Facilities and estates (hotel services)
- HR (Equality, diversity and inclusion), Recruitment
- Quality improvement, Organisational development
- Information (Planning and performance, Clinical records)
- Nursing and governance (Patient safety, Safeguarding, Infection prevention control)
- Involvement and engagement/coproduction/lived experience
- Communications (Complaints/PALS, Freedom to speak up guardian)
- Finance/contracting
- Clinical leadership (medical, therapies, nursing)
- Operational management (including community services)
- Executive leadership

The virtual training offers

- Dates:
    - Co-production 1 = 11th July
    - Trauma informed approach 1 = 17th July
    - Autism informed approach 1 = 9th September
    - Race equity 1 = 26th September

    - Co-production 2 = 14th November
    - Trauma informed approach 2 = 25th November
    - Autism informed approach 2 = 20th January
    - Race equity 2 = 30th January

- If you're taking part in the full support, please:
    - Make contact with your paired organisation
    - Work with your QI Coach to identify dates for the in-person follow up sessions

- If you're taking part in the light-touch support, we will be in touch about your in-person session in the coming months

Reflections on the in-person organisation support sessions so far

Emily Daly
Culture of Care National Advisor

Culture of Care Standards Overview

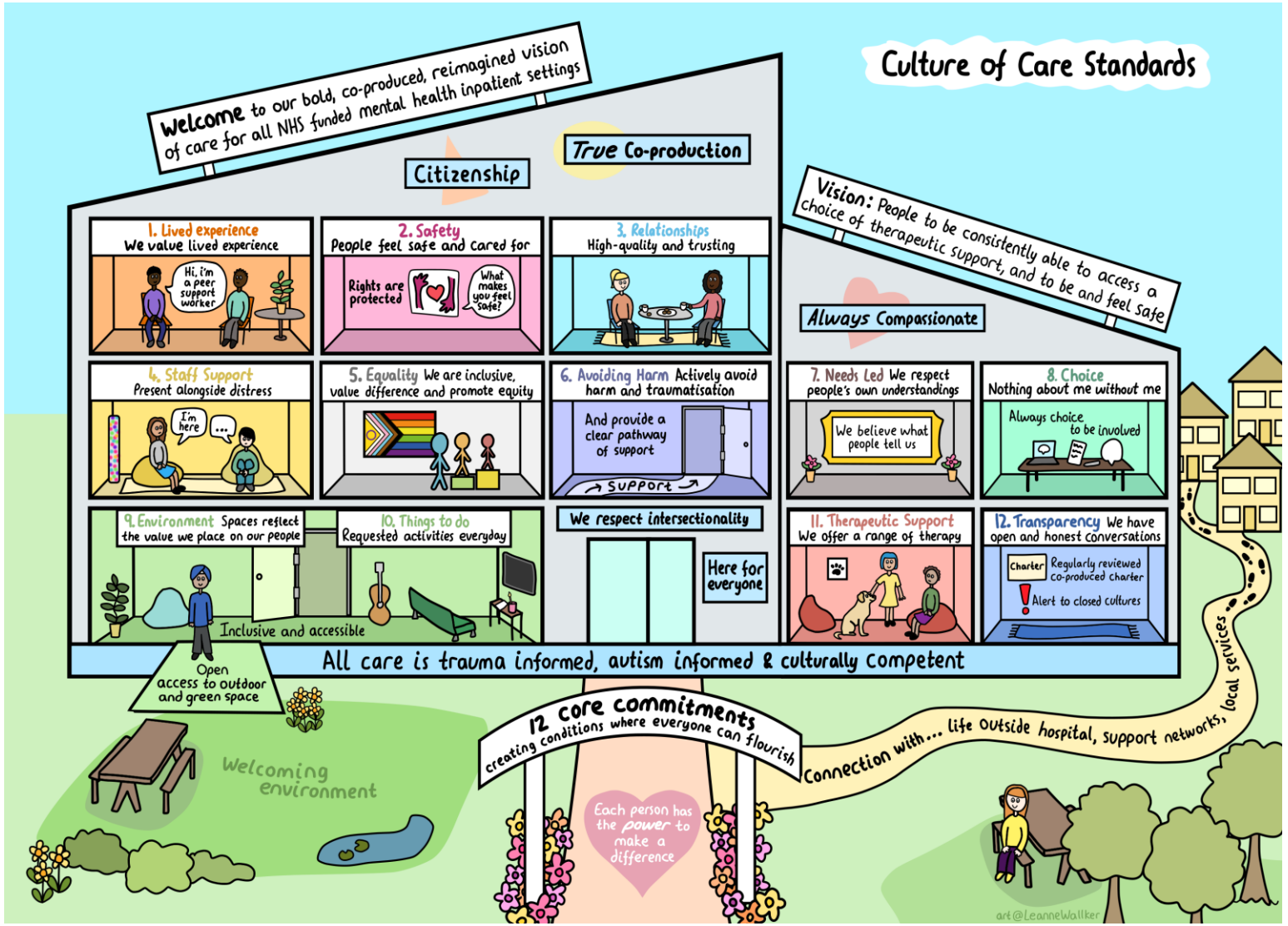
Emily Daly
Culture of Care National Advisor

Molly Anderton
Lived Experience Advisor,
Neurodiverse Connection (NDC)

Culture of Care

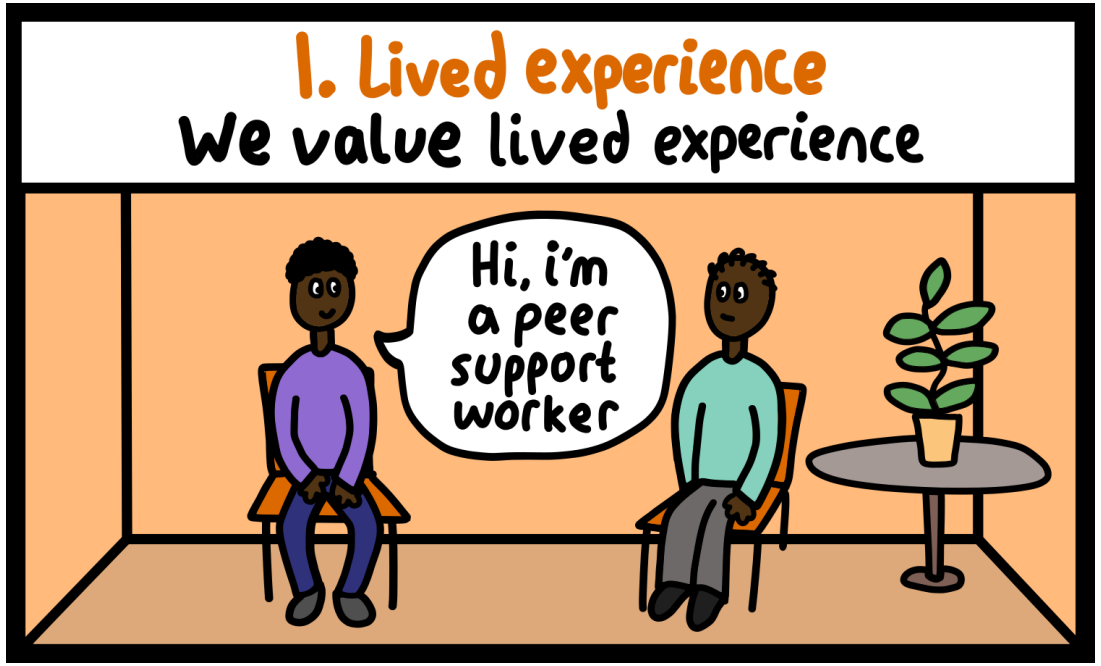
Culture of Care Standards

Illustration by Leanne Walker



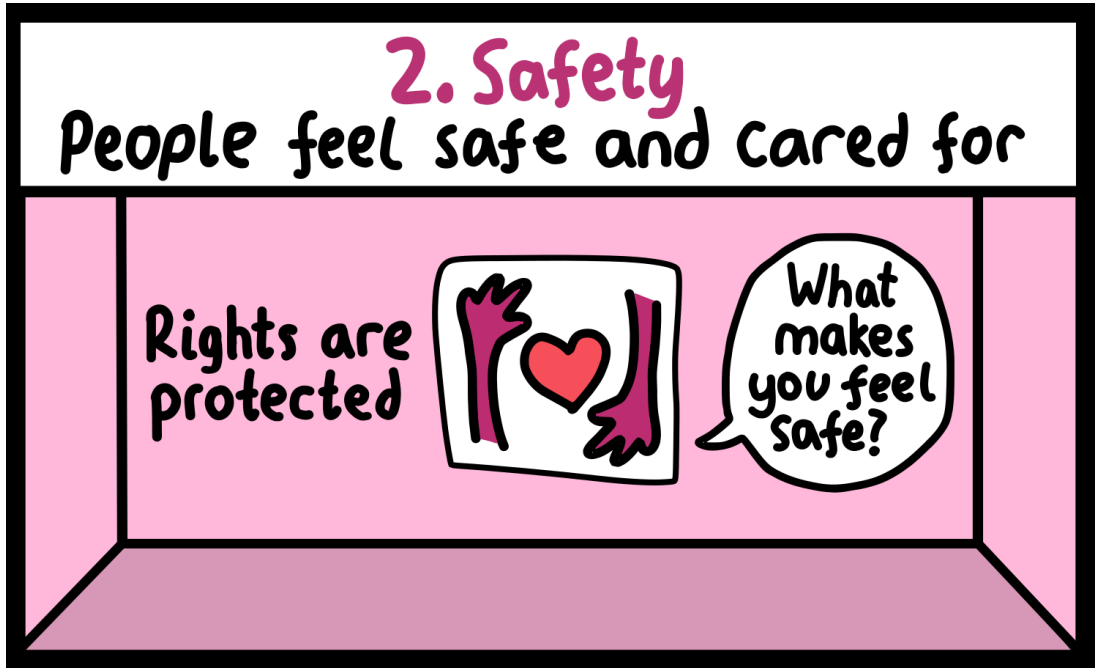
1. Lived Experience

- All patients are supported to have a voice in their care
- All patients' experiences are systematically measured, valued and used to improve care
- Paid peer workforce at all levels are an integral part of the multidisciplinary team (MDT)
- Lived experience leadership roles are at all levels of the organisation
- Lived experience representative of the service type and local community is embedded in service design, quality improvement, governance and oversight
- Infrastructure is in place to support people with lived experience in these roles, and designed by people with lived experience



