
Monograph:
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UNIVERSITY OF LEEDS

West Yorkshire
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Evaluation of the Sensory Friendly Ward Project

A two-year pilot focusing on autistic adults and adults with sensory needs who access support within Mental Health secure services across Leeds and Bradford.

Evaluation report written and researched by Gary Blake, West Yorkshire Health and Care Partnership and Gabby Keating, University of Leeds

October 2024

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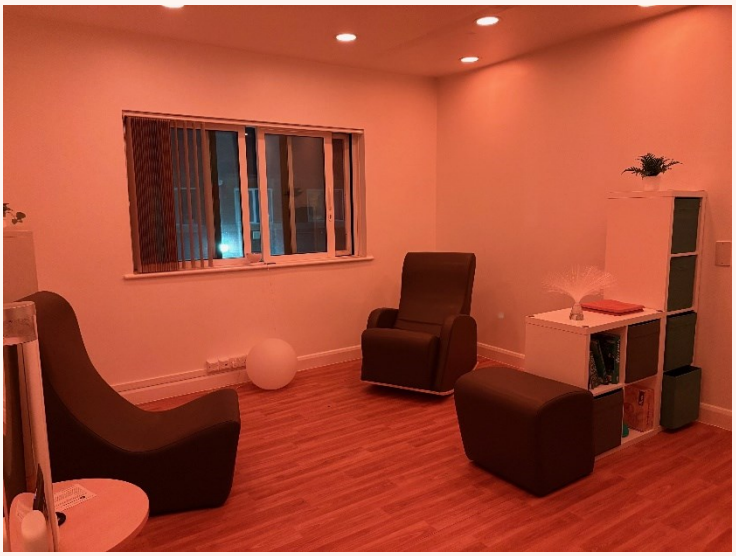
Summary

This evaluation aimed to test the proposals of the Sensory Friendly Inpatient Environments project within a range of high dependency adult mental health services across Leeds and Bradford. This project was a collaboration between Bradford District Care NHS Foundation Trust and Advonet / Autism AIM to improve the sensory experience of inpatient mental health wards through dedicated roles, resources, lived experience input, training, pathways and procedures.

After conducting interviews and field visits of two mental health wards, the main recommendations are as follows:

- Inclusion of other departments during ward assessments (building staff, health and safety staff)
- Necessity of dedicated project co-ordinator
- Maintaining progress with in-house sensory champion
- Consistent data collection and evaluation
- Promotion of equal access to training, particularly on neurodivergence
- Taking a trauma-informed approach.



Photograph of a “Make It Your Own Space” room

Introduction

What are sensory-friendly environments?

A recent publication from NHS England (2022) on resources to result in improvements to the sensory environmental for Autistic adults says:

> “Sensory sensitivities are related to the development and maintenance of mental ill health and impairment in everyday functional skills in autistic people of all ages. Yet the sensory environments in hospitals commonly evoke extreme aversive reactions from people with sensory sensitivities. For example, noisy or incessant alerts, strong smells of cleaning agents or food, fluorescent lighting, or unpleasantly textured materials. Typically, neither staff nor patients have flexible, autonomous control over the sensory environment, which can compound issues.”

> “Environments that are not ‘autism friendly’ can impede the effectiveness, or hamper the delivery, of therapeutic intervention, exacerbate poor mental health and lead to the use of restrictive practices such as restraint, seclusion or segregation.”

The Care Quality Commission’s (CQC) 2020 report, ‘Out of sight – who cares?’ reviewed the use of restrictive practice in hospitals and concluded that many ward environments are chaotic and non-therapeutic, often triggering behaviours that necessitated the use of segregation and restraint.

What were the aims of the pilot?

Written originally as part of the proposal for the pilot, the proposal aimed to primarily focus on Autistic adults (18 plus) with sensory needs who access support within MH secure services. The research team aimed to test the proposals within a range of high dependency adult MH services across Leeds and Bradford. This was to provide rich learning on the impact of our proposal across different clinical environments, with people who have very different support needs.

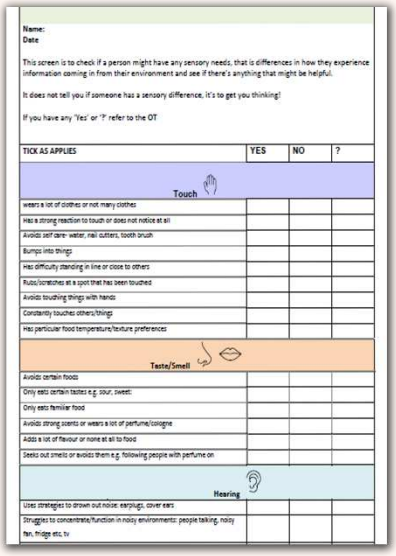
The project proposal identified the following priorities:

Advonet / Aim:

- To create routes for people with lived experience to feed into inpatient environmental assessments via training and toolkits.
- To conduct environmental assessments at identified sites and produce reports outlining recommendations.

A sensory champion to:

- **Develop staff awareness and knowledge** – to ensure staff have adequate training to improve sensory awareness and buy in to NHSE 'sensory friendly wards' principles at identified sites.
- **Develop pathways** - to embed a sensory pathway across four additional pilot sites split between Bradford District Care NHS Foundation Trust (BDCFT) and Leeds and York Partnership NHS Foundation Trust (LYFPT).
- **Manage and allocate resources** - to ensure identified sites had access to resources and adaptations to the environment in line with NHS England's 'sensory friendly wards' principles and informed by environmental reports by Advonet / Autism AIM.
- **Develop a sensory network** - development of a local / national specialist interest sensory network to support knowledge sharing.


Name:
Date:

This screen is to check if a person might have any sensory needs, that is differences in how they experience information coming in from their environment and see if there's anything that might be helpful.

It does not tell you if someone has a sensory difference, it's to get you thinking!

If you have any 'Yes' or '?' refer to the OT

TICK AS APPLIES	YES	NO	?
Touch			
wears a lot of clothes or not many clothes			
Has a strong reaction to touch or does not notice at all			
Avoids self care- water, nail cutters, tooth brush			
Bumps into things			
Has difficulty standing in line or close to others			
Rubs/scratches at a spot that has been touched			
Avoids touching things with hands			
Constantly touches others/things			
Has particular food temperature/texture preferences			
Taste/Smell			
Avoids certain foods			
Only eats certain tastes e.g. sour, sweet			
Only eats familiar food			
Avoids strong scents or wears a lot of perfume/cologne			
Adds a lot of flavour or none at all to food			
Seeks out smells or avoids them e.g. following people with perfume on			
Hearing			
Uses strategies to drown out noise: earplugs, cover ears			
Struggles to concentrate/function in noisy environments: people talking, noisy fan, fridge etc, tv			

Image shows the Moorlands View sensory screening tool

How was the pilot evaluated?

