NHS Resolution

Mental Health Matters Series

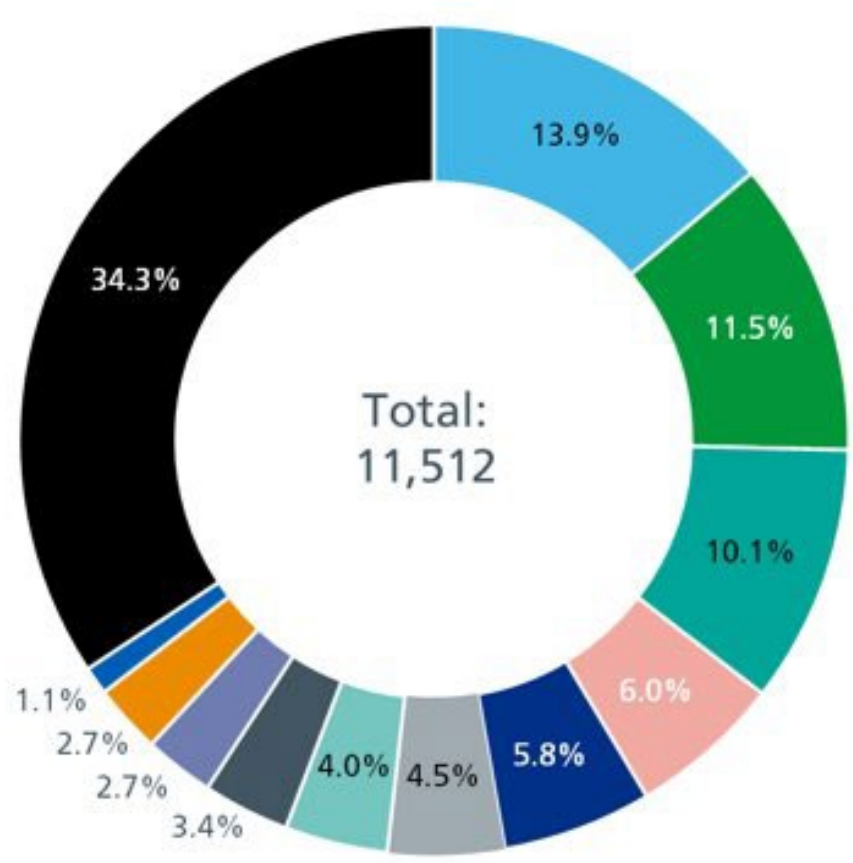
Episode two: Mental health inpatient care and treatment

Louisa Bradley – Safety and Learning Lead – North

Agenda

Time	Item	Speaker
13:00	Introduction to the session	• Louisa Bradley, Safety and Learning Lead – North
13:05	NHS Resolution - workplace violence report	• Louisa Bradley, Safety and Learning Lead – North
13:25	South London and Maudsley - reducing restrictive practices	• Faiza Aurangzaib, Interim Consultant Nurse – Reducing Restrictive Practice • Samar Mohamad, Interim Lead Nurse – Reducing Restrictive Practice • Simon Sherring, Deputy Chief nurse
13:55	Greater Manchester Mental Health – trauma informed care	• Keely Oates • Elin Benjamin
14:15	Tea break	
14:20	NHS England - Mental Health, Learning Disability and Autism Quality Transformation –Culture of Care Standards and programme	• Leanne Gelder, Head of Quality Transformation (Improving Practice and Culture)
14:40	Mental Health Act (MHA) update	• Simon Lindsay, Partner for Bevan Brittan LLP
15:00	**Questions and close** led by Louisa Bradley	

Volume of clinical claims received in 2024/25



- Emergency medicine 13.9%
- Orthopaedic surgery 11.5%
- Obstetrics – non-Early Notification 10.1%
- Gynaecology 6.0%
- General surgery 5.8%
- Radiology 4.5%
- General medicine 4.0%
- Psychiatry/mental health 3.4%
- Ophthalmology 2.7%
- Urology 2.7%
- Obstetrics – Early Notification 1.1%
- Other 34.3%

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NHS Resolution Insights: Preventing and managing workplace violence

Advise / Resolve / Learn

Reflections and review of WPV publication: 18 months on..

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Purpose:

1	**Identify and share insight into the volume, cost, causes and injuries associated with WPV**	3	**Disseminate the shared learning with members to use this as a driver for change improvement.**
2	**Identify age, sex, job role of staff, common themes**	4	**Shared with other NHS bodies to inform Policy and guidance.**

Findings:

- 5,287 claims 2010-2020
- Total cost of 4,674 closed claims = **£61.4 million**
- 63% closed with no damages paid
- 37% closed with damages paid
- Damages paid = **£31.3 million**

Since 2020... Claims headlines source: NHS Resolution FOI 6874

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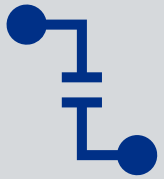
Employer liability where claim is closed and cause is ‘assault’ (seven financial years)

Year of Closure	No. of Claims	Damages Paid	NHS Legal Costs Paid	Claimant Legal Costs Paid	Total Paid
2017/18	165	3,583,227	754,963	2,822,312	7,160,502
2018/19	224	5,844,197	1,173,421	4,096,113	11,113,731
2019/20	244	7,734,444	1,283,875	4,238,626	13,256,944
2020/21	209	3,393,322	806,183	2,544,355	6,743,860
2021/22	180	3,393,484	704,505	2,735,636	6,833,624
2022/23	252	3,587,844	849,495	2,890,754	7,328,093
2023/24	222	3,819,034	609,679	2,899,961	7,328,674
Grand Total	**1,496**	**31,355,551**	**6,182,120**	**22,227,757**	**59,765,428**

Our call to action:



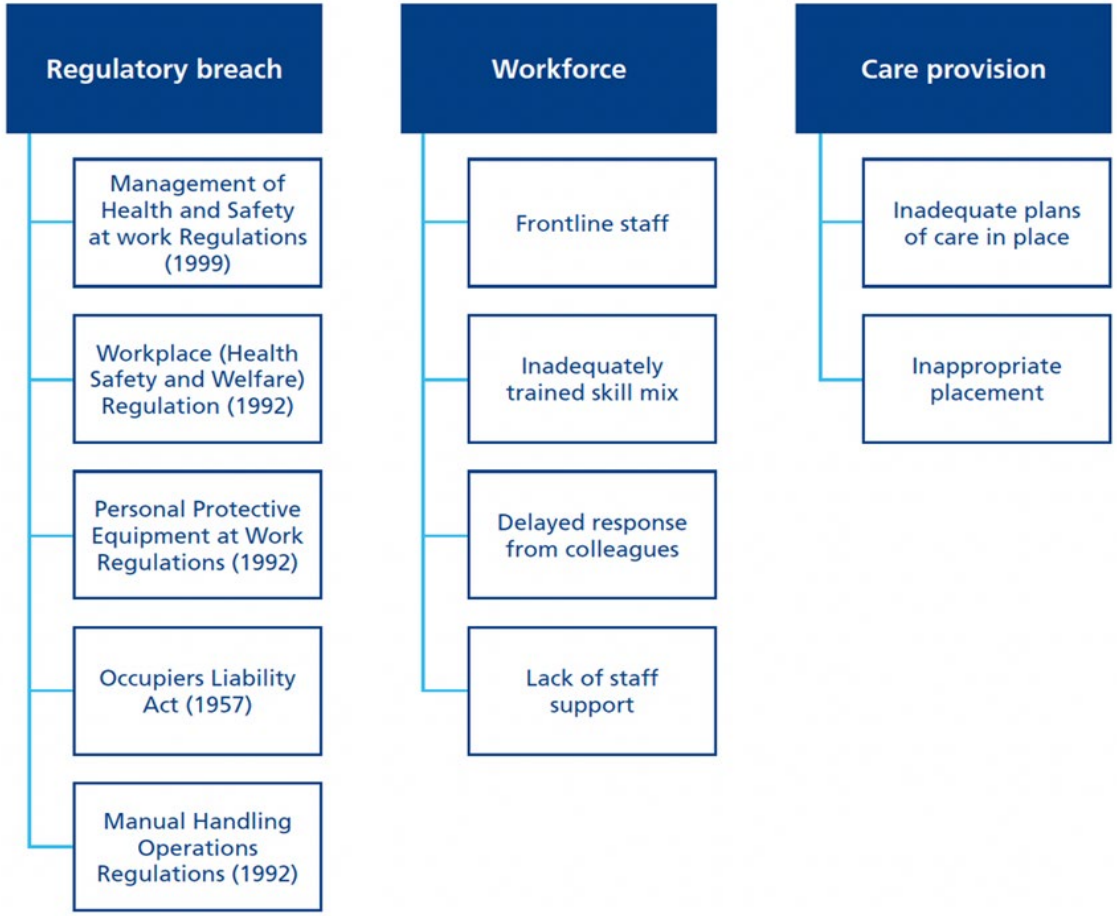
1. Use your Liability to third party scheme data to identify cost of claims relating to violence and share this with wider teams as a lever to improve staff safety.

2. Take a system approach to understanding the multiple factors contributing to claims and use these insights to support re-design.

Recap… high level findings from WPV report

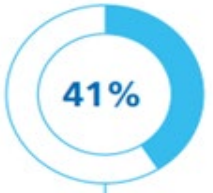
NHS Resolution

Figure 5: Most identified themes identified in the qualitative analysis of 40 successful claims



Our analysis of successful claims found that:

65% of those pursuing a claim for workplace violence were female and 35% were male.



41% of those pursuing a claim for workplace violence worked in a healthcare support role[b].

Mental health settings accounted for the highest volume of workplace violence in 58% of the successful claims.