2. Safety

- All people (patients, staff and visitors) feel safe on the ward
- We respect and protect people's civil and human rights
- Staff prioritise building therapeutic relationships to support patient safety
- People always receive a compassionate response when they feel unsafe
- The approach to safety is relational
- People's mental health and physical health needs are understood and met



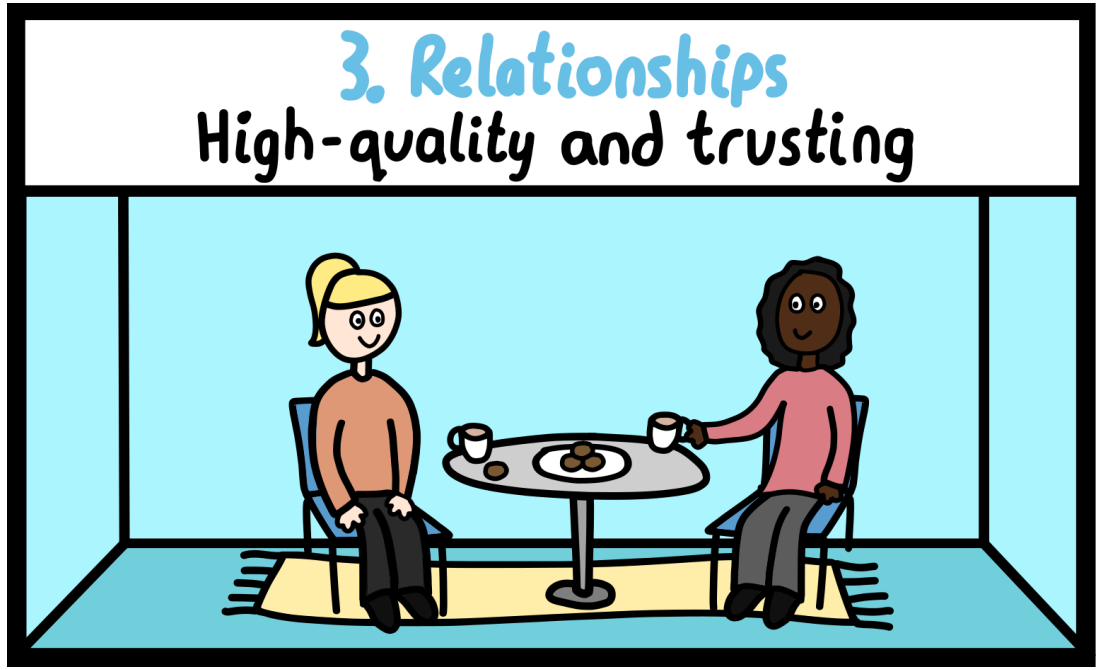
Safety

Safety is not the absence of threat; it is the presence of connection

Gabor Mate

3. Relationships

- Staff take the time to get to know the people on their wards and build a trusting relationship with them
- Staff are competent in building relationships with different people and responding compassionately to extreme states of distress
- Staff understand and respond to different individuals' needs, for example with reasonable adjustments
- The ward builds and maintains consistent relationships with people's chosen support network
- People and families feel care is culturally competent and meets people's diverse needs
- The organisation supports staff to protect and prioritise the therapeutic relationship
- The organisation supports the development of healthy team dynamics that positively impact on patient care and patient experience



4. Staff support

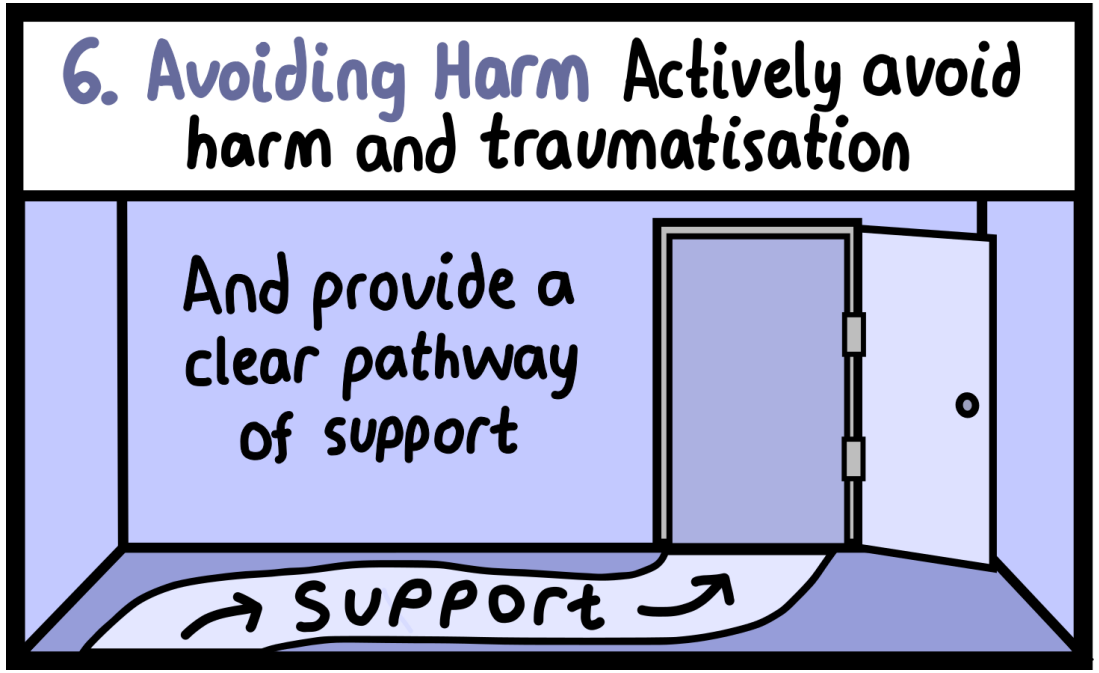
- Staff have the practical and emotional support they need to remain compassionate, understanding and emotionally available. This is evident at every level of the organisation and underpinned by HR policies
- Ward leaders have the skills and training to foster a compassionate culture on the ward
- Freedom to speak up systems are in place for staff to raise concerns and be heard
- Staff experience is systematically measured and used to improve care
- Reflective practice is mandatory for all staff providing care on the ward, regardless of role
- We have enough skilled staff on the ward to deliver safe and therapeutic care
- Staff know spending time with patients is a measurable priority, and that administrative tasks are never prioritised over providing compassionate care

5. Equity

- The organisation understands its local population and takes action where certain groups are over- or under-represented in services. And where outcomes for particular groups are poor, we take steps to mitigate these and share learning
- Patient experience and outcome measures are captured and analysed by protected characteristics (including for levels of restrictive practice)
- The organisation fosters connections with local community services, VCSE providers and other statutory organisations to take a collaborative approach in identifying and addressing health inequalities across the whole care pathway

6. Avoiding harm

- We acknowledge and avoid the harm and traumatisation that can occur when people are in hospital.
- There is a clear pathway of support for patients who have experienced abuse/harm, including access to advocacy
- We understand that restraint and coercion is harmful and we only use it as a last resort; that includes the use of blanket restrictions
- We do not use mechanical restraint
- Our inpatient services meet the needs of trauma survivors in crisis
- We are trans*-accessible and inclusive