An evaluation team (which included two researchers from University of Leeds, Ka Yeung and Gabby Keating) worked with Gary Blake, Training and Development Manager, West Yorkshire Health and Care Partnership, to evaluate the effectiveness of the **Sensory Friendly Ward Project**. The team were provided with an academic overview and supervision by Professor Stephen Coleman, Professor of Political Communication at University of Leeds. The team worked from December 2023 to July 2024 and undertook thirteen transcribed interviews with a wide range of stakeholders including project team members, Clinical Team Leads, Senior Staff Nurses, Psychologists, Ward Managers, Occupational Therapists and Service Users.

In addition to these transcribed interviews, other interviews and discussions took place with other stakeholders and service users that were unrecorded but important in the research team developing their understanding of the development and delivery of the project. The research team also undertook five 'field visits' to different hospital wards in Bradford and Leeds. In addition, the project team reviewed different data sets including training evaluation, service user feedback, questionnaires, and other data.

In evaluating this two-year pilot, the research team focused on the following three elements:

1. Increasing Lived Experience Involvement.
2. Staff awareness training and support.
3. Improving Sensory Friendly Ward Environments.

Increasing lived experience involvement: introduction from Professor Stephen Coleman, University of Leeds

Too often we write reports evaluating great innovatory initiatives and we forget to ask the people they are intended to benefit to tell us what change means to them. The research reported here places people with lived experience at its core, based on the fundamental principle: Nothing about us without us. Learning from lived experience amounts to more than simply asking people to complete a questionnaire. It involves i) experiencing the environment that people with lived experience are being invited to reflect upon so that the researcher is

not merely asking questions about some exotic region of life; ii) enabling people with lived experience to add to the researchers' pre-prepared questions, raising new areas of interest that they might not know about; and iii) genuinely listening to the answers given by people with lived experience and paying attention to what they say as recommendations are devised. Gary Blake and Gabby Keating have admirably followed these principles in this evaluation study, every line of which is written with users' interests and sensitivities in mind.

Creating environments in which people feel comfortable is not just a challenge for mental health wards. It applies to classrooms, polling stations, football grounds, shopping malls and cafes. Too often we build things in our society to be functional, but not comfortable. Sensory wards arise from a recognition that small changes in a specific environment can release certain people from unnecessary stress and distress. As the report demonstrates, sensory wards depend more upon human awareness than massive infrastructural changes. I hope that the messages emerging from this evaluation and recommendations will result in kinder environments in which particular lived experiences can be fully acknowledged.

(Professor) Stephen Coleman, Professor of Political Communication at University of Leeds.

The Ward Reports

How were people with lived experience involved in this project?

The Advonet/ Autism AIM Group, based in Leeds, was the lead organisation for the element of this project that co-ordinated much of the involvement of increasing lived experience. This mainly focused on training and supporting people with lived experience to become "Ward Checkers" and to work with the project to use their experience and knowledge to develop new e-learning package for staff around sensory awareness. Advonet / Autism AIM have more than twenty years expertise in delivering high quality advocacy and developing innovative user led services.

People with lived experience becoming ‘ward checkers’

Advonet / Autism AIM developed training for people with lived experience to visit mental health wards and complete sensory reviews of environments used by autistic people using a co-worker model to help manage any overload. In developing this training, they developed a survey to gather lived experience feedback that would be used to shape the way it would be developed and its approach. The survey looked at people’s lived experience on mental health wards who are neurodivergent and have sensory needs.

In an interview with Advonet / Autism AIM they explained that they first envisaged developing the training and then to “get people who were volunteers” trained to undertake ward visits and complete ward assessments and complete written recommendations on how to improve these wards to make the environments more sensory friendly. It was also first envisaged that some of these ward checkers (or “ward sensory champions”) would be service users.

However, Advonet / Autism AIM explained that it was soon realised that this would mean,

> “Putting people who are going to be really overloaded by the environment, into a situation where you know it’s very challenging, whilst also getting the information down as well as dealing with what it’s like being on an acute mental health ward.” Because of this Advonet / Autism AIM explained that they “trained mostly people within our own team rather than other volunteers. This, rather than training people on the wards, as it was going to be more difficult and being in those environments.”

However, as nearly all members of Advonet / Autism AIM are people with direct experience of neurodivergence, this still meant that people with lived experience would be trained to become ward checkers.

In developing the training for ward checkers, Advonet/ Autism AIM worked with a consultant “who led a similar project for a children and young people’s ward.” A project worker explained:

> “It’s a generalisation to say that autistic staff members need 50% more time than non-autistic staff members, it very much depends on the person, but there is a lot of support that is needed there.” Advonet / Autism AIM also explained, “The cost in the first year were higher as they always are when you have to do more development”.

Nine people with lived experience were trained by Advonet / Autism AIM to become ward checkers and from 2022 to 2024, they visited mental health wards in Bradford and Leeds to undertake ‘sensory checks’ of wards. These visits were usually undertaken in one day and after these visits, comprehensive reports were produced outlining recommendations around improving the sensory environments of these wards to enable them to become more sensory friendly.

The reports outlined short and long-term recommendations which address the sensory concerns raised, and how to implement them via self-management and institutional provisions. For example, providing earplugs, or eye masks for all service users, or considering room allocation suitability for service users. As well as redressing the positioning of sensory adaptation tools, such as the wall placement of sound proofing tiles. In addition to this as the reports developed, they highlighted recommendations, not just around improving the sensory environments for service users, but also to highlight recommendations around improving the sensory environments for staff working in these wards.

Six of these reports were shared with the research team and each report averaged twelve-thousand words and varied in size from thirty-four to forty-three pages. As more reports were produced, they were refined and developed to include pictures and room-by-room assessments.

Advonet / Autism AIM explained that they first started off using the checklist and the tool that would auto-populate into an Excel spreadsheet (which proved more difficult to read and process the information in that format). They prefer now to write room-by-room notes that can be extended in detail that may not be listed on the checklist. They described,

> “Scaling is a learning point, for example, some of the scaling about whether they feel overwhelmed or whether it was painful was not something they felt could be answered in a 1 to 10 scale. A lot more flexible to use notes, either handwritten or using a tablet. Now have a two people going with the checker so they can do the social interaction and the other can do the checking and solely focus on the sensory environment. This has made the observations more detailed as they aren’t separated from the checking.”

Advonet / Autism AIM also explained that the writing of the reports was the hidden cost that they didn’t anticipate would take so much time. There is a lot of time needed to process the

report and the issues on the wards. However, writing the reports is essential, especially in a form that is accessible for other people and also ‘do it justice’ by putting in the detail.

Were staff experiences included in the report and recommendations?

As well as having recommendations around ways of improving sensory environments for service users, the ward reports also had information and recommendations around improving the environment for staff. Advonet / Autism AIM explained:

> “Since partnering with Bradford, trying to include staff experiences and the staff room area, because if the staff are in a heightened area, they won’t be able to support the sensory needs of other people on the ward.”