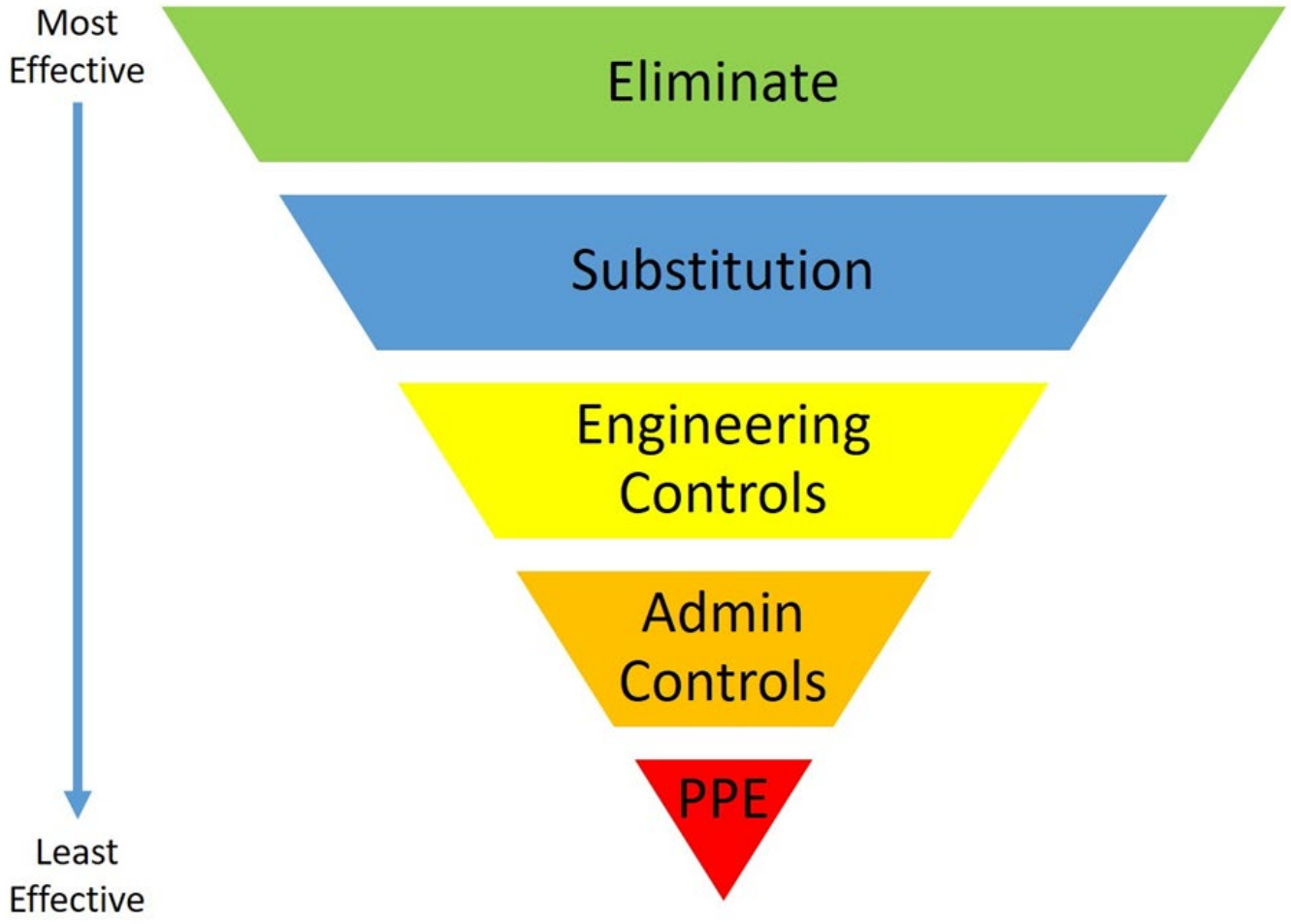
Orthopaedic injuries were most commonly reported and accounted for 56% of successful claims.

- The quality and accuracy of risk assessments were noted to be inadequate and did not acknowledge escalating risk of violence.
- Staffing levels often did not include an adequate number of people who had completed training in the prevention and management of workplace violence.
- Organisational policies and procedures on the prevention and management of workplace violence were not always in place.
- Organisational response and support to members of staff who have experienced workplace violence is variable.

Common observations and feedback from roll-out of WPV report

1. Claims learning points corroborate national findings and **reflects local LTPS risks.** Staff and managers largely unaware of NHS Resolution local data.
2. Barrier to improvement is **acuity** (e.g. staff shortage, competing priorities, money) and adequate **administrative controls**. So, getting buy-in difficult.
3. Structural organisation and reporting - challenges in progressing effective system wide improvement across organisations due to local line management reporting, hierarchies and common perspective.

What we mean by system change in WPV: Hierarchy of Controls:



Redesign high-risk pathways e.g. smooth patient flow, correct patient placement, lone-working

Adopt trauma-informed approaches instead of restrictive practice (RCT ↓ conflict ~15% and ↓ containment ~26%)

Safer ward, controlled access, reception barriers/screens, safe room, CCTV, fixed and mobile duress alarms. Targeted use of body worn video - impact context dependent and part of wider system.

Change way people work. NHS VPR standards, leadership, governance, data, robust reporting, workforce, interventions, violence checklist (e.g. Brøset) support for staff

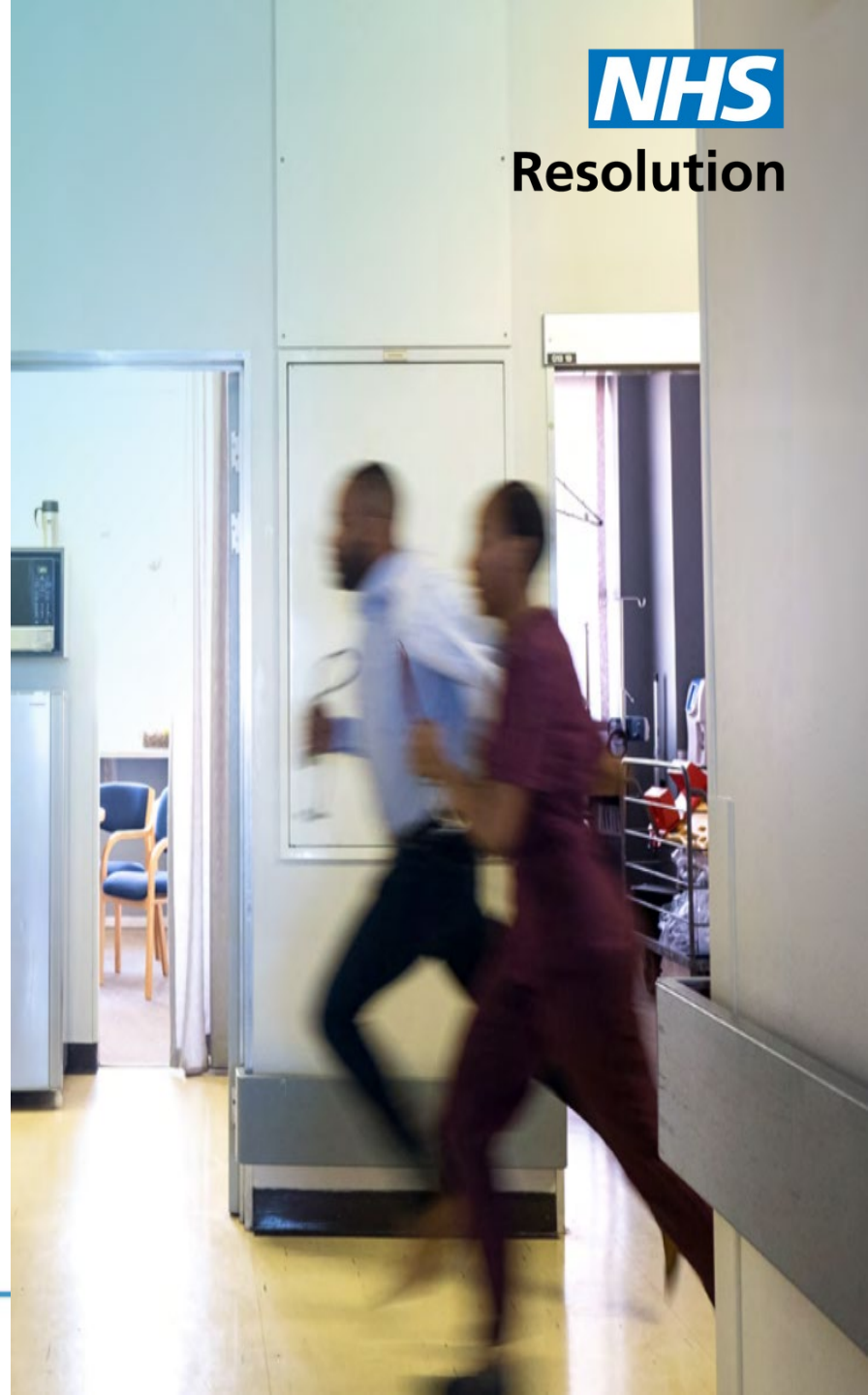
Lone worker alarms and task specific protective equipment – aligned to local policy

How can we learn from claims

This is an illustrative case story based off themes found within workplace violence claims. The aim is to share the learning from these.
We encourage clinicians and organisations to reflect on how to prevent similar incidents, enhance patient safety and better protect staff.

Consider:

- Could this happen in my organisation?
- How are workplace violence risks managed, and are staff adequately supported in high-risk situations?
- Do I (my team) feel safe to escalate concerns?
- How effective is communication within my organisation?
- Who could I share this with?
- What can we learn from this?



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Illustrative MH case story – Workplace violence **with damages paid**

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1. Situation

- HCA returns from leave for night shift. Allocated to general observations.
- 2 RMN were administering depot which had not been given in day.
- While observingng patient struck HCA in face causing injury.
- Duress activated but delay response.

2. Background

- Handover had run late due to clinical acuity and staffing. Staff VR trained.