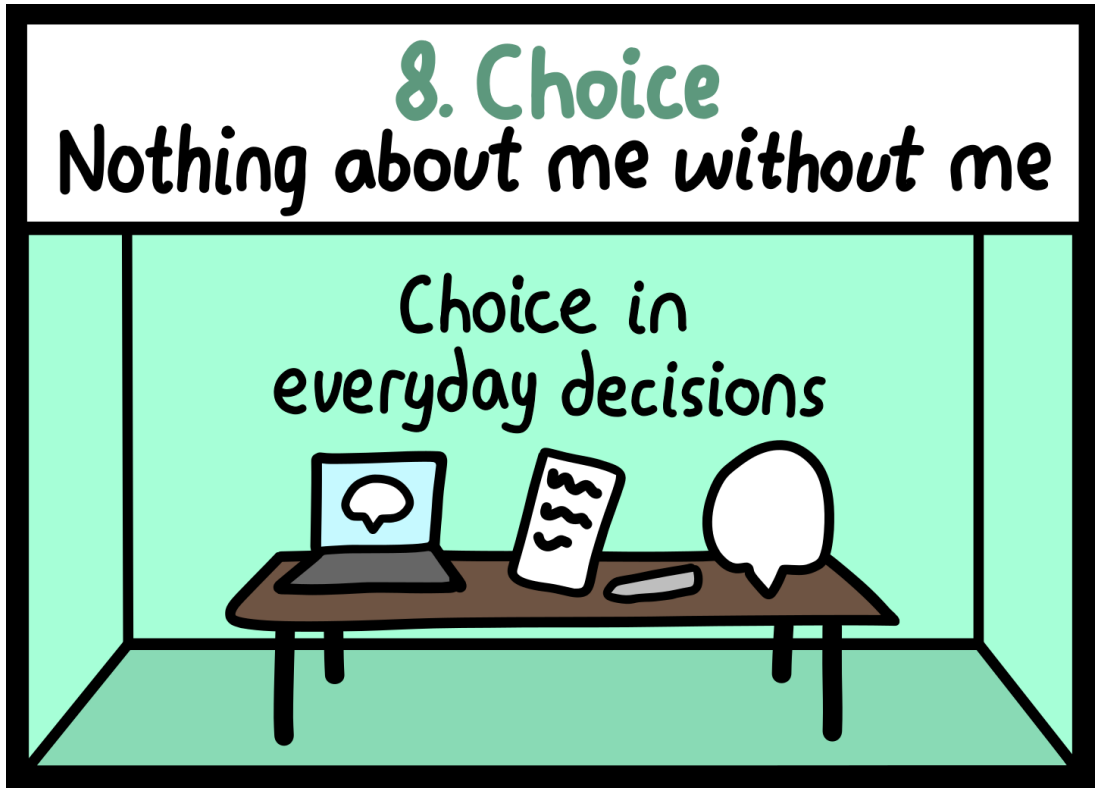


7. Needs led

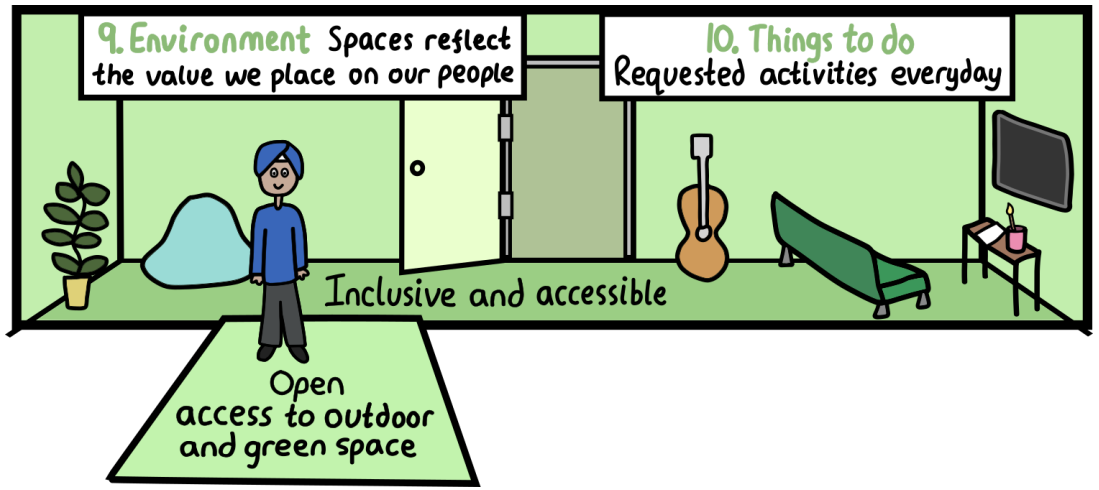
- We are needs-led, not diagnostically driven
- People are supported and encouraged to define their needs
- The MDT respects people's individual understanding of their distress
- We validate patients' feelings, and respect their culture, values and beliefs
- We take a capabilities approach and recognise that everyone has something to offer
- We meet the needs of people's chosen support network
- Patients' needs and wishes are listened to in the admission and discharge process

8. Choice

- Patients always have the choice to be present at meetings about them
- We adhere to the evidence-based approach of Open Dialogue and its key principles
- Patients are supported to be involved in the decisions about them
- Patients have choice in everyday decisions
- Patients have the choice to collaborate in the writing of their notes and/or have access to their notes so that they know what has been recorded about them at any point during their inpatient stay
- Patients have informed choice over their preferred treatment and who is involved in their care
- Where legislation overrides personal choice, this is explained in a clear and transparent way
- Patients have the choice to be supported by people who know them well, by an advocate or by a peer worker



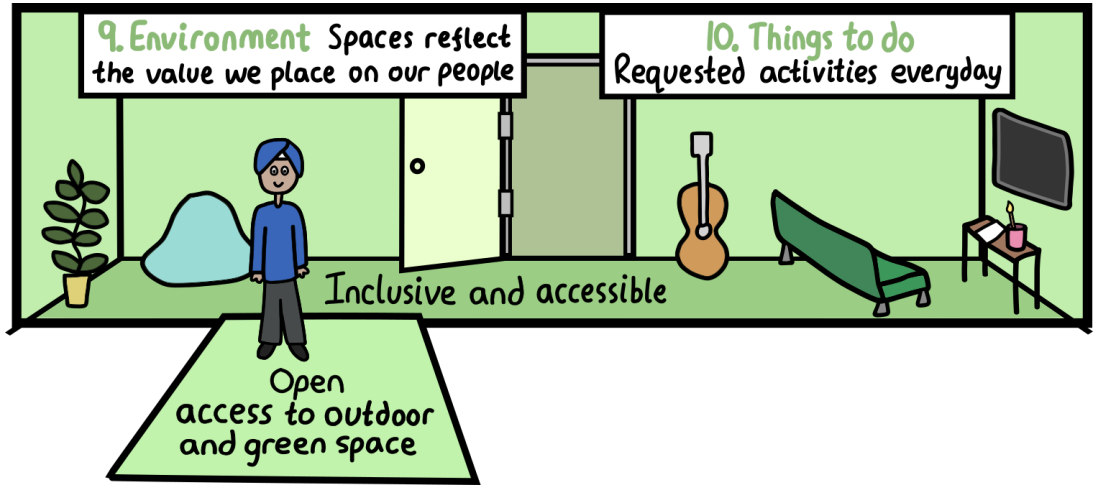
9. Environment



- The environment is inclusive and accessible, including through making reasonable adjustments where appropriate
- The environment is autism-informed, trauma-informed and sensory friendly
- Comfort is prioritised alongside the space being clean and hygienic
- To prioritise relationships, there are no locked staff offices on the ward
- All people have open access to outdoor and green space
- The ward environment and procedures foster a sense of community, for example eating together
- The environment has been co-designed with people with lived experience and the needs and preferences of patients are evident

10. Things to do on the ward

- People are supported to spend their time doing activities they enjoy
- Patients decide which activities are on offer, including those that are culturally appropriate
- Wards collaborate with VCSE and lived experience partners to deliver those activities
- Activities support physical wellbeing

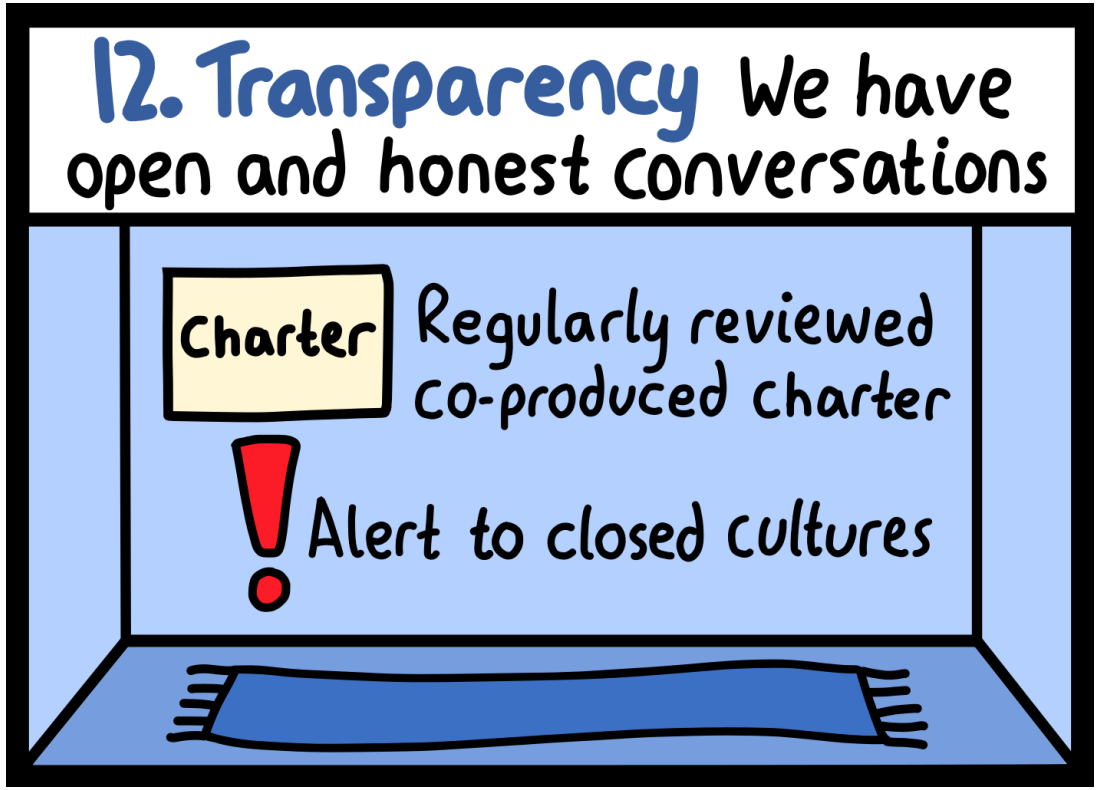


11. Therapeutic support

- People have access to culturally sensitive support and treatment that is helpful
- People can choose their preferred therapy from a range of options, including trauma-specific therapy
- People have access to support around their social needs, including to maintain links with any community-based health and social care services and to plan for transition

12. Transparency

- We are honest with patients about our decision-making
- We have a regularly reviewed, co-produced charter that clearly sets out values and expectations
- The organisation has a transparent, compassionate, safe and responsive complaints process
- We are alert to how closed cultures can develop and take steps to avert this in partnership with people and families
- Independent organisations and advocacy are welcomed onto the ward
- We are transparent about the names, roles and responsibilities of everyone working on the ward



Coproduction and valuing Lived Experience

Jess Worner
Lived Experience Network Manager,
NSPA

Molly Anderton
Lived Experience Advisor,
Neurodiverse Connection (NDC)

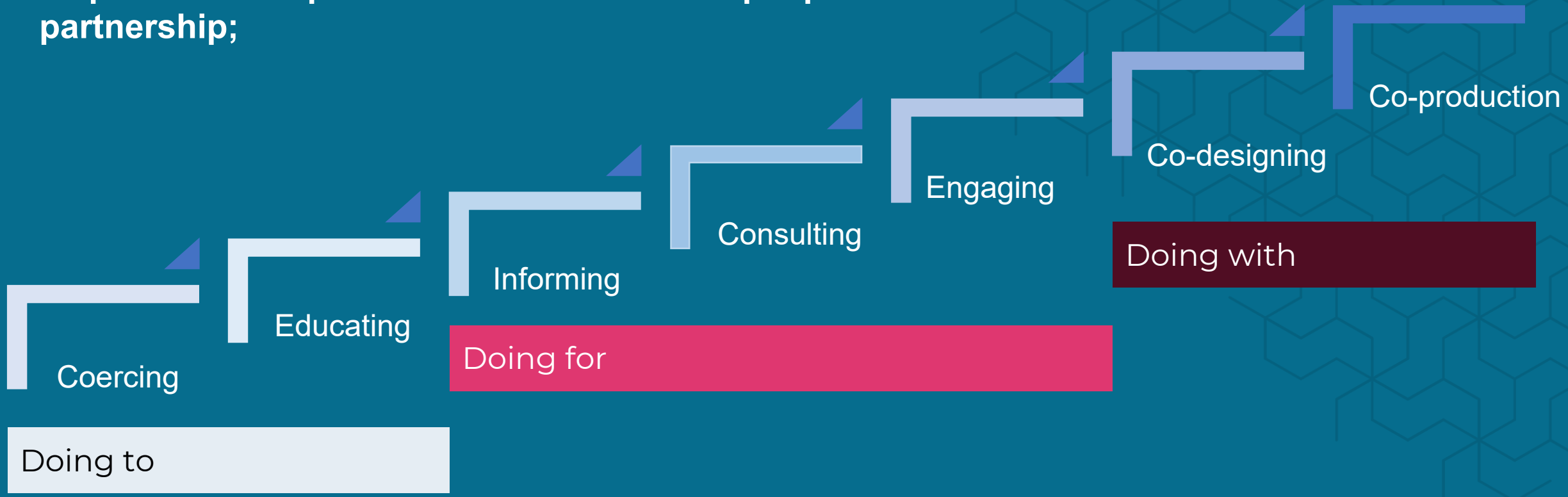
Culture of Care

Some terminology to consider

- **Service user and carer participation**
- **Coproduction**
- **Lived/Living Experience**
- **Expert By Experience**
- **Peer worker**