Advonet / Autism AIM gave an example of how they had spoken to an occupational therapist who was also autistic, and it was explained their needs are not being met on a daily basis as an autistic staff member. Some parts of the ward are under stimulating also as there is not a lot to do. For example, if there’s three colouring books / one TV channel, they can be institutionalised and people are under-stimulated and that can really change people’s experiences and mood, and the way they interact with people.

How and with whom were these ward reports shared?

Advonet / Autism AIM was asked whether after each time a Ward Report was produced was it only shared with ward managers, but also followed-up with a meeting arranged to discuss with ward managers. They confirmed that those in Leeds had at least two meetings with ward managers at Becklin Centre (one meeting before and a follow-up meeting). Also, normally they would get in contact after the report to allow time for them to digest the information and share it amongst the staff. For example, they had a brief meeting with a ward manager from a Bradford mental health ward in the staff room. They also explained that they offered ‘quick win’ solutions during meetings with ward managers, such as considerations around slamming doors or moving furniture which are no-cost solutions that can change people’s overall daily sensory experience.

Did these ward reports result in positive change?

Advonet / Autism AIM was asked, “How have ward managers taken the recommendations?” They explained:

> “Overall, there’s been some good buy-in, they’ve tried to streamline the process of both Advonet’s steps and the NHS steps so there’s more of a joined-up approach that happens in a sequential order. Good buy-in, as the average stay for an autistic person on the ward is 5.3 years, so there is clear demand there.”
>
> “If you’re looking at a invest-to-save agenda, then it pays huge dividends to get these things right. Lot of enthusiasm, more for the easy wins over the longer-term things.”

Advonet / Autism AIM were asked to give some examples of these “easy wins” that were implemented and explained:

> “Felted bottoms on dining room chairs have been implemented quickly in [a Leeds mental health ward] as it is very low cost and removes the scraping noise and removes the echo in the room. This will hopefully encourage people to eat in the communal space rather than their room.”

Advonet / Autism AIM also said there was:

> “Variation in attitude towards the recommendations in some of the wards due to difference in understanding and education around sensory training and sensory needs.”

What did ward staff think about the ward reports?

Interviews were undertaken with occupational therapist leads from a few of the mental health wards. They were asked what they thought of the produced reports and the feedback. They commented that the reports were very easy to read and clear what the recommendations were. They highlighted that it was nice they were included, and this clearly showed that they were produced by people with lived experience of the environments. Because of this, they showed a clear awareness of the fact of the actual environment itself and some of the

limitations of this environment and were “realistic with what would be implemented in an ideal world.”

The therapists also fed back that they felt the report was “a bit like a story” and the reports included feedback such as “quite overwhelming to go into your dining room at lunchtime because there was so many different smells, so many noises, people queuing.”

The occupational therapists were asked with whom and how were the ward reports shared, and they explained that they have been shared at the Green Light forum where they have autism champions on all the wards. Their Green Light champion was very involved in the reporting and involved in all the assessments that happen. They also explained that the reports had been shared with staff, including the leadership team to think about what they can easily change as well as the things that may take more consideration and time.

The occupational therapists were asked if and how work had begun on enacting or responding to the recommendations from the report and feedback; one of the wards is working on a welcome pack/induction booklet which picks up some the recommendations. This is going to highlight things like the layout of the ward, where things were, signage, and it will be taken through a governance process once it has been put together. This process is being managed in house by the ward managers, but that “quick wins” were already being enacted. One example of this is the introduction of sensory lighting for both service users and staff.

Were recommendations from ward reports responded to in the same way across all wards?

In discussions with Advonet / Autism AIM, the research team asked if meetings or discussions were arranged with ward managers following the publication of the Ward Reports, for which the ward managers had responsibility for. Advonet / Autism AIM confirmed:

> “Yes, normally contact was made after the report was shared to allow time for them to digest it and share it amongst the staff.” They did though give an example of where a specific ward that “had a friendly ward manager who had good buy-in” but they “haven’t heard from them since the report was sent.”

In response to this, the research team decided to contact this specific ward to ask for a meeting to discuss the ward reports with relevant ward staff and to discuss and review the progress that had been made in planning and implementing these recommendations. As participants in this research were offered anonymity, we are describing the ward as “ward 1.”

The ward visits took place April 2024, which was approximately fifteen months after the ward report had been undertaken. Prior to the ward visits, the research team curated a checklist based upon the recommendations from the initial Advonet / Autism AIM report. When organising the date to visit the ward, the staff were informed of the aims of the visit and sent the checklist to look at before speaking with the research team during the visit.

The aim of the visit was to go through each recommendation on the sensory environment and discuss their practicality, benefit to the service-user and the overall benefit to the wards.

Conducting ward visits

Discussions with staff at ward 1

At the meeting with ward 1 staff to discuss the Ward Report and the implementation of the recommendations, staff were asked, “What were your first thoughts when you saw the report?” The ward manager explained that they thought it was an “exceptionally long document, I do like the pictures, they are really helpful, but aside from that I don’t think it is something that everyone is going to just sit and read.” They were asked to further elaborate on this and said:

> “As a ward manager I would obviously take the time to sit and go through it but if I was disseminating this to my team they would not sit and read this document as it is so long. It would need to be something much shorter, a couple of pages or just a snapshot, these are the key points, for them to get a grasp on what the main outcomes were and then obviously any of the questions they can come to me. I would obviously send the full report, but I know that for a document that long they are not going to just sit and read it. They just want the key points – just what they need to know.”

Another member of staff said:

> “I agree, I think, I can appreciate a detailed report which it is, but if I am thinking outside myself and how other people may receive that, I can’t honestly say that I would then trust that people would go through it themselves. I know my manager will read it but to take that information and hand that on to the rest of the staff, I know for a fact she will be sat in the office thinking I know no one is going to read that and if they say they have, they have probably skimmed through. If there was a way it could be condensed or just summarising the key points and then if a member of staff wanted further explanation or wants elaboration on certain points, then at that the point the full report can be referred to. If the full report is what you are asking people to read first then I am not entirely sure they will, if they say they have I would not trust exactly how much they have taken in.”

During the interview staff were asked “What sort of training are staff offered around sensory needs, autism or ADHD, for example?” The response to this question was:

> “It’s very limited, obviously there is the online Green Light Autism training but in terms of other neurodivergent training, it’s very limited, there isn’t anything face to face, there no training regarding understanding neurodivergent issues, it’s very reliant on staffs’ experience and knowledge.”

Staff were asked “Do you feel that staff here would be confident in adapting the sensory environment?” They disclosed:

> “I suppose it depends on what level – I would like to think that staff, even if they didn’t have that experience ….that they would seek further guidance on that and speak to a Senior Nurse or other members of the team about what support can be provided. Signage and things like that – absolutely fine, one of my OT’s is really good at that.”

The research team were keen to find out what contact or follow up had happened following the sharing of the ward report. Staff fed back:

> “There was no one that has been out or has come and seen us about what we can do, what we can change.”