3. Assessment

- **Elimination - i**nappropriate patient placement. Adequate safeguard, escalating patient behaviour of concern.
- **Administrative controls change way people work** e.g. risk screening – patient unpredictability and history of violence not clearly passed between shifts. **PPE** – alarm. (culture of escalation)

4. Recommendation

- Safe working procedures handovers, revisit risks, .
- Safety culture – empowered to use alarm
- Embed safety review into daily operational huddles – SEIPS helps reveal system factor beyond individual performance

So, what happened?

- Inadequate risk assessment
- Inappropriate patient placement
- Delayed activation and response to duress

Breach of Duty – Regulation 5 safe system of work

- No formal safe system of work for high risk assessment, flagging risk to staff in advance (handover).

Causation

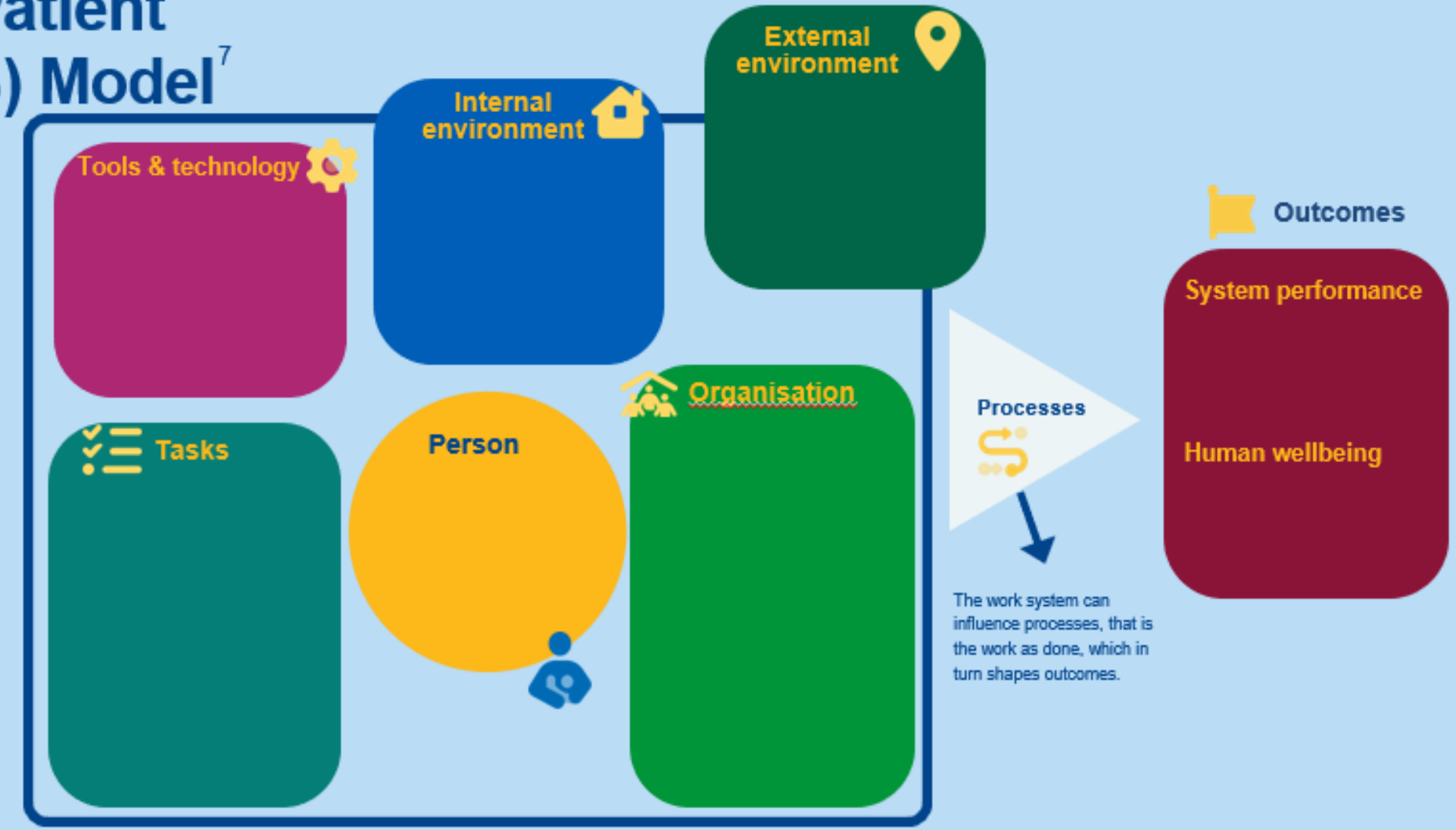
- Had the risk been shared there maybe no injury

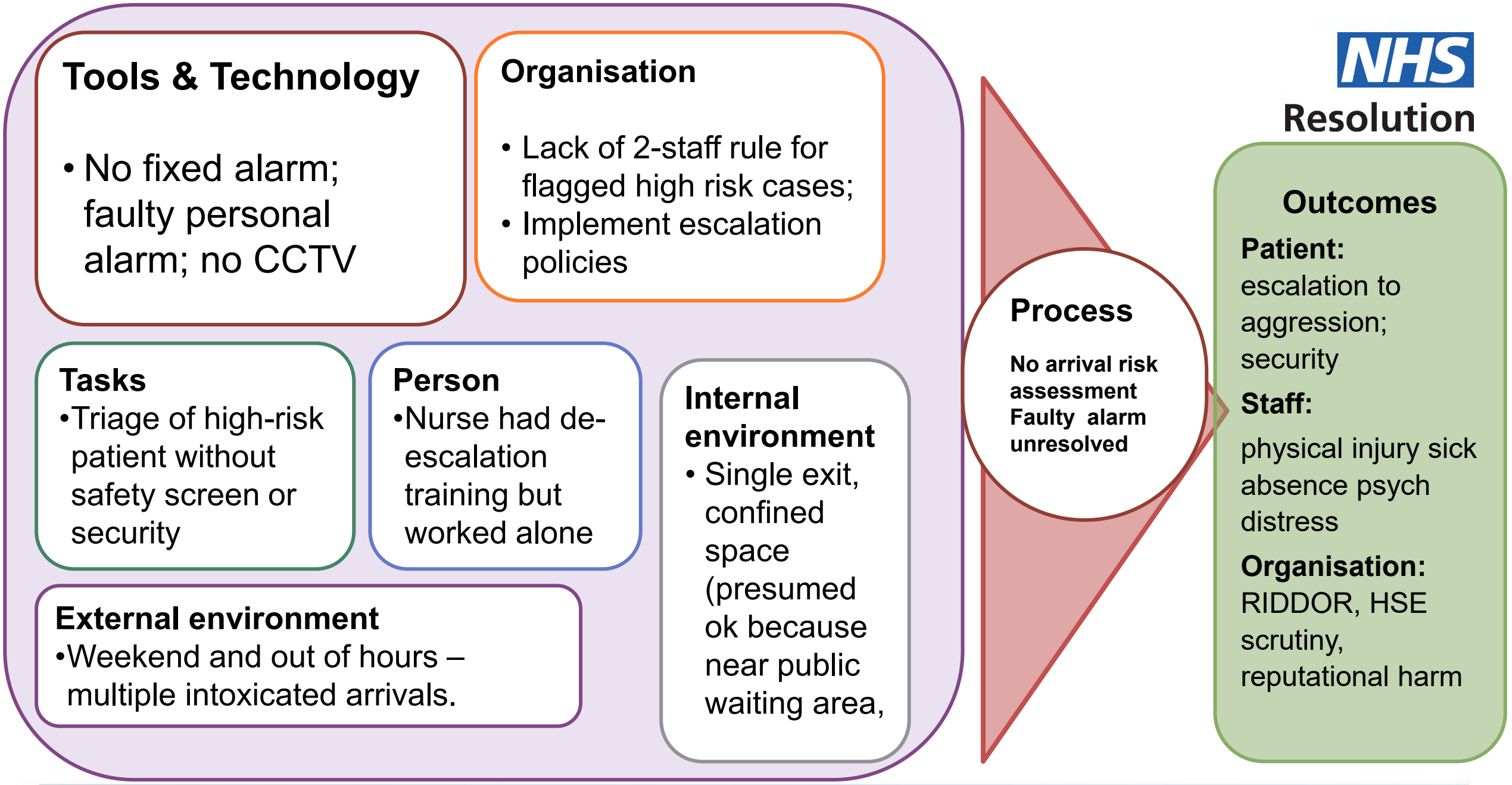
Injury

- Facial and psychological damage

System Engineering Initiative for Patient Safety (SEIPS) Model[7]

The SEIPS framework is used here to demonstrate the potential for learning from this claim to support system-wide improvement.