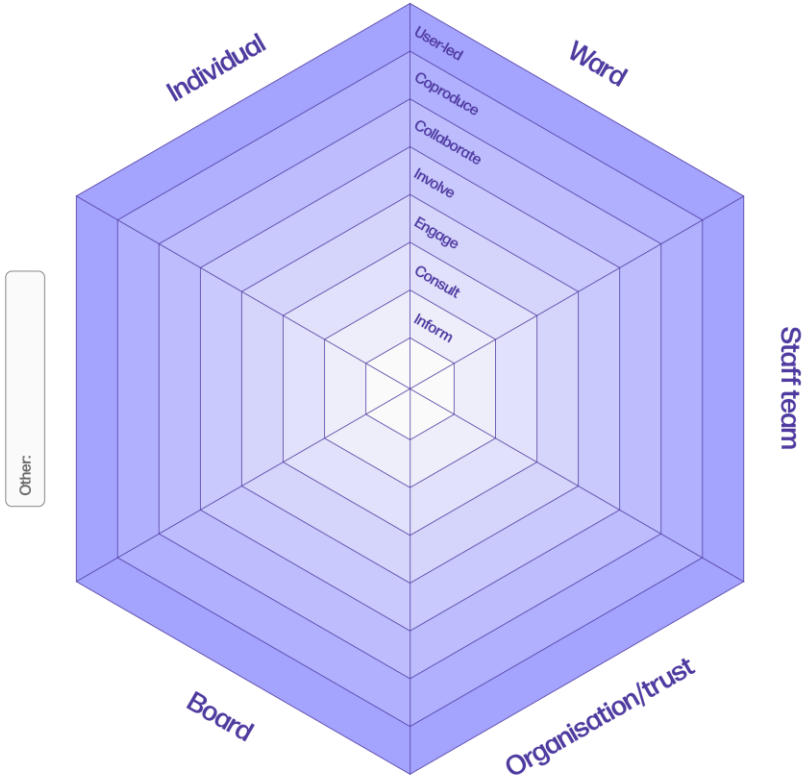
Coproduction ladder

Sherry Arnstein's citizen ladder of participation (1969) has helped us conceptualize how we work with people in partnership;



Spectrum of Coproduction

- Governance
- Service design
- Service delivery (Peer support)
- Quality improvement
- Service evaluation
- Research



Benefits of coproduction and valuing lived experience

What do you think some of the benefits are of involving or co-producing with people with lived experience?

As we go through the training on coproduction,
please feel free to share your thoughts in the chat

Benefits of coproduction and valuing lived experience

- Bring about change in services
- Improve service outcomes
- Right thing to do
- Help humanize healthcare
- Reduce waste
- Improve patient experience
- Bring a different type of knowledge and expertise
- Build trusting relationships
- Help spot problems, provide early warning signs
- Save money
- Challenge health inequalities
- Support people to be heard & believed about their experiences
- Support patients & staff to develop new skills
- Challenge stigma & discrimination
- A way of valuing people & families
- Prioritise person centred perspective
- Support justice for harm caused
- Ground discussions in reality
- Increase individual self worth & confidence
- Connect staff with their values

Myth busting

- People on wards are too poorly to be able to participate in coproduction.
- People don’t have capacity, and don’t always know what is best for them.
- One person can't represent all patients, so what is the point?
- We always hear from the same people.
- People have an axe to grind and use it as an opportunity to complain.
- People want things that we just don’t have the resources for.
- People with lived experience might not understand confidentiality.
- We haven’t got the time to do this.

Getting started

- Ethos of making space to listen to and value patients and families
- Don’t let perfect be the enemy of good
- Pause and reflect on what you do well already
- Ward meetings, patient feedback, advocacy, partnership with VCSE, complaints
- How can we strengthen, amplify, pay more attention to?

Progressing participation

- CofC gives impetus to be brave and try to progress this agenda and move to more partnership working
- Explore existing involvement and peer support structures in trust
- Explore existing user led and community organisations locally
- How to safely bring people into project team as equal partners
- How to remunerate people fairly
- How to support people well

Diversity within coproduction

- Diversity of voice is the inclusion of perspectives, opinions, thoughts and influence from people from a range of different backgrounds and experiences.
- Coproduction naturally introduces diversity of voice into service design and delivery.
- Diversity of voice is important as it allows organisations to reflect on their services from the perspectives of different groups and individuals, to identify gaps and harms, and to ensure all communities needs are being adequately met.
- It’s helpful to think about the nine protected characteristics when considering diversity of voice.
- It is also important to ensure that coproduction spaces are themselves diverse.

Working with autistic people

Autism is a lifelong neurodevelopmental condition with autistic individuals experiencing differences in their sensory and social processing and communication.

When working with autistic individuals it is important to take these differences into account and support with providing accommodations to both the physical and social environment to meet individual needs.

Some accommodations to consider:

Give clear information, in as much detail as possible, about tasks.

- **Consider the sensory environment of where any meetings are held.**
- **Encourage different forms of communication, acknowledging that this may change in different situations.**
- **Be aware of any potentially triggering situations/conversations and offer information in advance about these.**

Working with people from racialised communities

- Not enough to say 'we are not racist' or that the door is open to everyone. Must be actively and intentionally anti racist and reflecting anti-racism practice.
- Cultural curiosity- willingness to explore what you don’t know and be open and curious to learn.
- Acknowledge and understand the impact of racism and racial trauma for black and brown people accessing services.
- Building trusted relationships may take time and investment, may require a trusted community bridge.
- CofC is not a separate endeavor to PCREF, they are intrinsically linked.

Working with people who have lived through trauma

Inpatient mental health wards can work effectively with people who have lived through trauma by adopting a trauma-informed approach that emphasizes safety, trust, empowerment, and collaboration.

Trauma-informed care requires staff to understand the pervasive impact of trauma on an individual's mental and emotional well-being and to actively avoid practices that could re-traumatise or distress patients.

Safety **Trust** **Empowerment** **Collaboration**

Payments and remuneration

- Lived experience work should be appropriately and fairly remunerated.

- Payment for lived experience work should be aligned to the values of both the Culture of Care programme and patient involvement work more widely. Payment should reflect the important value of lived experience involvement and represent equal involvement between experts with experience and experts by training. Additionally, payment needs to reflect the additional emotional burden of lived experience work.

- Whilst there is no national standard on lived experience payments, align with your local practice in your organisation or ICB.

- If creating new roles, these could be adapted from similar roles within the organisation.

- Many organisations will have a payment policy in place for service user involvement.

How might the broader organisation support meaningful coproduction on wards?

- What are wards doing well all ready? What good practice is in place to engage patients and families across the spectrum of coproduction?
- Are we making the most of patient experience data and friends and family test? Complaints and compliments? How is this informing care?
- Do we have a fair and flexible payment policy to support coproduction?
- Do we have infrastructure to provide Experts By Experience with meaningful support?
- Do we have approaches in place to ensure diversity of representation? How are we hearing from those most marginalized?

Break

5 mins 

Lived Experience Leadership

Jess Worner
Lived Experience Network Manager, NSPA

Emily Daly
Culture of Care National Advisor

Culture of Care

Why is working together with patients and carers so important?

- There is a long history of activism across mental health and psychiatry. This is undoubtedly intertwined with the experience of harm, and human rights breaches within mental health services.
- The spectrum of participation from involvement to coproduction creates opportunity to work together with people with lived experience to create change and improve **outcomes and experience** across mental health services.
- Coproduction is a way of working that values experiential knowledge alongside learned or professional expertise. It is ethically the right thing to do but is also about disruption and creating change.

Power

- Many people will have had experiences of powerlessness in their lives.
- Trauma, especially inter-personal trauma has a 'power over' element.
- Patients entering the mental health system may be subject to forced medication, detention, being labelled, being described in their notes. They may experience powerlessness.
- For people in services for a long time this can be ingrained and embodied.
- We must think about power and the impact in order to support safe and meaningful coproduction.

Lived experience leadership

A broad term used to describe what happens when people use their Lived Experience to lead change, shape or create something to benefit others in the broad field of mental health

What more is needed?

Nurturing lived experience – any support should be underpinned by principles of;

- being LE-led,
- learning from the past,
- acknowledging inequalities and harm,
- and being visibly, genuinely diverse.

Creating supportive contexts for LEL – as so many challenges were linked to systemic problems, there is an urgent need to focus on contexts and organisations people with LE are trying to work in. This includes leading by example (in the case of mental health charities, ensuring LE is embedded at all levels), highlighting the value of LEL, supporting organisations to embed LEL, making a substantive commitment and investing resources, and having brave intra-organisational conversations. **(Rai Waddingham NSUN, 2021)**

Training and support

- For lots of people their lived experience is ongoing, and they may face current challenges that require reasonable adjustments in order for them to access work and be able to contribute fully and meaningfully.

- But perhaps more significantly lived experience work and involvement can be emotionally difficult for lots of reasons.

- We must be thoughtful and robust about training and support for everyone working in lived experience roles.