Another team member commented:

> "No, I think it has been down to ourselves and to take what we need to do which is fine I guess but again it's tough when there are things, we put in place immediately and there are going to be things that are more long term and complicated. I think confidence is a thing to bring up as well, we are confident in being able to identify what changes need to be made. But you can't expect other members of staff to have that level of confidence, if I'm not on shift or I don't do the admission or if there is something that isn't picked up on then it is kind of up in the air that point and it's just a case as and when it is recognised. I think generally we are very good at it here and we do what we can, when we can and to the best of our ability of what we are working with but there is always that route for improvement."

Ward 1: Summary of recommendations and implementations made since the ward report

Following the meeting with the ward team, the research team discussed the recommendations made in the Ward Report and first discussed these recommendations and then accompanied a ward team member to see and identify how many of the recommendations in the report had been responded to. The research team identified 48 different specific recommendations from the ward report for Ward 1 and the following is a categorisation of these 48 different recommendations and a summary of how many of the recommendations had been implemented:

1. Long-term recommendations needing significant investment

Eight recommendations were identified as being long term and ones that needed significant investments. These recommendations including things such as sound proofing noise from the car park and installing a new alarm system.

Of these eight recommendations, none had yet been carried out as they were long term recommendations that needed significant capital investment.

2. Medium-term recommendations

Five recommendations were identified as being medium term. These recommendations included things such replacing tilling for sound reasons and changing the colour of lights on the wards. Of these five recommendations none had yet been carried out.

3. Short-term and quick fix recommendations

Thirty-five recommendations were identified as being short term or quick recommendations. These recommendations included things such as ensuring lamps are available for staff and service users, swapping cleaning products for unscented alternatives and the labelling of cupboards. Of these thirty-five recommendations, eight (19%) had been fully completed and four (11%) had been partly completed.

What were the reasons behind unresolved quick-win recommendations?

In discussions with Ward 1 staff team, it was identified that approximately 20% of these short-term recommendations had not been completed due to reasons relating to “Health & Safety”, “Infection Control” and “Risk Factors.” Examples of things this applied to were providing barriers to unwanted to textures, changing the plastic chairs in the art room and moving stationary bedroom furniture.

In addition to this, approximately 10% of these short-term recommendations had not been carried out as they were no longer applicable. For example, having instructions on how to access the building; there was now a full-time receptionist that was able to give this information. Another example of this was around a recommendation of providing communication guides to improve staff support when services users are taking part in self-catering – service-users now have induction meetings with staff to identify the support they require to take part in self-catering.

Why is it important to understand communication issues from neurodivergent service-users?

Other examples of quick win recommendations not carried out included such things as offering written information on menstrual support, more signage in bathrooms and providing

written guidance on support around acquiring heat packs, or water bottles. When reasons were explored with the ward team on why these recommendations had not been carried out reasons given included: “if this was needed it would be available”, “service users can personalise their rooms with own possessions” and “service users are informed on induction of this information.”

While the research team had confidence that if service users had requested things such as heat packs or water packs that they would be provided, this was reliant on service users being both aware that these things were available and having the skills and confidence to ask and request.

In a report titled ‘More than words: supporting effective communication with autistic people in health care settings’ (Economic and Social Research Council and University of Brighton, October 2022) it explains: “Many autistic people will, at times, experience significant difficulty using words to express themselves.” The same report also explains “the autistic patient before you may be having a vastly different experience of thinking, speaking, listening, seeing, and knowing their feelings.”

Because of this, the research team felt it was important that a more proactive approach to providing support to service-users could have been adopted and not to assume that information given at induction or relying on service users to identify and verbally communicate their support needs, was the only approach to take. Therefore, it was felt that if staff had more training around neurodivergence and sensory needs, more of these “quick wins” would have been achievable.

Can there be a compromise on sensory needs provisions being unimplemented due to generalised safety guidance?

While the ward report for Ward 1 had led to several quick-win recommendations being carried out, several had not been carried out due to reasons given around “Health & Safety”, “Infection Control” and “Risk Factors.” It was not possible for the evaluation team to know if these reasons meant that it was impossible to undertake these quick or easy wins, or if there were alternatives that could be implemented that did not go against “Health & Safety” or “Infection Control.”

The research team felt it was potentially important for the wards to think about ways to measure the “risks” of not undertaking these quick wins to improve the sensory environment alongside potential risks of “Health and Safety” and “Risk Control.”

Is there a need to provide training to mental health ward staff?

One person interviewed as part of this evaluation expressed the view that:

> “Working in cooperation and offering the reports and the training in unison is much better than being delivered separately.”

Discussions with different ward staff clearly showed that not all wards had responded to ward reports in the same way. This is to be expected and is clearly linked to knowledge, experiences, levels of awareness, motivation and especially levels of confidence in doing so. In an interview with Advonet / Autism AIM around how wards had responded to the recommendations, they reported:

> “There had been variations in attitude towards the recommendations in some of the wards due to difference in understanding and education around sensory training and sensory needs.”

This view was shared by a senior nurse when discussing progress in implementing the ward report, who said:

> “I think confidence is a thing to bring up as well, we are confident in being able to identify what changes need to be…but you can’t expect other members of staff to have that level of confidence. I think generally we are very good at it here and we do what we can, when we can and to the best of our ability of what we are working with but there is always that route for improvement.”

A psychologist who was interviewed as part of this evaluation said:

> “Sometimes people underestimate the resistance to change” and “The wards and the teams on the ward’s face a lot of pressures and it is a very emotionally demanding job.”

Another member of staff working on a ward explained that there was a need to get a better "buy in" and a realisation that the "initial investment will pay dividends".

In an interview with Advonet / Autism AIM they explained they had "big concerns" around whether the process (report recommendations) had always been followed and the sustainability as then the changes can be lost. They also said that they would like to incorporate more contact in the future to improve buy-in.

A member of the project team discussed how they thought the ward reports and recommendations could be supplemented with training and suggested:

> "Share the report first and then training as follow-up to maintain momentum and sustainability."

The research team thought having a model of where ward reports were shared alongside training for ward staff would have a positive and beneficial effect in improving "buy in" and in improving "sustainability." This suggestion was also echoed by Advonet/ Autism AIM who said:

> "Good in the future to have more direct training with staff from Advonet/ Autism AIM's side. Training can be applied larger than just autistic people. Having lived experience angle in training is important. Risk that buy-in and enthusiasm will get lost."

Evaluating after the ward visits

What were the benefits of conducting two ward visits?

While there had been clear positive changes to ward environments as a direct result of the ward reports, the research team felt that if there should be a formalised model that included a follow up visit. This should take place approximately six to twelve months after the ward report had been shared and this visit should focus on looking at how successful the ward had been in implementing the recommendations.