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South London and Maudsley NHS Foundation Trust

Reducing Restrictive Practices

FAIZA AURANGZAIB, INTERIM CONSULTANT NURSE – REDUCING RESTRICTIVE PRACTICE

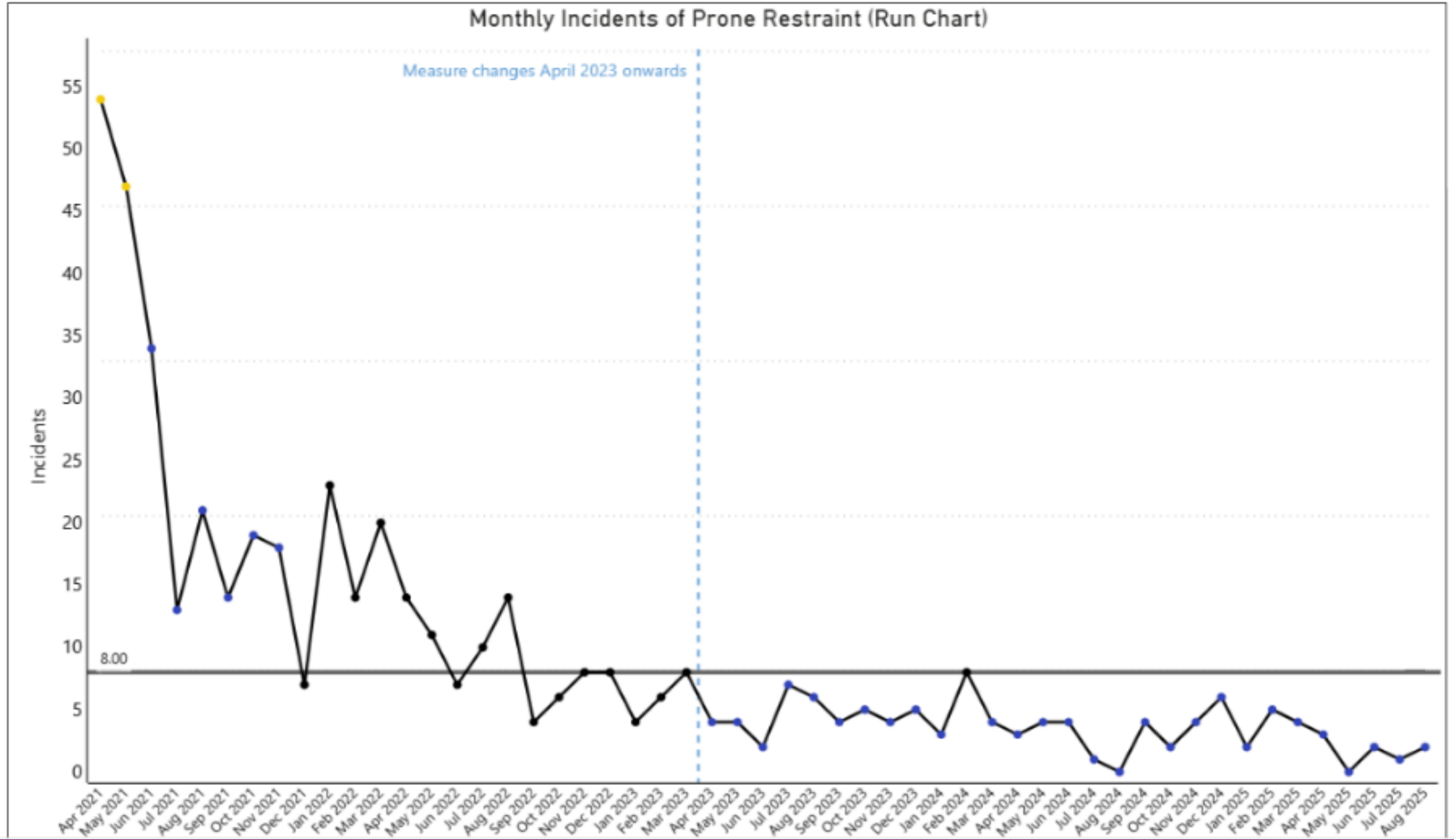
SAMAR MOHAMAD, INTERIM LEAD NURSE – REDUCING RESTRICTIVE PRACTICE

SIMON SHERRING, DEPUTY CHIEF NURSE

Looking Back

We were one of the top 3 trusts with the highest number of prone restraints (NHS Benchmarking 2018)

- Average 13 prone restraints per week
- Average 69 restraints overall per week
- Average 44 violent incidents per week


Monthly Incidents of Prone Restraint (Run Chart)
Measure changes April 2023 onwards
Incidents
8.00
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10
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20
25
30
35
40
45
50
55
Apr 2021
May 2021
Jun 2021
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Mar 2025
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May 2025
Jun 2025
Jul 2025
Aug 2025

South London and Maudsley NHS Foundation Trust

2022/23

The Safety Improvement workstream has been focusing on reducing violence and restrictive practices across our services.

In 2022/23 there were:

- Average 2 prone restraints per week (**84.6% reduction** from 2018)
- Average 40 restraints overall per week (**42% reduction** from 2018)
- Average 38 violent incidents per week (**13.6% reduction** from 2018)

At Present – 2025/26

- **An average of 0.4 prone restraints per week** – we continue to see a year-on-year reduction
- **An average of 62 restraints overall per week** – a slight increase specifically in the last year, this increase is likely due to:

A stronger reporting culture, driven by improved staff understanding of restrictive practices (RP) and reporting requirements

Change of reporting: Recording one incident per patient rather than per event following the implementation of statutory MHSDS RP reporting requirements

Over-reporting of rapid tranquilisation (RT) use for patient safety purposes

A **few acutely unwell patients contributed to a high number of RP incidents**

Key work around reducing restrictive practices

South London and Maudsley NHS Foundation Trust

Weekly ELT huddle

RRP Lead Nurse Role

Trust wide RRP committee

Blanket Restrictions Register

Seni Lewis Training programme

5 key patient safety interventions

South London and Maudsley NHS Foundation Trust

5 Must Do Patient Safety Interventions

South London and Maudsley NHS Foundation Trust

Safewards

What is it?

Package of 10 interventions that aim to reduce incidents of conflict and containment on wards.

-

Standard 1

All 10 interventions are used routinely
Teams review and refresh application of the interventions regularly

What's the rationale?

International evidence base

Ward-Stockham et al. (2022) - Systematic review
Rates of conflict and containment reduced **(15 –26%)**
Improves **staff and service user cohesion**, encourage therapeutic relationships through **enhanced communication** and promote a sense of **calm and safety on wards**

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Safety Huddle

What are they?

Short, stand-up meetings for the whole team focused on safety now and over the next shift.

Standard 2

Safety huddles are held at least twice per day everyday and attended by a varied membership from the whole ward team.

What's the rationale?

Research evidence:

Supports patient safety in the broadest sense.

Taylor-Watt et al. (2017) - **40-57% reduction in violence**

Pimentel et al. (2018) - positively impacted: **efficiency**; **communication** across clinical roles; **situational awareness**, staff perceptions of safety; **safety climate**; staff **satisfaction and engagement**; clinical **care** e.g. decreased medical errors and adverse drug events

Local findings:

Reductions in violence, restraint and self-harm seen in wards testing safety huddles.

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DASA

What is it?
Validated scale that helps objectively assess risk of aggression.

Standard 3
DASA is used routinely including during safety huddles to inform responsive care planning

What's the rationale

Best Practice - **NICE** - NG10 - 1.2.11 Consider using an actuarial prediction instrument such as...the DASA-IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings.

Effectiveness - The tool is **better at predicting aggression** than clinical assessments by senior clinicians. (Griffith et al. 2013, Nqwaku et al. 2018)

Early evidence in younger and older mental health populations.

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Safety Pods and Deltoid IM

What is it?
Training in equipment to support safer restraint and injection technique for deltoid site.

Standard 4
All staff are trained and assessed as competent in use of SafetyPod and deltoid techniques. Safetypods are used routinely in planned and reactive restraint scenarios.

What's the rationale?

<u>Local evidence:</u>
Reduces average weekly prone use to close to zero

Staff and service users say it's better

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Mobile phone charging

What is it?
Short lead phone charges and USB charging plugs in patient bedrooms.

Standard 5
Ward bedrooms have USB charging points and wards have a supply of short charging leads available at all times. Patients are made aware of these at admission.

What's the rationale?

Part of work to **remove blanket restrictions**

Local evidence:

Service users like it

Releases staff time to care

Seni Lewis Training Programme

A whole system approach to improving quality of life, safety and experiences of mental healthcare for all

Black Thrive

NHS South London and Maudsley NHS Foundation Trust

Maudsley Learning

Background

2018

Case for change identified: Concern that restraint curriculum was no longer meeting the needs of Trust staff and patients

2018

Trust review launched: Wide membership review group created to investigate the efficacy of restraint training

2019

New Restraint Reduction Network (RRN) standards: Designed to protect human rights and support the minimisation of restrictive practices

2019

Review Report published: 20 recommendations across five domains to be implemented using Trust resources and community partnerships

2021

Co-Design & ongoing engagement: Core project team formed to create and implement recommendations

2022

Co-Design and implementation planning: Core design team ongoing work.

From Old to New

Restraint trainings ‘as is’	Seni Lewis Training Programme
Emphasis on restraining WELL	Emphasis on restraining LESS
Curriculum focused on physical holds and restraint	Curriculum focused on human rights, understanding communities and functions of behavior
An Us (Staff/institution) vs. Them (Patients) culture	Training based on patient and staff collaboration and fostering positive relationships
Focus on Risk	Focus on Prevention and Quality of Life

Course delivery structure

LEVEL 1

Aim: Understand and demonstrate fundamental principles of engagement and building positive relationships

Staff group: All staff

Length: 1 day

Delivery mode: Blended: - e-learning and face to face

LEVEL 2

Aim: Understand and demonstrate safe approaches to de-escalation building on primary approaches

Staff group: All staff in patient facing roles

Length: 1 day

Delivery mode: Face to face

LEVEL 3

Aim: Understand & demonstrate care planning, de-escalation, use of minimal physical skills building on primary & secondary approaches

Staff group: Clinical inpatient staff including Nurses, Medical staff, Allied health professionals & others

Length: 3 days (1/2 Day whole MDT)

Delivery mode: Face to face

PATIENT SAFETY ADVISOR PROGRAMME

South London and Maudsley NHS Foundation Trust

Looking Forward

Seni's Law implementation via Patient Carer Race Equality Framework (PCREF) Structures

Ongoing implementation of Seni Lewis Training programme

Focus on quality and sustainability of the 5 patient safety interventions whilst ensuring they are implemented business as usual.

NHS
Greater Manchester Mental Health
NHS Foundation Trust

Trauma Informed Care - Keats Ward

SALFORD ADULT ACUTE INPATIENT

#TakeALookAtMeadowbrook

Improving Lives

Overview

What is Keats Ward?

- Keats Ward is a Mental Health Acute Ward for Adults of Working Age.
- Based in Meadowbrook Unit, Salford, part of GMMH.
- Keats Ward has 18 beds.