Support

- Lived experience contributors **building relationships** with a key member of the team
- Good **clear, accessible information** about the work and what **the ask** in plenty of time before a meeting or event
- Being **transparent** about the parameters of the work
- **Pre meet and debriefs**
- **Support with admin** and accessing information
- **Support with invoicing** and claiming payments for the work
- Lived experience **supervision/ reflection**
- **Peer support** with other lived experience contributors
- Replicating **wellbeing offer** for all staff for people in LE roles

Training

- **Introduction** to the CofC standards and equity principles
- **Training** on history of service user activism
- **Models of peer support** and peer approaches
- Training on **human rights in mental health**
- **How to influence up**
- Training on **structure of NHS** and how services are commissioned
- **How to chair a meeting**
- **Open Dialogue**
- Training on **voice hearing and unusual beliefs**
- Training on **compassionate approaches to suicide and self harm**
- Developing **facilitation skills**

Facilitating coproduction and lived experience leadership

- Through CofC we have seen a range of lived experience leadership roles across lots of different organisations.
- Opportunity to be ambitious and consider where LE posts could add value;

    Patient safety team (PSPs)

    Lived Experience exec director

    PALS/complaints/patient experience

    Comms/social media

    Quality improvement/ transformation

How might the broader organisation support meaningful lived experience leadership posts?

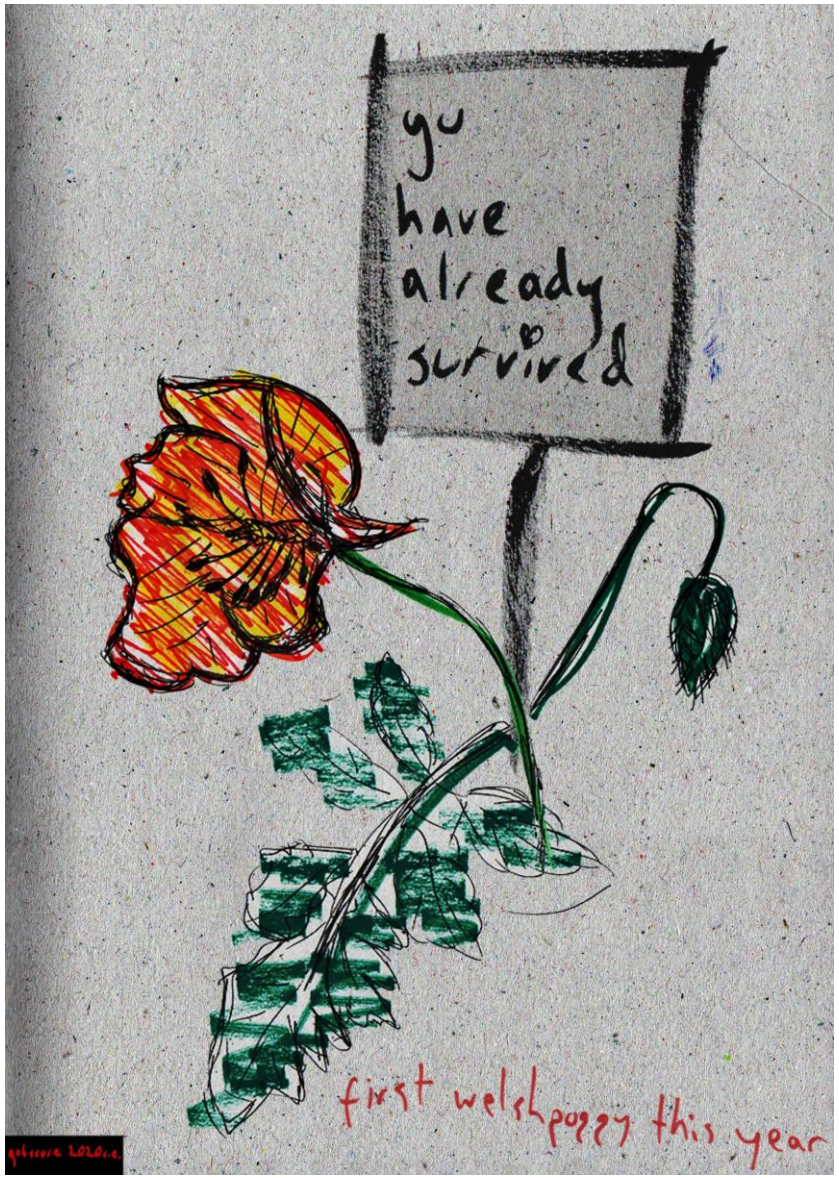
Homework before the first in person session...

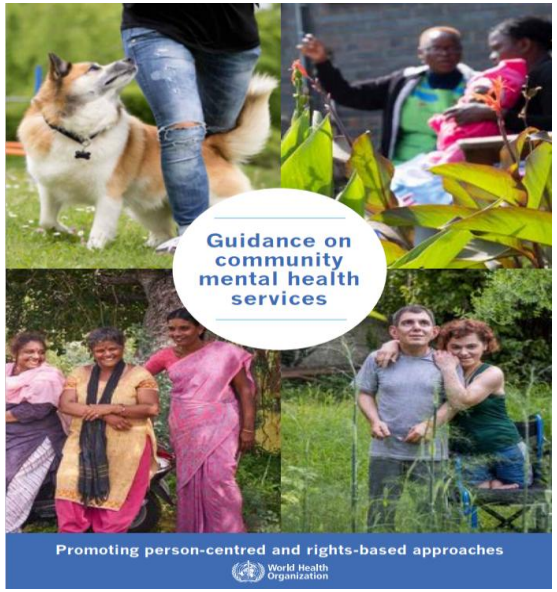
- What LE leadership roles do we have already? Are the people in these posts part of this conversation?
- Do we have opportunities for career progression for people in lived experience roles?
- What training and development opportunities do we provide for people with lived experience?
- Do our HR policies support people in LE roles to thrive? Are they trauma informed?
- Where might lived experience leadership have an impact in our organisation? Where are the opportunities for these roles to impact?

Growing and developing a thriving peer support workforce

Mark Allan
Peer support lead, CofC delivery team
Head of peer work, TEWV
Hearing Voices Network England, Vice Chair
mark.allan1@nhs.net

Culture of Care


go
have
already
survived
first welshpoppy this year


Guidance on community mental health services
Promoting person-centred and rights-based approaches
World Health Organization

Definitions

- **Peer Support**
  - When people with lived / living experience (LE) connect & support each other
  - Can happen informally or formally

- **Peer Workers / Peer Support Workers (PSW)**
  - People with LE employed to deliver ‘peer support’
  - Formalises the practice of working to peer values to create peer relationships
  - Adds a role with the primary remit of LE expertise to team skill mix

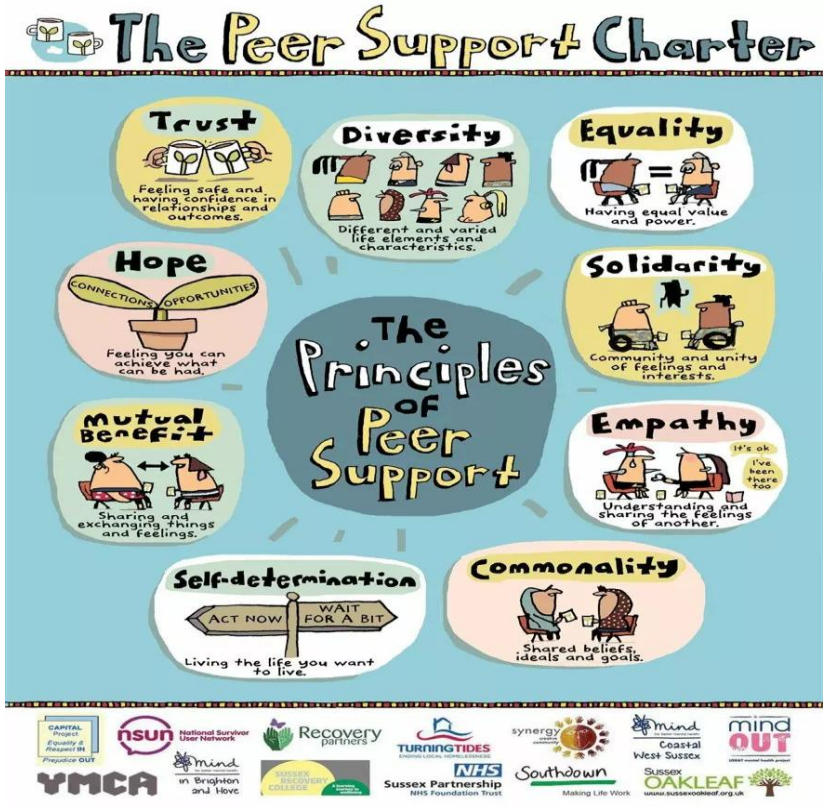
Models

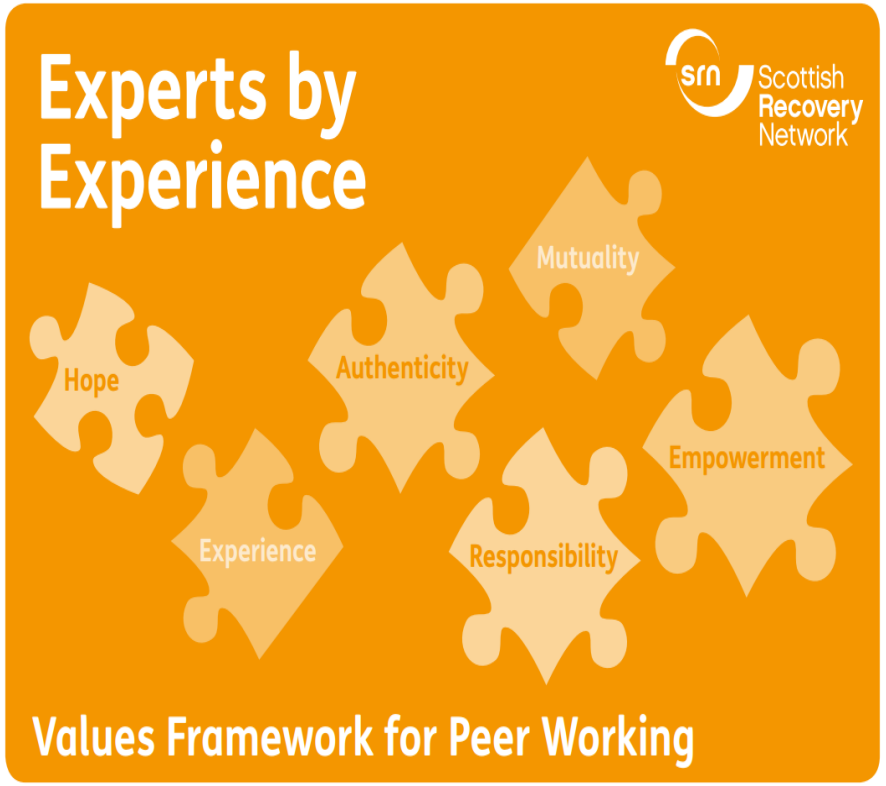
- Provider employed PSW within teams:
  - Nottinghamshire Healthcare NHS Trust
  - Central North West London NHS Foundation Trust