In supporting the wards to undertake positive ward changes, a summary checklist should be produced for wards that is shared alongside the full ward reports. These should be similar to

the recommendation checklists that were produced by the research team that were used to audit the number of ward recommendations that had been carried out. These checklists could be regularly updated by wards and used as a "live document" to review and update progress being made in undertaking the ward recommendations.

These checklists could also be used in the follow up ward visits in checking progress made in implementing positive changes. This suggestion was supported by Advonet / Autism AIM who felt having a second ward visit would mean you are "able to see growth, buy-in and accountability." Also, during this second visit advice and support could be given to staff around ways to implement the recommendations not yet undertaken and also give advice on ways of sustaining the recommendations that had already been undertaken.

These recommendations should not be seen as a criticism of the way that the ward reports were undertaken and produced, as there is a recognition that there were not the resources available to Advonet/ Autism AIM to do this for all the wards that reports had been produced for. Also, it cannot be understated how challenging it can be at times for VCSE organisations, such as Advonet/ Autism AIM, to develop partnerships with statutory organisations such as the NHS. When this was discussed with Advonet / Autism AIM they explained:

> "The ethos of getting the third sector and the NHS working together is a great idea but practicalities are different, but this is good example of where it's worked."

This pilot project was just over two years old, which is a relatively short amount of time in developing a meaningful cross-sector partnership, but there are clearly examples of "where this has worked" and there are opportunities to "make it work more."

In terms of practicalities, the research team had experience of how challenging this can be as it took the team several months to arrange the first ward visit.

What is the value of having a sensory champion working "on the inside"?

Within Bradford District Care Trust (BDCT) a "sensory champion" was recruited to promote and embed the benefits of sensory skills within mental health inpatient services. For the second half of this project this person was "Freddy" and much of their work focused on doing this within wards in Bradford.

The aim of this approach was to take a “whole system approach” at one specific mental health ward to improve the sensory environments within mental health wards. This approach included the development and delivery of training, providing support and advice to staff and working with staff to implement positive change to the ward environments.

Having someone “on the inside”, i.e. working within the NHS had many advantages compared to someone that was working within a VCSE sector organisation. As the Sensory Champion was mainly “based on site” this meant they could do things like being involved in ward inspections with estate teams, knew the limitations of what could and couldn’t be achieved through navigating challenges around some of the things relating to “Health and Safety”, “Infection Control” and “Risk Factors” that can sometimes challenge or stop the implementation of positive change.

Staff working in the ward were asked what they thought about having a sensory champion (Freddy) based there and said:

> “Feedback from staff has been about her positive passion”, “Freddy has been a really good champion to really communicate things clearly” and “She frequently visits which is a plus.”

A project team member said: “Helpful to have Freddy who is passionate and takes on those barriers head on to continue the partnership.”

What did service-users think about the sensory environment at Freddy’s ward at the start of the project?

Near the start date of this project (April – June 2022), service-users from different wards were asked in a survey how they felt the current sensory environment impacted them. Examples of typical feedback included:

> “It just make(s) me feel irritated and sometimes makes me mad”, “It makes me feel dull, uninspired, less happy and it doesn't feel homely” and “I feel anxious and shaky and nervous, and I go into fight or flight and feel like I need to protect myself.”

Service-users were also asked: “How did this ever affect your engagement in things you would like or need to do?” Typical of responses included “I will stay in my room”, “I can’t sleep or relax” and “I want to be able to do more activities, but they are not many available.”

In this same survey, service-users were asked to identify from a list of eleven suggestions “Which if any do you feel may help?” From this list, the following four ranges were most identified (% of service users that identified this change):

- 72% - Environmental adaptation to reduce overall sensory input on the wards such as, removal of fluorescent lighting, buffers on doors and cupboards, limited clutter in communal areas, reducing noise and smell.
- 62% - A quiet space where you can control the environment with everyday items to regulate your sensory system.
- 47% - Items for you to use on the ward environment such as noise cancelling headphones, hats and caps, sunglasses etc.
- 42% - Staff trained in sensory processing to help them to support service users with sensory needs.

Did having a sensory champion lead to positive changes in the sensory environment?

Having a sensory champion on-site had led directly to things such as adaptations to lighting, changes to unscented cleaning chemicals but also the development of a Sensory Room – or a “Make It Your Own Space” room. Other positive changes viewed in this centre included newly installed fish tank within wards, many service users had “adopted” and given names to “their fish” and taken responsibility for looking after them. A psychologist when discussing the newly installed fish tanks said they had:

> “[This] helped some service users to have focus and something they are caring for”.

A member of the project team said:

> “Massive factor in mental health wards is to have stimulation, instead of the only real activity being a TV in the communal area and some rooms are underused.”

There were also pet rabbits that a member of staff said service-users "[found] them soothing to hold them and look after them." Another staff member explained that the idea of having rabbits was first discussed about two years ago and at the time they saw a lot of practical hurdles to get them in, but even now there were times when it is difficult to get funding for their feed.

In the Bradford District Care NHS Foundation Trust, Quality Account 2022/23 (page 82) it identifies how these "therapy rabbits" have statistically reduced "antisocial incidents on the ward."

It reported that one of the wards "has also adopted two therapy rabbits, which are fully cared for by the Service Users, where their hutch, run, and diet are tended to by our service users. This has seen the biggest impact on our service users in improving a caring culture on the ward, and statistically reducing abusive and antisocial incidents on the ward."

What do staff think about the 'Make It Your Own Space' room?

In a staff survey at beginning of the project (June 2022), staff were asked: "Do you ever notice the ward environment affect service users' engagement in their recovery?"

Several staff identified the difficulty of not having a private space to meet with and to support service users. One member of staff reported:

> "Lack of 1:1 private space on [one particular] ward. Doing 1:1 in communal areas with people coming into the room or walking past."

Another fed back:

> "Unfortunately, there is no suitable private space on the ward meaning 1:1 time is often spent in the Dining room or the lounge which other service users come and go from which is obviously distracting."

Within the sensory friendly ward project, some resources were allocated to purchase a limited amount of equipment such as individual dimmable lighting, "sensory suitcases" and resources to set up a sensory room, or what was named at Freddy's ward, a "Make It Your

Own Space” room. This room had been developed and resourced through this project. Both staff and service-users make use of this space.

Staff report they were using the “Make It Your Own Space” room when working with service users but also that some staff were using it on their own breaks and mentioned it was good for their wellbeing (as well as for the times they were with service users).

Staff were asked: “Were there any benefits of having this space to meet with “service users?” Staff reported it was great to have “Space away from the ward”, “People have found them quite soothing” and “Chairs have had good feedback and are quite soothing with the rocking.”

A psychologist said: “It’s confidential, quiet and a regular space that you can have every week” and then went on to describe how the space helps regulate and avoid service-users becoming overwhelmed. They also described how use of the light sensory aids (with fibreoptic threads) “has helped one service-user as he used it as a kid so has a memory link with it.” Another member of staff described how having this space meant they now had a place to meet with service users that they knew was not a “moving room” and explained “we don’t have protected one-to-one rooms on the ward.”