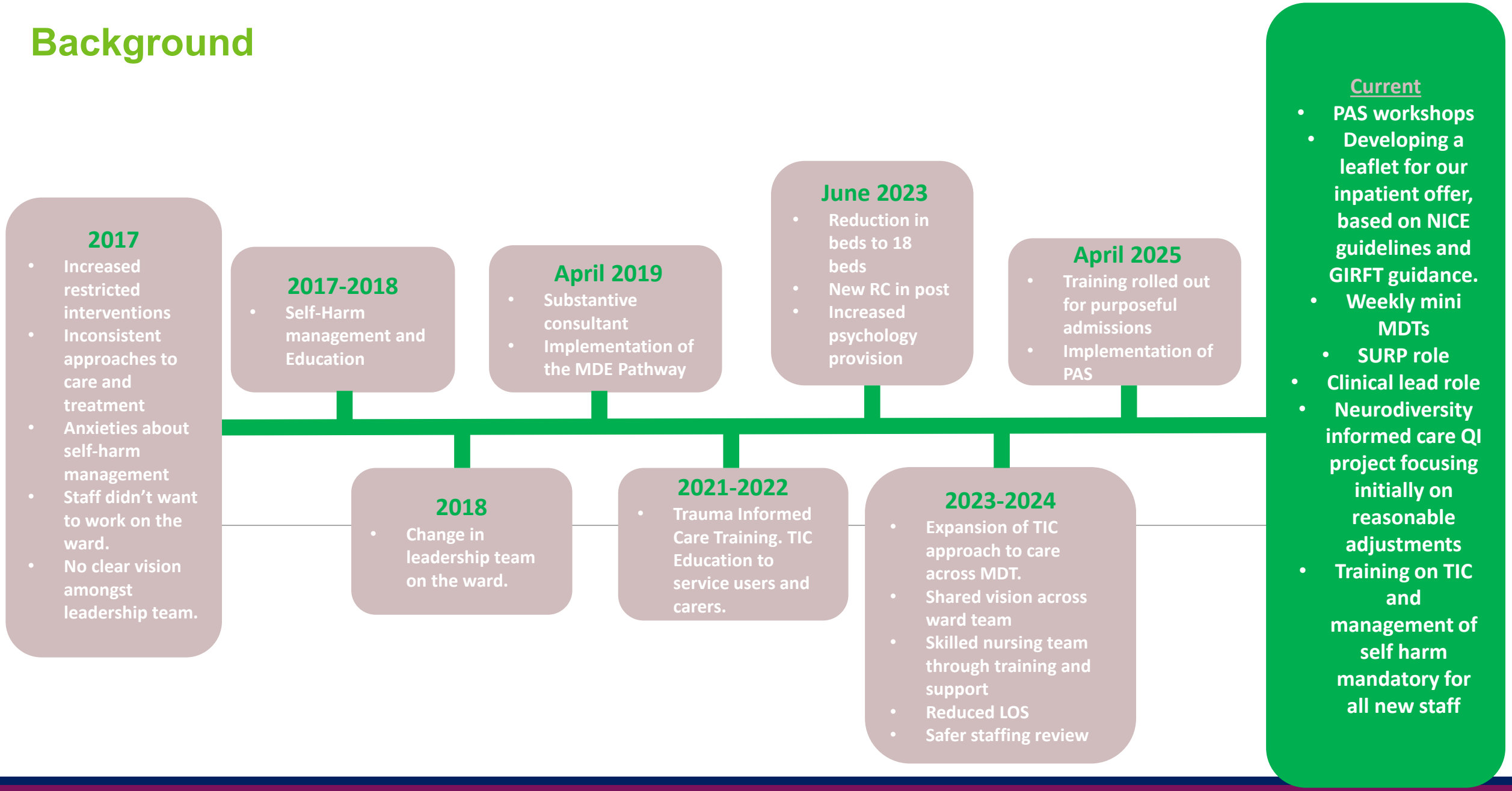
Multidisciplinary Team on Keats Ward

- Consultant Psychiatrist
- Junior medical team- ST, CT
- Advanced Clinical Practitioner
- Ward Manager
- Registered Mental Health Nurses
- Nursing Assistants
- Occupational Therapist
- 2x Support Time Recovery (STR) Worker

Multidisciplinary Team supporting unit

- Psychology- Principal Psychologist, Clinical Psychologist and Psychology Assistants
- PHCT- Physio, 2x Registered Nursing Associate

Background


2017
Increased restricted interventions
Inconsistent approaches to care and treatment
Anxieties about self-harm management
Staff didn't want to work on the ward.
No clear vision amongst leadership team.
2017-2018
Self-Harm management and Education
2018
Change in leadership team on the ward.
April 2019
Substantive consultant
Implementation of the MDE Pathway
2021-2022
Trauma Informed Care Training. TIC Education to service users and carers.
June 2023
Reduction in beds to 18 beds
New RC in post
Increased psychology provision
2023-2024
Expansion of TIC approach to care across MDT.
Shared vision across ward team
Skilled nursing team through training and support
Reduced LOS
Safer staffing review
April 2025
Training rolled out for purposeful admissions
Implementation of PAS
Current
PAS workshops
Developing a leaflet for our inpatient offer, based on NICE guidelines and GIRFT guidance.
Weekly mini MDTs
SURP role
Clinical lead role
Neurodiversity informed care QI project focusing initially on reasonable adjustments
Training on TIC and management of self harm mandatory for all new staff

A **Trauma Informed Care QI project**

- Trauma Informed Care training for all staff and professionals
- Trauma Informed Care leaflet created
- Proactive discussions with service users and carers about TIC and least restrictive management of self harm on the ward
- Development of collaborative mutual expectations care plans
- Education for carers around purposeful admissions
- Carer contact completed within 24 hours of admission using standardised proforma to gain important collateral information
- EDD set in initial MDT
- Criteria led discharges

Purposeful Admissions

Purposeful Admissions Formulations and Purposeful Admission Statement

- Initial workshop with Inpatient teams, reviewing what the inpatient offer is and what cant be achieved in community setting.
- Training- focusing on harms and benefits of admission, inpatient offer
- Roll out of Purposeful Admission Formulation/ Statement completed by MHLT, HBTT, CMHT prior to admission
- At the point of discharge, reviewing benefits of admission and considering any harms

Managing Difficult Emotions Pathway

Aim

The aim of the MDE Pathway is to provide support and structure to people who find it difficult to manage their emotions.

Compassion Focused Therapy

The MDE Pathway is underpinned by Compassion Focused Therapy (CFT). CFT focuses on 6 skills for development; sensitivity to own needs, care for self-wellbeing, non-judgement, empathy and distress tolerance. These skills aim to counteract the feelings of shame, worthlessness, fear and self-criticism which often lead to maladaptive coping strategies such as self-harm, aggression and substance misuse.

Individuals can be commenced on the MDE Pathway by their primary nurse following discussion with the individual, and where appropriate their family, friends or carers. The MDE Pathway may also be prescribed following ward round review with the consultant.

Structured Sessions

- Each week the individual will be offered three structured sessions. The sessions consist of two 1-1 sessions and a group session.
- If the individual requires support outside of their allocated sessions, staff will support them to reflect on their safety plan. This will encourage the individual to develop skills that will support their independence and help feel in control of their recovery.
- Both the groups and the 1-1 interventions have been created to be completed repeatedly, in order to support individuals to gain new skills.
- Should an individual be ready for discharge, they do not need to complete each intervention prior to discharge. Should they be readmitted at any time, they can be placed back on to the pathway and continue with the interventions.

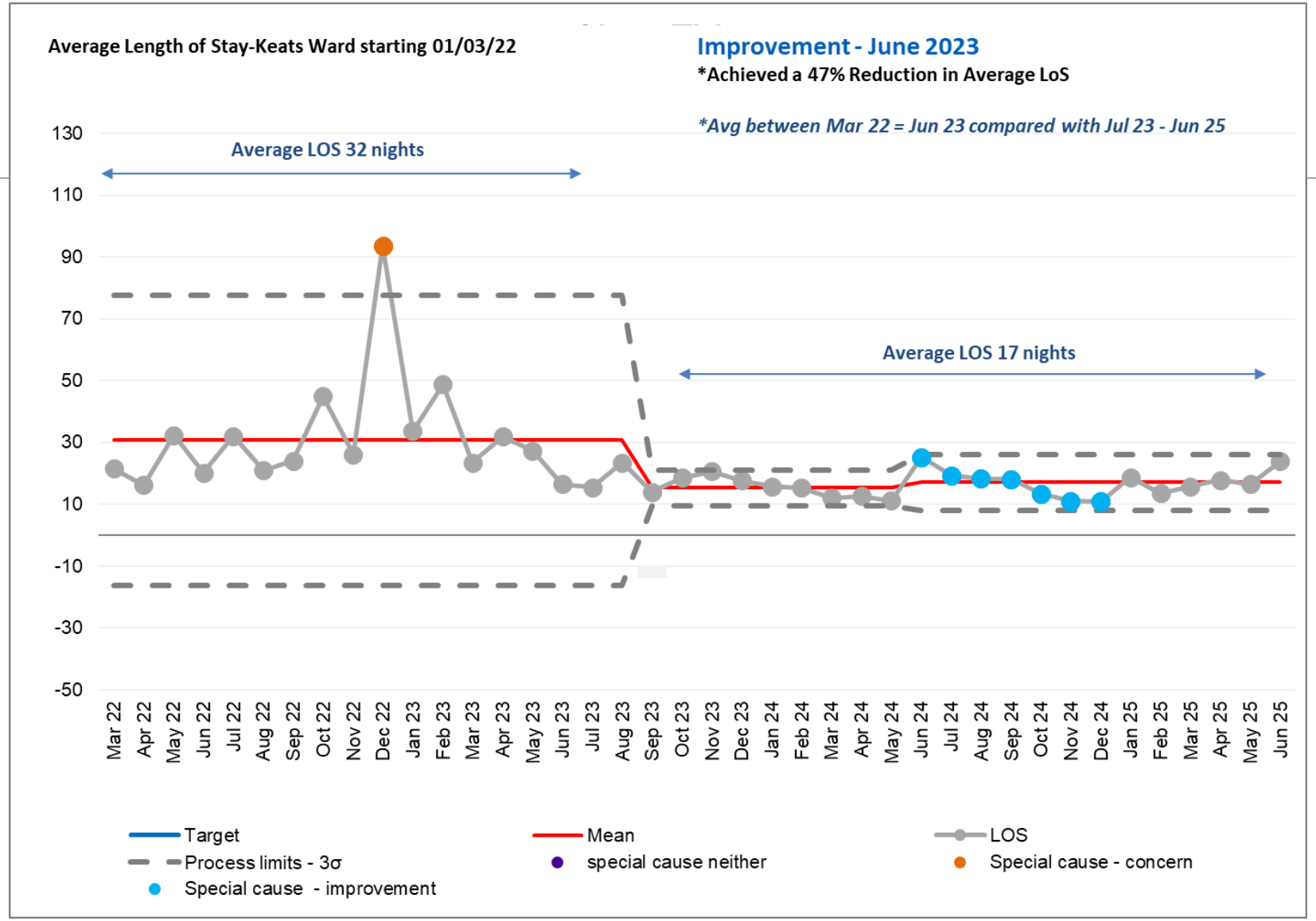
Trauma Informed Care Approach – Impact on PF KPI's
Good Quality Clinical Care = Reduced LOS = Reducing Restrictive Practice