- VCSE employed in-reach PSW:
  - Culturally Appropriate Peer Support and Advocacy Service - Black Thrive – Lambeth

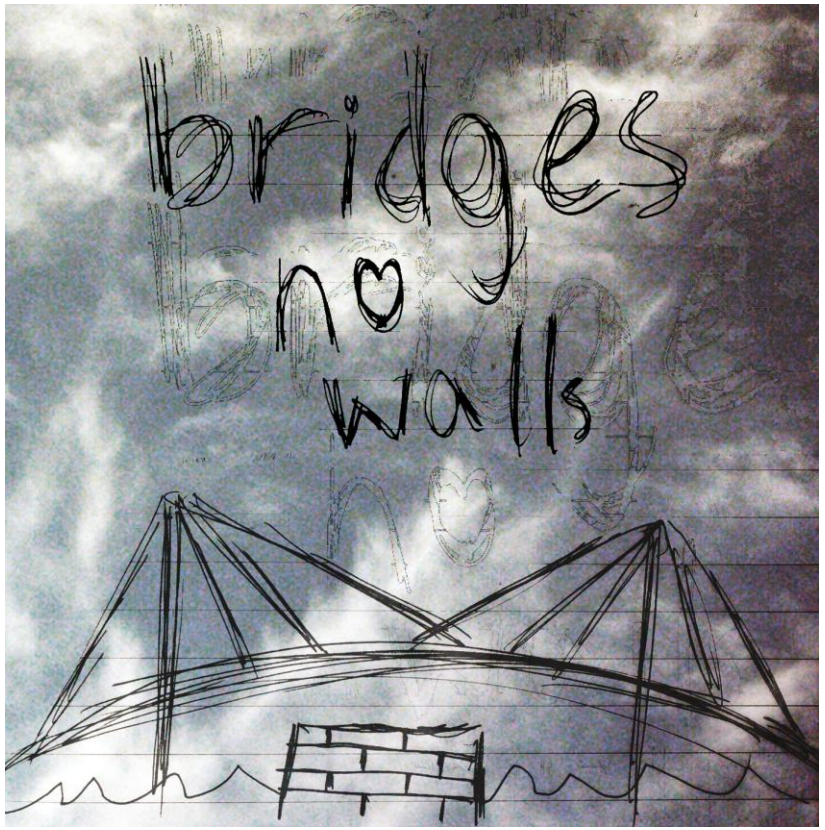
- Ideal approach has both as peer-led contributors to a networked system

Values


The Peer Support Charter
Trust
Feeling safe and having confidence in relationships and outcomes.
Diversity
Different and varied life elements and characteristics.
Equality
Having equal value and power.
Hope
CONNECTIONS
OPPORTUNITIES
Feeling you can achieve what can be had.
The Principles of Peer Support
Solidarity
Community and unity of feelings and interests.
Mutual Benefit
Sharing and exchanging things and feelings.
Empathy
It's ok I've been there too
Understanding and sharing the feelings of another.
Self-determination
ACT NOW
WAIT FOR A BIT
Living the life you want to live.
Commonality
Shared beliefs, ideals and goals.


Experts by Experience
srn Scottish Recovery Network
Hope
Authenticity
Mutuality
Empowerment
Experience
Responsibility
Values Framework for Peer Working

Co-production



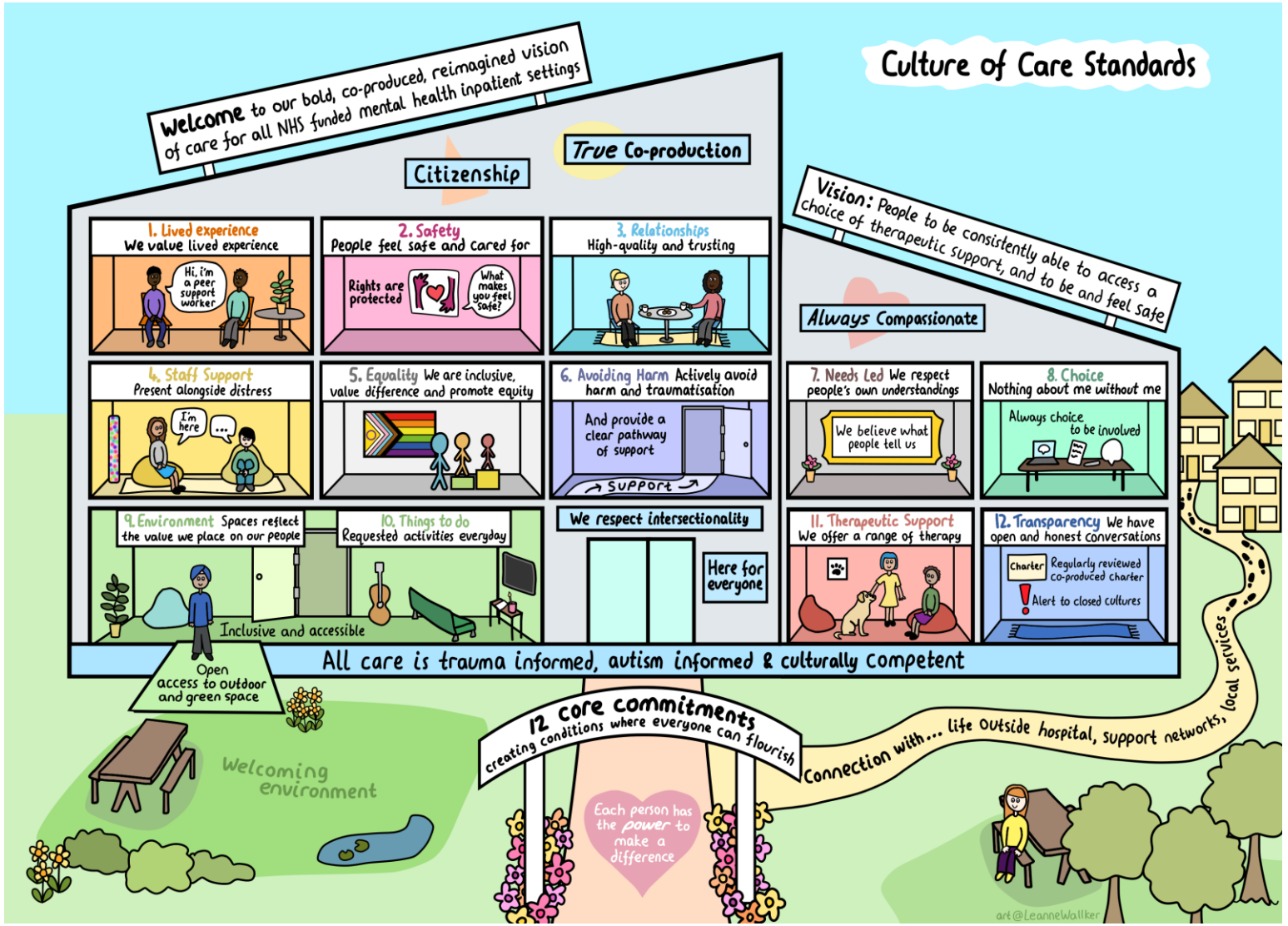
- **Co-production:** embedding LE in the design, delivery, governance and evaluation of services

- **Peer support is keystone of co-producing the delivery of services:**
  - Peer support is LE delivering the care we developed
  - Supports people to co-produce their own care
  - Provides real time LE input into the service

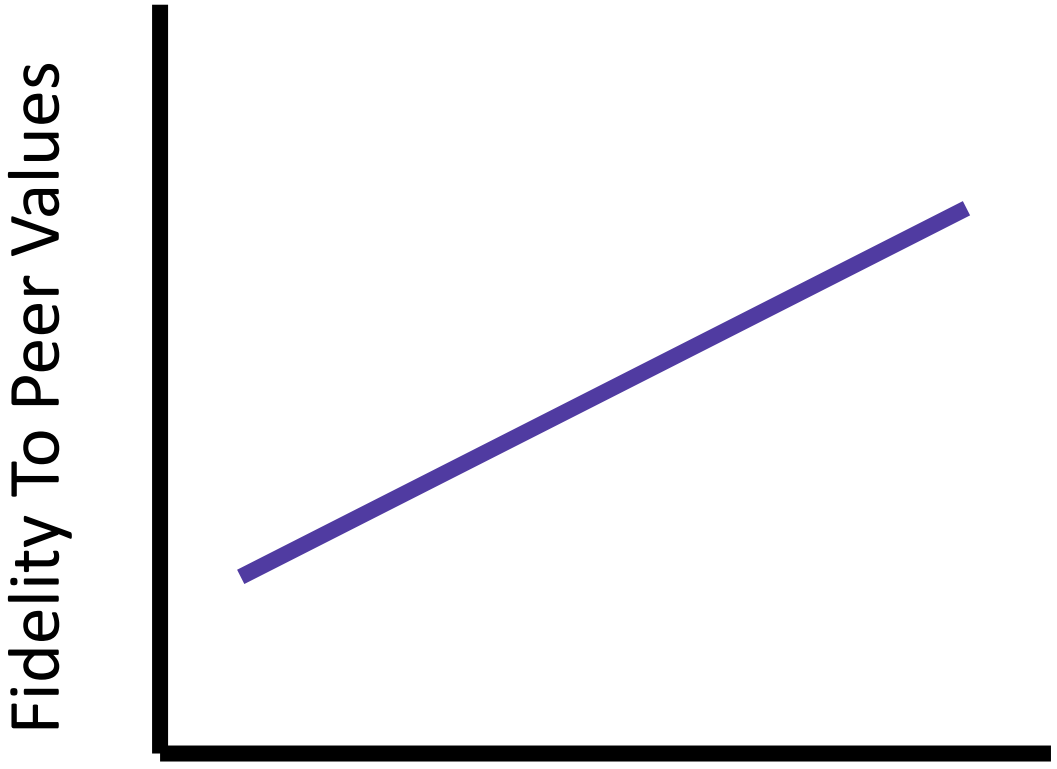
- Also **support co-production of the design, governance and evaluation of services** – adding our LE expertise and working to bring collective voices of those we work with and our peer communities forward

Culture of Care Standards

Illustration by Leanne Walker



Evidence: Role Fidelity



Research on new posts clearly defines peer support as about innovation not re-tasking

Clear role remit with fidelity to peer values is crucial to successful implementation of PSW roles:

- Increases engagement in peer support from SU
- Creates roles that match with peers values
- Focuses peers work on what uniquely they offer
- Provides clarity for colleagues
- Minimises overlap with other posts

In short: Peer roles are an innovation that is about adding peer support to teams that don't have it. It is not about bringing in LE to do (often cheaply) more of that which is already done!