What do service-users think about the ‘Make It Your Own Space’ room?

Staff were asked what they thought service-users thought about the “Make It Your Own Space” room and they described that service-users are enjoying being able to change the lighting; they think it’s “cool” and “nice to have somewhere to relax”.

In interviews conducted by the research team with service users’, comments fed back about the room included: “I could come here when I’m feeling stressed and talk to someone”, “It’s really good”, “I could spend all day in here, how long can I stay?” and “It really helps me.”

The research team also undertook a transcribed interview with a service user that regularly used the room, they were first asked: “What makes you use that room?” and the service-user responded:

> “It's secluded. It's away from the ward. No one can hear me because I've got a loud voice and you think I wanted everybody to hear me, but I don't, especially some of the more sensitive things that I'm saying, I don't want anybody else hearing. It's hard

enough for me to tell the staff that I'm talking to without, I've got a fear of it being used against me by other patients or anybody you know. I like to talk in private."

The service-user was asked in what situations they used the room and responded:

"I have psychology in there so I can talk about my feelings, what I'm thinking, how I'm feeling, things that I don't want anybody else to know. I don't even want the psychologist to know really, but I'm trying to get help…So I've had to lower my guard and open up a bit and be very truthful and honest and say these things that worry me and how I feel and what I perceive as faults which I wouldn't normally tell anybody in the world. So it's strange to do, but yeah, there it's, it's off ward, it's secluded. Hopefully nobody can hear me and that there's lights in there and a rocking chair."

The service user was asked: "Were things different before this room was available and have things changed?" They confirmed this to be true by saying:

"I've done it many a time when I've been talking to staff on the ward or the ward manager and when I'm starting to come out with stuff that I think sensitive I don't want no one else to hear. I thought to myself don't say this, don't say that. And then I've toned it down or said something similar, but a bit different because I'm weary of being overheard through the door to the ward. So yeah, I have changed what I've said, not said…so it does make a difference."

"Before I'll be careful what I said, but.. maybe I won't even initiate talking to staff through fear of being overheard. I would just sit in my room, and it would go around in my mind, round and round…I wish people understood, I wish people could get me. I want the staff to be to see, but I don't want no one else to be able to see…. So it does make a difference."

Conclusion on the "Make It Your Own Space" sensory room

The opening of the "Make It Your Own Space" room has undoubtedly lead to positive change at the ward; both for service users and for staff to have designated room to support service-users and for staff to use to relax during their breaks. All these stakeholders have provided evidence of this positive change. Staff talked in terms of "space away from the ward" and

how this allowed them time individually to think about their wellbeing but also a space to support service users that was “confidential” and a space that was not a “moving room.”

Service users talked about it being a space “I could come here when I’m feeling stressed and talk to someone” and another service user talked about how they now had a space where they can now “talk about my feelings, what I'm thinking, how I'm feeling, things that I don't want anybody else to know.”

What are “sensory suitcases” and “calm at night packs”?

Sensory suitcases were developed in the first year of this project as an important aim of the project was to develop a bank of sensory aids to support individuals. First developed were “calm at night packs” and the “sensory suitcases”.

The sensory suitcases contained things such as bouncy balls, fidgets, lights, cushions, artificial plants, room sprays, noise cancelling over ear headphones and weighted blankets. The costs of buying the items for the suitcases was relatively small, being around £160 per suitcase.

The suitcases were given to wards for risk management when deemed appropriate, two suitcases were given to the resources library with the suitcase only being accessible to qualified staff who had completed sensory training. Many wards in Bradford are now actively using these suitcases but there have challenges in having them available for use in wards in Leeds.

How are the sensory suitcases used?

A ward staff member explained that after sensory awareness training that had been delivered as part of this project, it had ignited interest in making the ward more sensory friendly and now staff wanted to have something practical to use.

Another member of the ward staff said about the sensory suitcases: “Staff are enthusiastic for them as they are an answer to a massive unmet need” and another feedback: “Staff want to offer better care and opportunities that provide extra learning.”

However, challenges in undertaking seemingly quick wins to ward environments is exemplified by the sensory suitcases. When these challenges were discussed with occupational therapists from Leeds, they explained that their trust has different stances to Bradford's trust in using some of the things, such as the weighted blankets.

They also explained when discussing the "wobbly cushion" that these "can be used inappropriately by staff that may not be aware of the how it affects an individual."

Another occupational therapist fed back on them "balancing potential risks" around using a massage ball that was in the sensory suitcase:

> "Using a tactile massage ball may show as effective, but there are nuances on how it must be used for that person that need to be considered too and not just added to their care plan without these extra prompts detailed."

Staff also raised concerns about the need that training was provided for staff that would use the suitcase with service users and a member of staff said:

> "Having clarity with the staff over the expectations and understanding how to use them is important".

However, despite these challenges and more than two years after this project began, in July 2024 agreements have been on ways and how to use these sensory suitcases both in Bradford and in Leeds. While these suitcases are an example of positive changes can take time within NHS settings, it also demonstrates on how having a sensory champion can lead to positive changes, even when, in the words of a project team member, "Experiencing stumbling blocks in terms of getting it all started".

How did sensory and autism training develop as a result?

A member of the project team said:

> "Staff don't feel as skilled with things like sensory difficulties or people with autism diagnosis as they do with people with mental health disorders."

One of the ways that this project aimed to make staff feel more skilled around sensory needs and autism was through the delivery of training. On-line training was developed by the Sensory Champion from Bradford District Care Foundation Trust. Five different online training videos were developed and an introduction to the videos explains: “By watching these videos, we will…better understand how people may feel and behave if they have sensory processing differences and how the sensory information impacts us individually!”

Each of these five training videos are approximately seven to eight minutes in length and cover: “What is sensory processing?”, “How senses are processed differently?”, “impact from sensory processing differences” and “How to improve sensory friendly.” The fifth training video was of two service users discussing the sensory environment at Moorlands and how this affects them. These training videos give a good introduction to Sensory Awareness from the viewpoint of both staff and service users. These training videos can be accessed by staff via a link and can be viewed at a time suitable for those watching. Data showed that these five training videos were watched a total of 136 times since they were developed.

Has there been a change since this training?

As well as developing and delivering on-line training, the sensory champion also developed and delivered in-person training around sensory processing and another training session around autism awareness. A range of staff took part in this training including occupational therapists, staff from estates and maintenance and other ward staff.

The research team looked at surveys with staff (carried out at beginning of the project in June 2023) and then then fifteen months later (carried out in September 2023). The findings from these surveys are as follows:

- Autism awareness training – at start of the project data (June 2023) showed that 38% of staff had participated in this training over the last two years, but at the time of a second survey, (September 2023) this had increased to 69% of staff having participated.
- Sensory processing training – at the first survey data showed that 60% had participated in last two years, after this had increased to 100% of staff having participated.