Culture of flow being everyone's business- about the patient journey- right care, right time, right place

- Understanding of risk formulation in line with TIC
- Positive risk taking
- Least Restrictive Approach is always the focus
- Use of Criteria Led Discharges
- Collaborative Mutual Expectations
- Proactive ward management team providing clinical leadership.
- Realistic assessment of need.
- Support from inpatient SLT in managing risk/ support complex cases/ clinical leadership.
- Support from Lead Consultant in service development related to flow.
- Engaged commissioners.
- Flexibility of funding panel.
- Team work within the division re. complex cases.
- Effective boardround (clinical) and MADE
- Weekly mini MDT's
- Constant review of the PAS
- Constant review of onward pathways

Challenges

- Unclear purpose of admission - leading to unmet need/ unmet expectation
- Varied engagement from care coordinators
- Different practices across inpatient wards
- Need for trust process re. Complex Cases
- ‘Burn out’ of staff


Average Length of Stay-Keats Ward starting 01/03/22
Improvement - June 2023
*Achieved a 47% Reduction in Average LoS
*Avg between Mar 22 = Jun 23 compared with Jul 23 - Jun 25
Average LOS 32 nights
Average LOS 17 nights
130
110
90
70
50
30
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-10
-30
-50
Mar 22
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Target
Mean
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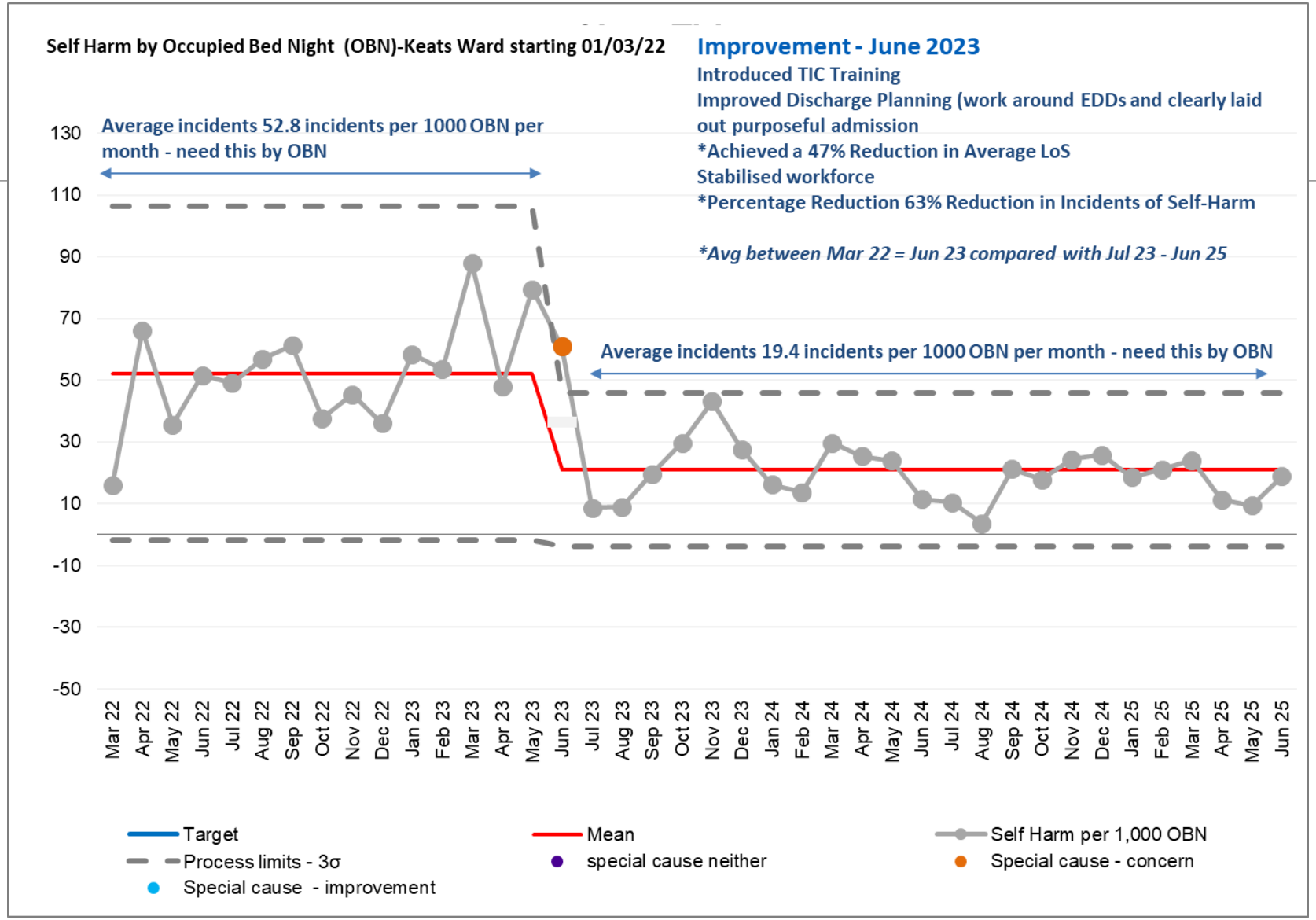
Process limits - 3σ
special cause neither
Special cause - concern
Special cause - improvement


Self Harm by Occupied Bed Night (OBN)-Keats Ward starting 01/03/22
Improvement - June 2023
Introduced TIC Training
Improved Discharge Planning (work around EDDs and clearly laid out purposeful admission
*Achieved a 47% Reduction in Average LoS
Stabilised workforce
*Percentage Reduction 63% Reduction in Incidents of Self-Harm
*Avg between Mar 22 = Jun 23 compared with Jul 23 - Jun 25
Average incidents 52.8 incidents per 1000 OBN per month - need this by OBN
Average incidents 19.4 incidents per 1000 OBN per month - need this by OBN
130
110
90
70
50
30
10
-10
-30
-50
Mar 22
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Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Target
Mean
Self Harm per 1,000 OBN
Process limits - 3σ
special cause neither
Special cause - concern
Special cause - improvement

Trauma Informed Care Approach – Impact on Quality Metrics

Culture of flow being everyone's business- about the patient journey- right care, right time, right place

- Reduction in self-harm incidents
- Reduced detention under the Mental Health Act
- Focus on strengths and what the patient can do
- Choice around care and treatment
- Minimal restrictive practices
- Improved patient experience
- Reduction in violence and aggression
- Reduction in complaints

I feel supported when on Keats because of the less restrictive approach. I found when on different ward my behaviour escalated because they would physically stop you and for me taking that choice away/ control from me was a big thing. Instead, they will see you, support you, take the time and try to deescalate the situation.

Having the less restrictive approach I have found has helped speed up my recovery as I have more control over myself and have learned to do this on Keats as the temptation isn't there. If I have felt overwhelmed, this is where the 1-1's have become effective by deescalating the situation.

1-1 always offered if you're feeling distressed or any issues. If they can't accommodate immediately, they will soon as.
MDE's are useful for having that therapy group chat.

Service User Feedback

#TakeALookAtMeadowbrook

Recently, whilst at Meadowbrook Hospital, I have been exposed to the treatment model of Trauma Informed Care. Trauma Informed Care and its inherent partner, Least Restrictive Practice, have been instrumental to my recovery. It has helped me recognise my worth, value myself as much as I value others and, perhaps most importantly, take responsibility.