Evidence: Benefits

Service User	Peer Worker	Service
Reduction of isolation	Access to work in a valued role	Key to culture change
Increase in hopefulness	Working to personal values	Core component of trauma informed approaches
Increase in confidence	Source of personal meaning	Core to recovery values-based practice
Increase in well-being	Increase in self-belief	Brings LE expertise into team skill mix
Feeling more in control	Increased sense of competency	Bridges the gap between SU and staff
Some evidence shows reduction in in-patient re-admissions	Can support personal recovery	Improved SU experience
		Improved SU outcomes

Evidence: Barriers

- Resistance from clinical staff (though many allies as well)
  - “What we need is more nurses”
  - “Just one more thing for ‘us’ to do”
- Lack of role clarity and fidelity to peer values
- Pressure to conform to clinical cultures
- Challenge of performing the emotional labour of using LE in often re-traumatising environments
- Lack of appropriate training, supervision and support etc
- Systemic challenges
  - Short term or insecure funding
  - Marginalisation of peer expertise
  - Absence of peer leadership and progression

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

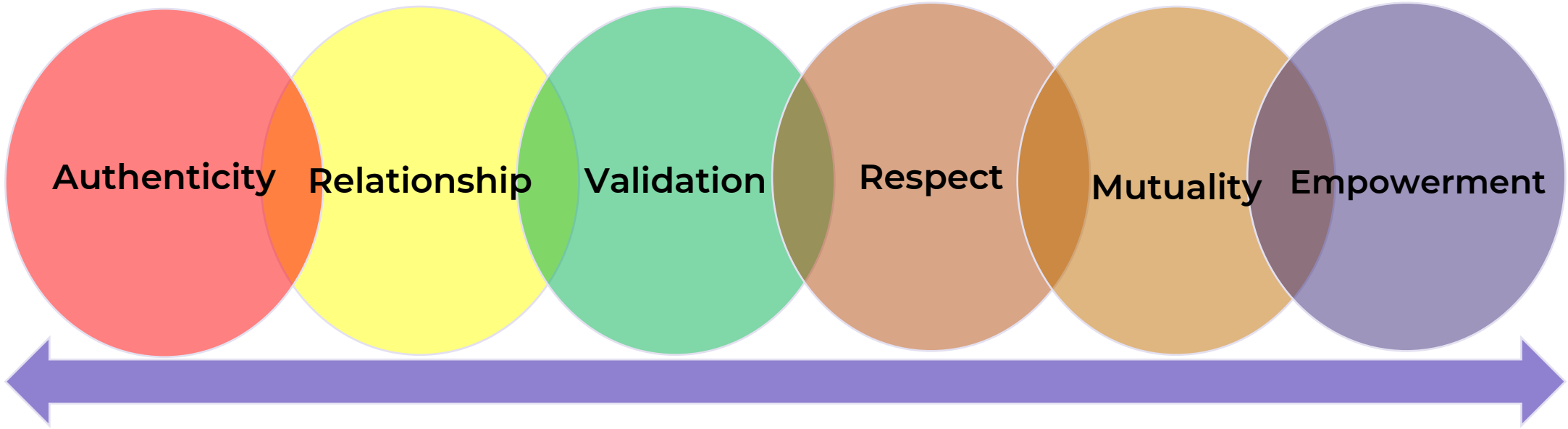
Neurodiverse Connection

Global Black Thrive

NCISH

Key Foundation: Peer Support Values

- The Key Foundation of Peer Support: Inform our peer support practice, and our work within our peer structures
- TEWV Peer Support values were co-produced with a reference group including peers, service users, carers and VCSE representation



Peer Work

Peer Work is a relational job role based on our own experiences of mental health, and our core peer support values and training.

The role is not intervention based but intentionally uses the relationship to identify mutually agreed support.

The skills of these roles are based around how to build a peer relationship with service users that allows us to learn from each other and our personal experiences.

We identify between us the most helpful way to use our time based on our unique combination of our experiences, needs, knowledge and skills.

What PSW Do (1)

One to One Peer Support

- Reaching out to connect and bring compassion
- Walking alongside - providing mutually agreed emotional & practical support
- Supporting people to navigate and engage with services
- Supporting people to access the resources available in their communities

Facilitate Peer Support Groups

- Bringing people together to connect with and support each other

What PSW Do (2)

Work within team processes:

- Bring lived experience & peer expertise to the skill mix
- Bridge the gap between care teams and service users
- Support service users to have their voices heard
- Service Development:
  - Embedding LE perspectives
  - Trauma Informed Approaches
  - Recovery Values
  - Culture of Care standards

What PSW Don't Do

Not involved in coercive or invasive practice including

- Control and restraint
- Observations
- Personal care
- Persuading compliance (or non-compliance!)

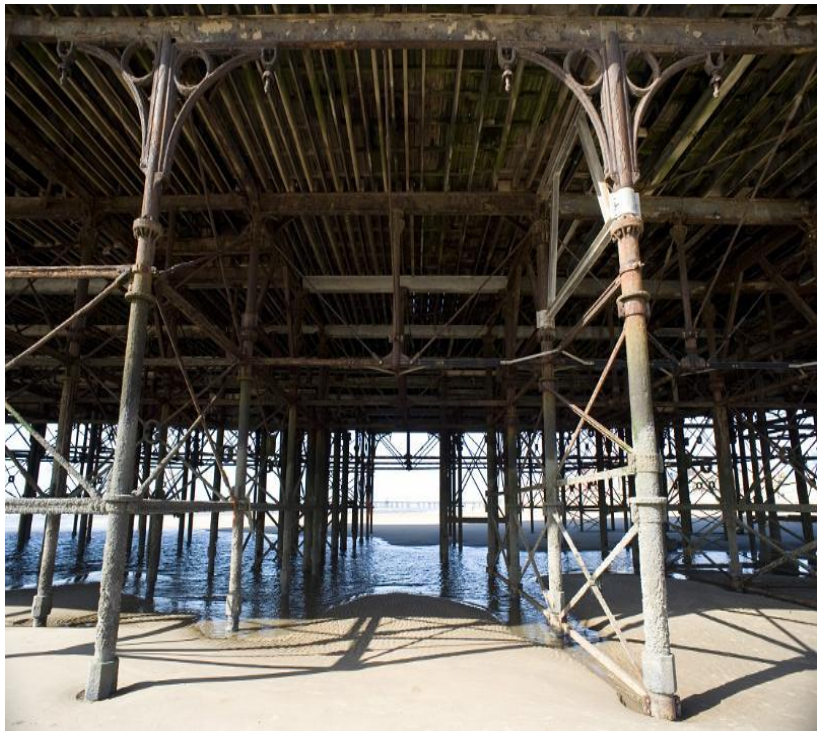
Not HCA / Support Worker Roles

Peer Support Workers must not be included in inpatient staffing numbers

Supporting Peers: Creating Sustainable Roles

Peers are part of a Trust Peer Community with Robust Professional Governance and Support Structures

- Peer led professional structure
- Lead implementations with leadership & supervision roles
- Roles based on peer values
- Employ peers on teams in pairs (or linked roles)
- Team preparation
- Peer led recruitment process
- Start with peer support training
- Ongoing 1:1 supervision from peer supervisor
- Creating strong peer community:
  - Monthly co-reflections
  - Monthly online social drop in
  - Monthly newsletter
  - Twice yearly development days
  - Twice yearly peer support and directors forum
  - Systemwide networks alongside VCSE peers
- The Daily Debrief

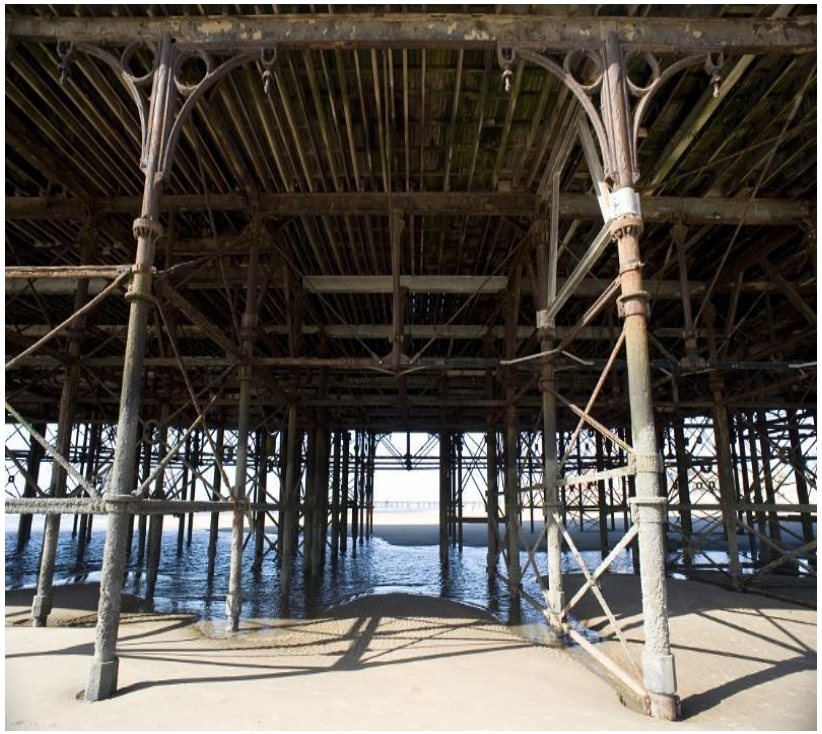


Supporting Peers: Creating Sustainable Roles

PSW also part of the Service Team:

- Line managed by team manager
- Champions in teams are also key
- Service induction
- Access to team/Trust supports

- Tripartite Approach
  - Management supervision
  - Appraisal process
  - Sickness absence management
  - Returns to work



Inpatient Pilot Impact: Service User Feedback

“Made me feel at ease. Didn’t judge me. Listened to me”

“Very supportive, caring, compassionate as they understand in a very good way”

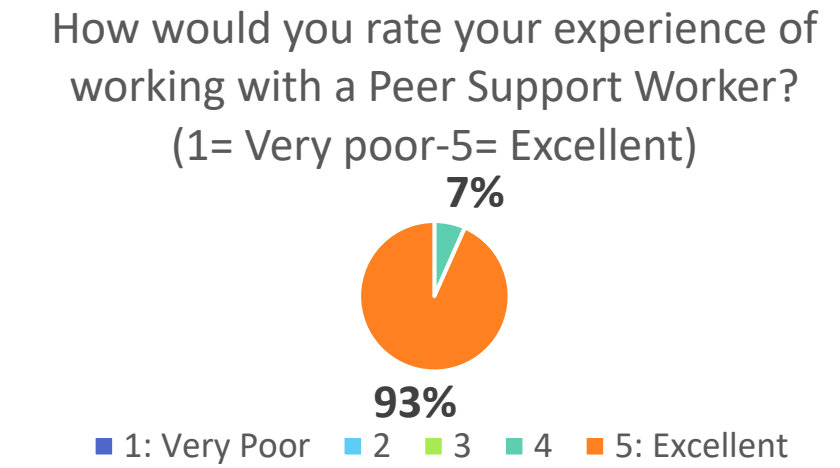
“I was understood and … able to express how I am feeling”

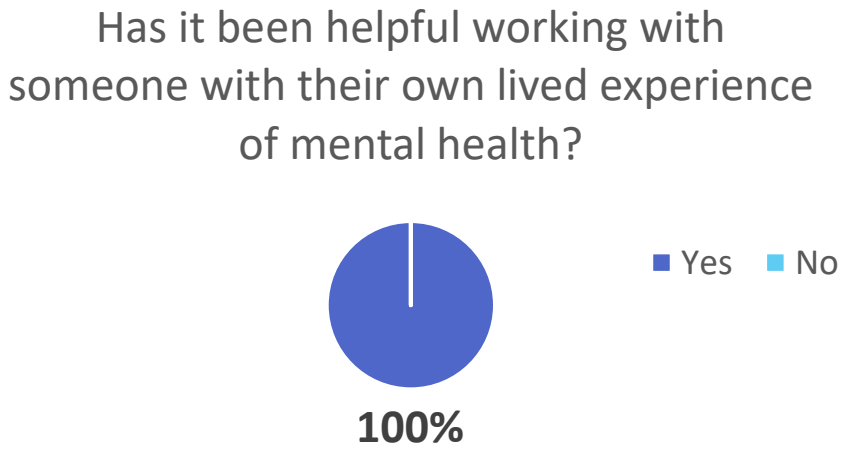
“Made me feel I wasn’t alone and the only one to go through things like this”

“Point you in the right way to other services that may not normally be obvious”

“Thank you for all your unconditional support and kindness”

A number of our PSW wanted to come into this work after working with a TEWV PSW





Inpatient Pilot Impact: Colleague Feedback

"Peer support provides an open space for patients to discuss their care and can form more of a relational role."

"Having a bridge between staff & clients. They have been good for the team."

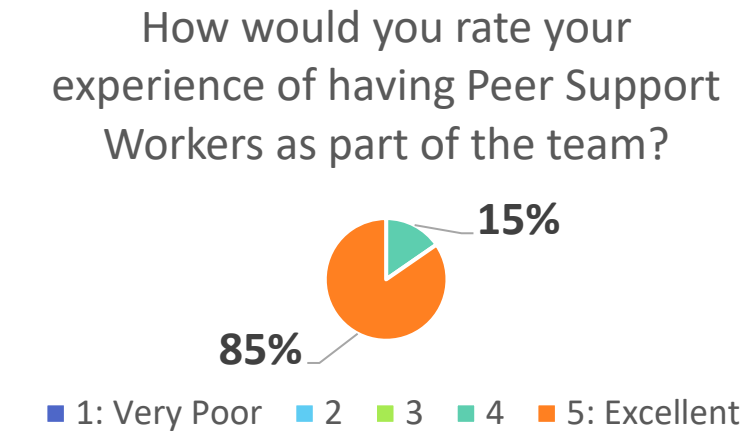
"Support for patients and staff"

"They provide a different view"

"Valuable insight"

"Really insightful into patient experience - vital member of the MDT"

"Excellent experience of working with the peer support team."



Recruitment

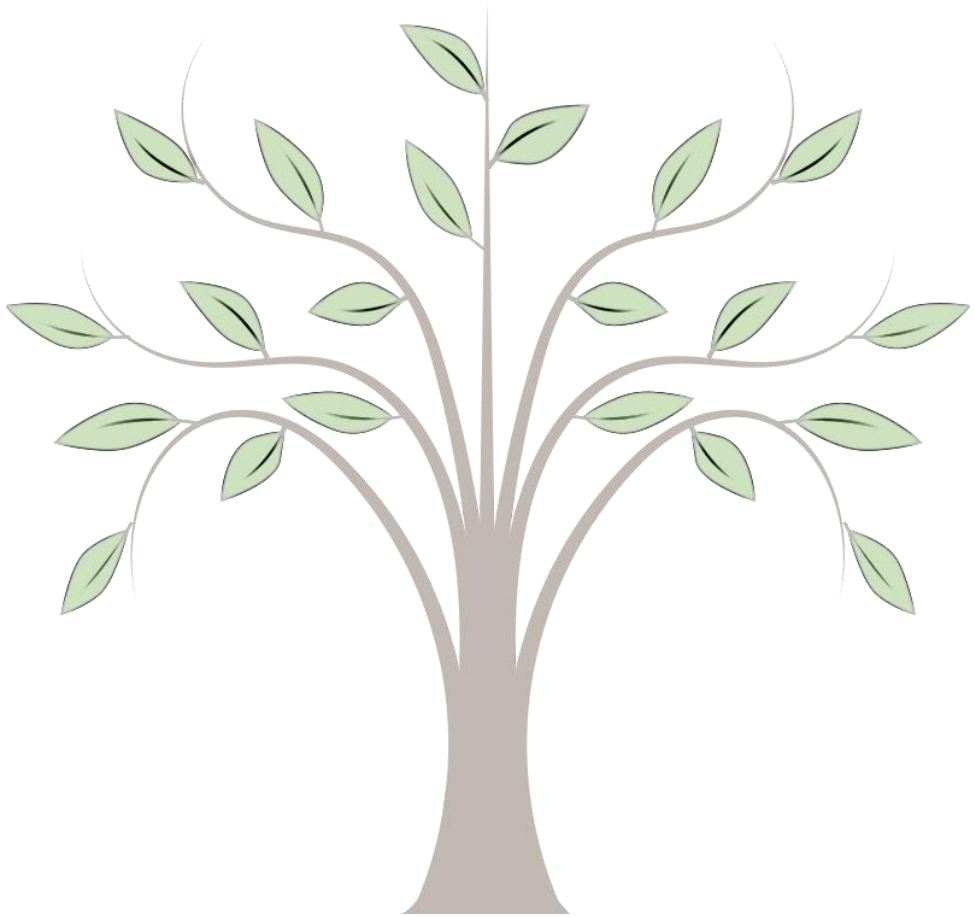
- Prior to lived experience leading our recruitments a couple of LE roles were advertised and not able to be appointed to!

- **2018**: 217 applications for 6 roles in Teesside community services
- **2021**: *120 lived experience applications* for 12 inpatient roles across the Trust
- **2025**: 236 applications for 6 Secure Inpatient Services roles

Retention

- **Retention Rates From Inpatient Implementation Year (2022):**
  - Recruited 16 Inpatient and 3 community peers:
    - After 1 year: 100% still worked in LE roles in the Trust.
    - After 2 years: 95% still worked in the Trust, 89% in LE roles, 84% in the Peer service
    - After 3 years: 84% still worked in the Trust, 79% in LE roles, 74% in the peer service
  - Our total 3-year retention rate as a service is 73%

Personal Experience of Peer Work Role



"I absolutely love peer work. It's honestly changed my life. When I first started I didn't have much understanding or knowledge, it just sounded like something that could really make a difference and something I would have loved for myself. Now I can't imagine doing anything else. I have met so many once-in-a-lifetime people through my colleagues and people I've built a peer relationship with, these people have changed me forever and I couldn't be more grateful ❤"

Beth Gell

Expansion of TEWV Peer Roles

- Community Teams
  - Rehab
  - E.I.P
  - Perinatal
  - Eating Disorders
  - Community Transformation Roles

- AMH Inpatient & PICU Wards
- Crisis Services
- Secure Inpatient Services
- Health and Justice Services

The more of us there have been – the better it gets

Have board backing to reach 100 roles

Peer roles make a unique difference

Unique form of emotional labour

Ethical and effective implementation:

- Peer leadership
- Peer values
- Role fidelity
- Robust role support
- Connects peer communities

Culture of Care Monthly Peer Support Implementation Space

- Invites were sent to all providers
- Encouraged to open to peer and operational leadership roles
- Space is a combination of
  - Sharing good practice
  - Connection and reflecting on challenges and successes
- All providers are welcome

Next Steps and wrap up

Matt Milarski

Culture of Care

Who’s in the room?

Please kindly scan the QR Code, or click on the link available in the chat, to add your details to today's register.

It will really help us to understand who has attended today and from which departments – thank you!

Registration: Org Support Virtual Learning Session 2: Lived Experience & Coproduction

https://forms.office.com/e/Uf6C0SnSEn

With gratitude

- Thank you so much for coming today and for the work you continue to do to influence services and try to improve things for patients and families.

- If you could kindly scan the QR code and provide your feedback.

Feedback Form - Culture of Care National Organisational Support (Coproduction)

https://forms.office.com/e/SstQAhEfPe