Training data was examined that asked participants to rate their knowledge in different areas prior to and after the training. This showed that through participation in training, their knowledge in the following areas had significantly increased:

- 56% increase in knowledge of sensory awareness
- 28% increase in knowledge of sensory processing issues
- 28% increase in understanding of interventions
- 28% increase in knowledge in tools and adaptations.

Feedback from participants on this training showed they thought it was “meaningful”, provided “a very good insight” and it was “thought provoking”. The following is typical of the feedback received:

> “Thank you for facilitating this session. I really enjoyed it. Sensory profiles and sensory interventions will definitely be relevant to the service users on my ward. I like how you explained things, you made the session interesting and meaningful.”

> “The training was a very good insight on understanding individuals’ sensory needs and understanding how and why people react to situations and environments the way they do relate to their sensory needs. After attending the training, I have a better understanding on how to approach and try to change and develop my understanding of different service users and their needs.”

> “The training was a very good insight on understanding individuals’ sensory needs and understanding how and why people react to situations and environments the way they do relate to their sensory needs”.

> “Thank you for yesterday’s training it was so eye opening and thought provoking.”

Conclusions on this training

The development and delivery of training around sensory awareness and autism has undoubtedly led to positive change, for example participants on average said the training had led to an increase of 56% in their knowledge of sensory awareness and a 28% increase in their understanding of interventions. It was also positive to note that participants on the training not only included clinical staff such as occupational therapists, but also staff from

estates and maintenance. This is important as having staff from estates and maintenance that have participated in training to raise their awareness around sensory needs and autism means having engaged that have responsibility around improving the physical sensory environments.

Moorlands' Sensory Screening Tool

At Moorlands a sensory screening pathway tool was developed and implemented. The aim of this was to be able to provide service users with a sensory screen and sensory preferences implemented into their care plans.

The screening tool looked at a service user' experiences of touch, taste/smell, hearing, sight, movement and activity level. The tool is completed with service-users and the results were shared in ward reviews and communicated with bank staff and updated in handovers. The outcome of using this tool was not to identify if a service user has a sensory difference but to get staff thinking about the possibility.

When this tool was used, the results were analysed to decide whether there was a need for further in-depth screening, and to identify if further personalised sensory plans were needed that would be embedded into service-user care plans. Also, a decision is taken on whether their needs have been identified as needing "complex" or "basic universal need" support.

In discussions with project staff about the use of this sensory screening tool, it was identified that across the wards in Moorlands, one ward had used this sensory screening tool with 100% of service-users and other wards had also used the tool with a significant number of service-users.

The research team felt that this tool was an excellent way of beginning to identify service users' levels of sensory needs and support and liked the fact that it was completed with the service user. The team also felt it was a screening tool that should be used with all service users and a useful tool that should be shared with other wards outside the ones that had taken part in this project.

Developing a Trauma Informed Approach at Moorlands

In a report produced by University of Brighton, “More than words: Supporting effective communication with autistic people in health care settings”(September 2022) it says:

> “Autistic people are much more likely than the general population to experience traumatic experiences that can result in PSTD and this can become a further barrier to accessing services. Taking a trauma informed care approach, built on the principles of safety, choice, collaboration, trustworthiness, and empowerment as standard practice can support autistic patients to access services.”

In another report, from King’s College London, and published by the National Autistic Society, “Post-traumatic stress disorder in autistic people” (March 2022) it says:

> “Research indicates that autistic people are more likely to report symptoms of PTSD. Although research has yet to establish clear prevalence rates, the rates of probable PTSD in autistic people (32-45%) are higher than those in the general population (4-4.5%).”

In guidance published by Office for Health Improvement and Disparities, “Working definition of trauma-informed practice” (November 2022) it says:

> “Trauma-informed practice aims to increase practitioners’ awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.”

In an interview with a service-user who had been in a secure ward for nearly three years, the service user was questioned around and “their ability to feel safe or develop trusting relationships with health and care services and their staff” in the ward. When questioned the service-user said:

> “I've seen different types of people, nice people, which I'm not used to, people that care, people that want to help you without their being no benefit in it for them, without them getting some. I'm not used to nice people caring and who you can trust and who are genuine, trying to help you. That is not what I'm used to, and it's nice, strange but nice. I didn't know there were nice people.”

The service-user was asked to give some examples of who were “nice people” and what was it that demonstrated to them that someone was a “nice person”:

> “Well, Freddy's one of them, there's loads of them, but Freddy's one of the best. She understands me, she don't get mad with me, she don't get offended by me, she generally tries to help. She sees me behind the mask, which is not what I want to do but, in this instance, it's ended up being a good thing and I've opened up to her. I’ve explained to her how I feel and what I think and what's going on and what I'm used to and why I'm like I am. And then she's filled in gaps that I didn't even know myself…. I was just used to all that negative energy, everything being negative and I can't believe the weight I've been carrying and no wonder I was drunk all day, every day because you have to be to live like that.”

The service user was asked if they had noticed any changes to them compared to when they first became a service user at Moorlands, they said:

> “Yes, a bit a big swing, a big change. I've gone back to the person that my mum and dad brought up, not the street bum that I turned into.”

During an interview with a psychologist based in the mental health ward, they explained that since Moorlands appointed a sensory champion: “there’s more on the radar on sensory needs” and work undertaken in “trying to promote psychologically informed care”. They explained how this approach had led to “getting out of that really unhelpful boundary of ‘this is illness’ and ‘this is behaviour on how we make judgements based on what assumption we’re making” and staff had become “more attuned to sensory needs.” This had then led to a “more holistic on why someone might be reacting in a way that they are and how we can help with that.”

The psychologist was asked: “Is psychologically informed care similar to trauma-informed care?” and explained “Yes, there is a big overlap” and “Psychologically informed care looks at what happened to the people in the lives themselves.”

The link between psychologically informed and trauma informed care is something that is identified in article by Homeless Link in, ‘Trauma-Informed Care and Psychologically Informed Environments’ (June 2024) that says:

> “Both the intent, and outcomes, of services adopting PIE [Psychologically Informed Care] or TIC [Trauma Informed Care] are essentially the same – that they are aiming to improve the psychological and emotional wellbeing of people accessing or working there. Both approaches stem from the recognition that an individual’s experiences will impact how they present and engage with support.”

The Business Case for Sensory Friendly Wards

According to Austicia in information about – Campaign to Break the cycle: “Too many people detained in mental health units are autistic. Many are stuck for years at a time, getting worse not better.” They also estimate that “Autistic people and people with a learning disability have an average length of stay of five and a half years.” According to analysis carried out by the Independent newspaper in Revealed: Scandal of healthy mental health patients trapped in hospitals for years (November 2023): “Adult mental health beds cost the NHS between £500 and £1,000 a day, compared to £5,000 per patient per year for community care”.

When this is considered, there are obvious significant potential costs saving to be gained. By making wards more sensory friendly, this can lead to a reduction in the average ward length of stay of five and a half years.