Service User Feedback

#TakeALookAtMeadowbrook

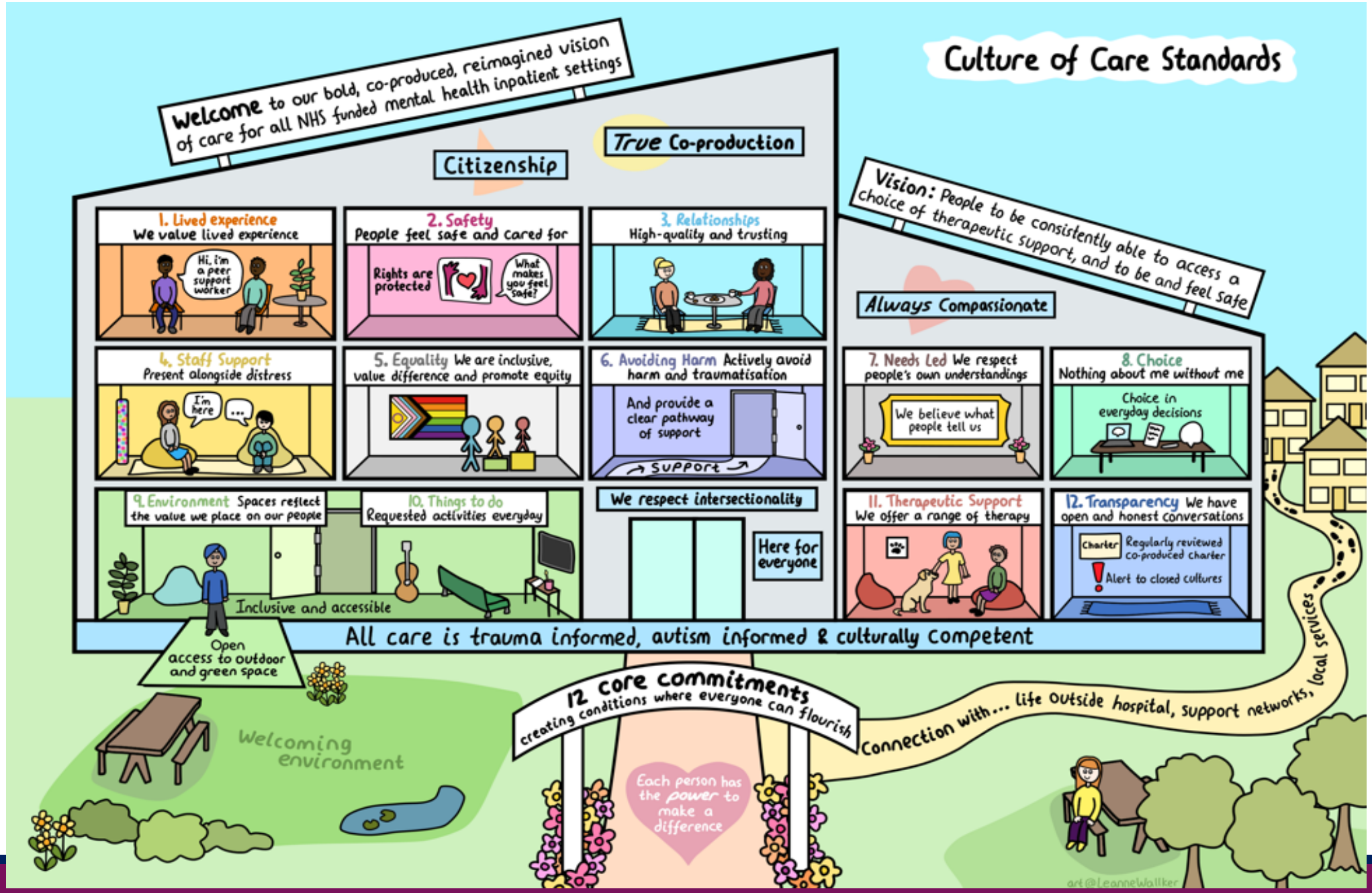
I was physically and sexually abused from a very young age. I was admitted onto a CAMHS ward at 17 and I self-harmed a lot during that time on the CAMHS ward. Staff would pin me down to the floor for hours and many times it would be male staff restraining me. I feel like I was retraumatised in services massively, and this caused deep emotional scarring. Keats tries to keep admissions short to make transitions to community less destabilising. Keats will rescind your section as soon as it is safe to do so to give you more control over your care. Keats offers the MDE Pathway which has been proven to be helpful for me and many other people. I think Keats Ward is a shining example of the way least restrictive practice should be implemented. As soon as I arrived on Keats I was informed about the model of care. My flashbacks have not been prolonged due to restraint. Staff manage situations by de-escalating verbally not by alarms/restraint. Keats has a calming, wrap-around, holistic model of care. I have not been re-traumatised on Keats Ward.

Service User Feedback

#TakeALookAtMeadowbrook

Mental Health, Learning Disability and Autism Quality Transformation – Culture of Care Standards and programme

April 2026


Culture of Care Standards
Welcome to our bold, co-produced, reimagined vision of care for all NHS funded mental health inpatient settings
Citizenship
True Co-production
Vision: People to be consistently able to access a choice of therapeutic support, and to be and feel safe
Always Compassionate
1. Lived experience
We value lived experience
Hi, I'm a peer support worker
2. Safety
People feel safe and cared for
Rights are protected
What makes you feel safe?
3. Relationships
High-quality and trusting
4. Staff Support
Present alongside distress
I'm here
...
5. Equality We are inclusive, value difference and promote equity
6. Avoiding Harm Actively avoid harm and traumatisation
And provide a clear pathway of support
Support
7. Needs Led We respect people's own understandings
We believe what people tell us
8. Choice
Nothing about me without me
Choice in everyday decisions
9. Environment Spaces reflect the value we place on our people
10. Things to do
Requested activities everyday
Inclusive and accessible
We respect intersectionality
Here for everyone
11. Therapeutic Support
We offer a range of therapy
12. Transparency We have open and honest conversations
Charter
Regularly reviewed co-produced charter
Alert to closed cultures
All care is trauma informed, autism informed & culturally competent
Open access to outdoor and green space
Welcoming environment
12 core commitments
creating conditions where everyone can flourish
Each person has the power to make a difference
Connection with... life outside hospital, support networks, local services
art@LeanneWalker

Core Commitments for Inpatient Mental Health Care

Core Commitment	Description
Lived experience	We value lived experience, including in paid roles, at all levels, including design, delivery, governance and oversight
Safety	People on our wards feel safe and cared for
Relationships	High-quality, rights-based care starts with trusting relationships and understanding that connnecting with people is how we help everyone feel safe
Staff support	We support all staff so that they can be present alongside people in their distress
Equality	We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes
Avoiding harm	We actively seek to acknowledge and avoid harm and traumatisation

Core Commitment	Description
Needs-based	We respect people's own understanding of their distress
Choice	Nothing about me without me - we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care
Environment	Our inpatient services reflect the value we place on our people
Things to do on the ward	We have a wide range of patient requested activities every day
Therapeutic support	We offer people a range of therapy and support that helps people to have hope things can get better
Transparency	We have open and honest conversations with each other and name the difficult things

Inpatient Culture of Care Improvement Programme

Executive Leadership Support	Enabling an organisational culture of continuous quality improvement working directly with Executive Teams, delivered through lived experience mentoring and reflective practice.
Cross Organisational Quality Improvement	Coaching support across organisations, working with teams such as corporate nursing, HR and Estates to realise the culture of care standards.
Ward Manager Leadership Development Programme	Leadership development for Ward Managers, developing confidence and skills required to support wards teams realise the culture standards together.
Staff Care and Support	Training and development spaces to explore building therapeutic relationships and relational approaches to care and team culture.
Quality Improvement for Ward Teams	Quality improvement coaching to ward teams over a two year period to realise change ideas in implementing the culture of care standards.
Personalised Approach to Risk: Practice Change	Supporting changes in practice from risk stratification to personalised approaches to safety planning. Delivered with lived experience leaders, through education, training and reflective practice.

Programme success

Every NHS provider of inpatient mental health, learning disability and autism services, including 6 of the largest independent sector providers, registered on the programme in May 2024.

Ward Teams & Ward Managers

- **380 ward teams** have participated in the programme.
- **180 ward managers** have completed the 3 month leadership & development programme.

Executive Leadership & Cross Organisation

- **101 Executives** have undertaken the coaching & mentoring programme, co-delivered with experts by experience
- **Cross organisational teams** have been thinking and working differently aligned to the Culture Standards

Personalised Approaches to Risk

- **10 pilot organisations** have been working to move away from risk categories and risk scores, to trauma informed, personalised approaches to risk and safety planning.

Promoting the equity principles

- **Publication of three supporting documents** that underpin the Culture of Care Standards – **Autism informed, trauma informed and culturally competent care.**

For further information please see the NHS England Culture of Care webpage

The 4 R's of trauma-informed care

Realise

Realise: all people at all levels have a basic realisation about trauma, and how it can affect individuals, families and communities.

Recognise

Recognise: people within organisations can recognise trauma, and how it can affect individuals, families and communities.

Respond

Respond: organisations respond by practicing a trauma-informed approach.

Resist

Resist re-traumatisation: organisational practices may compound trauma. Trauma-informed organisations avoid this.

Next Steps

Evaluation

- Each lead supplier to produce an evaluation report by June 2026
- Further independent evaluation being explored currently

Stakeholder engagement

- Working with CQC to discuss opportunities for embedding the Standards
- Celebration event planned for June 2026 to include key stakeholders and local commissioners

Embedding learning

- Learning networks continue to grow and come together nationally to share change stories and impact.

For further information please see the NHS England Culture of Care webpage and Futures page Mental Health, Learning Disabilities and Autism Quality Transformation Programme (MHLDAQT) - FutureNHS Collaboration Platform

Thank You

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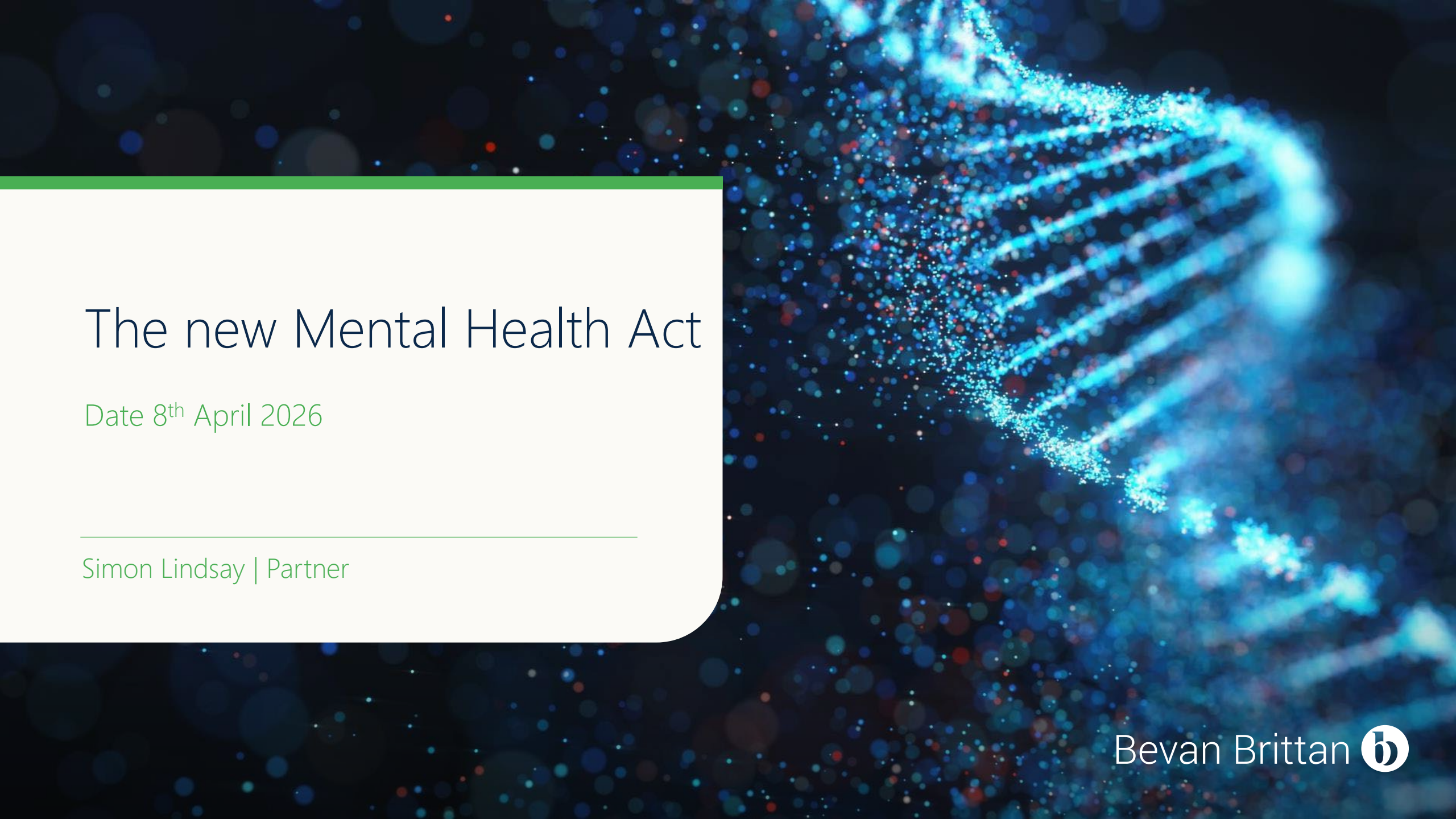
 england.nhs.uk



The new Mental Health Act

Date 8th April 2026

Simon Lindsay | Partner

Bevan Brittan

Royal Assent: 18th December 2025

Mental Health Act 2025

Amends the Mental Health Act 1983

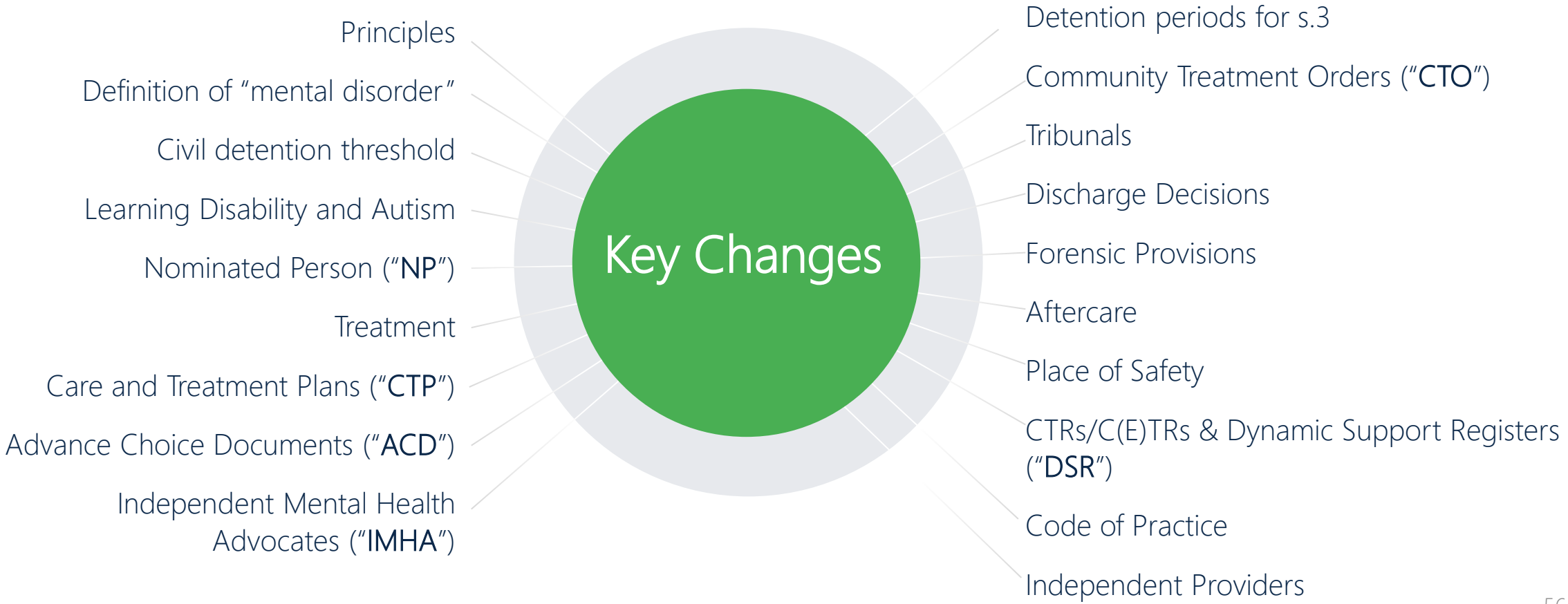
Mental Health Act 1983

Why the change?

- Rising rates of detention
- Racial disparities in detention and use of CTOs
- Negative experiences reported by patients
- Need to address impact of detention on people with LD and autism

The **New** Mental Health Act 2025

Key Changes



The **New** Mental Health Act 2025

Underlying Principles

Choice and Autonomy – involving patients in decision-making, ensuring their views and choices are respected, considering view of carers and other interested persons

Therapeutic Benefit – compulsory treatment only where it is effective and appropriate

Least Restriction – minimising compulsion and detention as far as is consistent with maintain patient and public safety

Person as an Individual – viewing and treating patients as individuals, with dignity and respect and considering their wishes, feelings and experiences

The **New** Mental Health Act 2025

Criteria for detention

Appropriate Medical Treatment	Treatment which has a **reasonable prospect** of *alleviating, or preventing the worsening of,* the *disorder* or one or more of its *symptoms or manifestations*;
Risk Threshold	**serious harm** may be caused to the health or safety of the patient or of another person (applies to detention and CTO)
Definition of Mental Disorder	Patient can only be detained under s.3/put on CTO if suffering a **psychiatric disorder** 'Psychiatric disorder' does not include Autism or LD

The **New** Mental Health Act 2025

Requirement for consultation

- When placing patient on CTO, new requirement to consult the community clinician
  - to confirm in writing that they agree the relevant criteria are met
  - on agreement to conditions
  - before varying or suspending a condition (unless consultation would cause unreasonable delay)
  - before recalling to hospital (unless consultation would cause unreasonable delay)
- To consult Nominated Person when:
  - Placing patient on CTO or revoking it
  - Placing patient on Guardianship
  - In relation to Care and Treatment Plan
  - Before transfer of patient
  - On renewal of detention, CTO or G'ship
  - On extension of detention, CTO or G'ship
  - For urgent ECT

New Mental Health Act 2025

Treatment under the Mental Health Act

- New requirement for Approved Clinician to create a Part 4 treatment checklist
- Treatment under s.63 can be given without consent for maximum of 2 months (instead of 3)
- Power to provide urgent treatment without consent where immediately needed to alleviate serious suffering limited to patients who are incapable
- Urgent ECT only if immediately necessary to save life/prevent deterioration with consent/consistent AD/LP or SOAD certification
- New requirement for Care and Treatment Plans

New Mental Health Act 2025
Safeguards

- Advance Choice Documents (ACD)
  - written statement about decisions/wishes and feelings relating to detention and treatment
  - Obligation on NHSE/ICBs to raise awareness and provide information
- New role of Nominated Person – appointed by patient or, if patient incapable, by AMHP
  - May apply to Tribunal if objections to detention not accepted
  - Power of veto for Guardianship CTO (subject to barring order)
- Timeframes for duration and extensions of detentions shortened to 3 months
- Enhanced role for IMHAs,
- Additional powers for Tribunals, shorter times for referrals
- Creation of Dynamic Risk Register for people with Autism/LD
- Extension of duties under Human Rights Act 1998 to independent providers (to include s.117 and informal patients)

New Mental Health Act 2025

UN Committee on the Rights of Persons with Disabilities recommendations (Aug 25):

- Mental Health Bill needs comprehensive human rights review. As a minimum it should prohibit deprivation of liberty on basis of impairment, remove language perpetuating medical model of disability (e.g. people with psychosocial impairments being called patients), introduce comprehensive community-based healthcare for persons with disabilities

Modernising the Mental Health Act, Final Report (Dec 2018)

- "*There needs to be a concerted, cross-organisation, drive to tackle the culture of risk aversion. This will need to include the Chief Coroner, CQC, NHSE, NHSI, ADASS, LGA, patients, carers and provider boards, to understand the cultural drivers behind their different conceptualisations of risk and how they can be harmonised*"

Bevan Brittan

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NHS Resolution

Thank you

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