As this pilot ran for just over two years and as for many pilots, this time also includes a lot of initial development and often barriers that weren’t always perceived, the actual delivery time will always be less. However, it was reported in Bradford District Care NHS Foundation Trust, Quality Report 2022/23 (page 29) that one of the wards in Moorlands:

> “Has seen a 40%+ reduction in violent incidents in 2022-2023, as well as an overall reduction in all incidents, and a significant reduction in the use of seclusion, and the duration of seclusion episodes. Thornton was also responsible for the most discharges in 2022-2023, though discharges were up across the unit compared to 2020-2022.”

It impossible to identify specifically if this project directly contributed to this “40% reduction in violent incidents” or towards “the most discharges”. It also needs to be acknowledged that work had already begun at Moorlands, before the start of this pilot that was described in the ‘Quality Report 2022/23’ (BDCT Foundation Trust, page 29) as:

> “Moorlands View undertook a piece of work looking at health and wellbeing within the Secure Environment, focusing on how we engage our population in recovery and rehabilitation. We focused on what was going well within the Unit and how things could be done differently, more creatively.”

However, the ‘Sensory Friendly Wards’ project has continued and further developed this work to find out “how things could be done differently, more creatively” and the outcome has been that this has resulted in greater engagement from service users, positive collaboration, improved communications and an openness to sharing challenges and barriers to positive change. Because of this approach, alongside working within a culture of being Trauma Informed, it is not surprising that there has been an increase in discharges and a reduction in violent incidents.

In addition to this, discussions with staff indicated that Moorlands was a place where agency staff asked to go to, there had been a reduction in staff sickness and an increase in staff retention. However, the data and evidence reviewed around this is not yet robust or mature enough to evidence amounts of cost savings and it was difficult for the research team to sometimes have access to some of this data. However, evidence around this shows potential cost savings and somethings that needs to be reviewed more longer term.

Moorlands had also installed large training kitchen where service users can prepare their own cooked meals instead of being provided with meals. Service users are allocated funds to buy their own ingredients and supported by staff in the preparation of their meals. In discussions with staff that was anecdotal evidence that this had led to a reduction in the level of drugs that service users were being provided. This would potentially be another area of cost savings but again the data around this is still needs to be reviewed more longer term to see if there has been positive change.

Recommendations

The ward reports

The model of supporting and training people with lived experiences to become ‘ward checkers’ is a great model and the production of the ward reports that give both quick win recommendations as well as more medium- and long-term recommendations was also very good. However, if this model is replicated the ward reports should also include a summary checklist will be useful for staff that will have responsibility for undertaking these recommendations and to be used as a tool to monitor progress being made.

After the ward reports are produced and shared with wards, there should be a formalised follow up procedure where the ward manger(s) are contacted to formally discuss the ward report(s) and identify any on-going support that may be needed.

In addition, there should be training available for ward staff that aligns with the sharing of the ward reports. This training should include sensory and autism awareness as well as practical advice around how to make ward environments more sensory friendly and ways of responding to recommendations in ward reports.

Two-ward visit model

In addition to the ward visit(s) to develop the ward reports, there should be follow up visits in approximately six to twelve months to monitor progress being made in undertaking the recommendations in the reports. The produced summary checklist should be used as a tool to record progress made as well as challenges encountered in making progress.

Lived experience volunteers as ward checkers

In the early days of this project, it was envisaged that volunteers would take on roles as ward checkers, however asking volunteers to take on this role was complex, and this led to paid staff becoming trained as ward checkers. It is recommended that in any replication of this model that the role of ward checkers is a paid role(s) and those undertaken this role should have direct lived in experiences.

This recommendation also applies to many other projects where people with lived experiences are being asked to contribute to the development of health and care services.

Developing ward reports within a framework of what is and isn't possible

When discussing progress in undertaking ward report recommendations, several recommendations had not been undertaken for reasons around health and safety, infection control and other risk factors. If ward reports are replicated in the future discussions should take place with health and safety staff around what is and isn't possible.

This recommendation is also relevant for other projects that involve making recommendations around development of health and care services.

A need to have an overall operational project co-ordinator

This pilot initially started out as two separate projects and considering this, along with the challenges associated with developing a cross-sector partnership, it has made significant progress in the development of a cross-sector partnership. However, the project and partnership may have made more development if there had been an overall operational project co-ordinator within the project team.

While there were some good examples of joint project working, particularly in year two of the pilot, with good cross partnership working on the development of the ward reports and co-operation around training, having an overall operational co-ordinator would have improved co-ordination of the different pieces of the pilot.

Having an overall co-ordinator would mean having someone responsible for overall project co-ordination, sharing of best practice, being able to co-ordinate training and responsibility for the operational development of the partnership. While recognising resources for this were not included in the received funding, it was felt that if this project was replicated this should be considered.

This recommendation would also apply to similar cross-sector projects and having someone that can make sure that the project is able to respond to learning, being able to implement examples of best practice and able to provide the leadership to "bring things together".

Moorlands' sensory screening tool

The Sensory Screening Tool that was developed by and used in Bradford is a good example of a Screening Tool and one that is completed in partnership with service users. There was however a variance in how often it was used in different wards, with one ward having used it with 100% of service users and other wards using it much less. It was a useful tool that could also be used on wards outside of Bradford and work should be used on promoting the use of this tool. In addition, more research should be done around the experiences and outcomes of using this tool with service users.

Having someone "on the inside" worked

Having a sensory champion that was working within the structures of the NHS meant having a champion that had a working knowledge of 'how things work' within the NHS, knowing 'who needed to be talked to' and who needed to be engaged when there were barriers to positive change. Also having a sensory champion that had experience of working within mental health ward settings and experience of engaging with mental health ward staff was a positive, along with having a Sensory Champion with a positive and proactive attitude. If this project is to be replicated then having someone with this knowledge, skills and experience is important.

This another piece of learning and recommendation that would apply to other projects, including ones that are cross-sector.

Longer-term monitoring of data to evidence cost savings

Limited data provided evidence of positive change, for example a 40%+ reduction in violent incidents in one of wards that this pilot was focused on, in 2022-2023 (first year of this pilot) when compared to the year before (before this pilot started). In addition to this anecdotal evidence showed there had been reductions in staff turnover and in staff absence levels. Also in another ward, that this pilot focused on. there was in 2022-23, a significant increase in the number of ward discharges.

This pilot has demonstrated that positive changes can be made to the sensory environments of wards, it has also shown the potential of this leading to significant potential cost savings.

However, the data around this needs to be monitored more longer term and resources available to maintain and continually improve sensory friendly ward environments.

Lessons learnt that can be used on other projects

Much of the above recommendations made around the Sensory Friendly Ward pilot could also be applied to other projects and services, for example a project to make wards more sensory friendly for younger people or older people. In addition to this, below are some of the lessons learnt through this pilot and through the evaluation of this pilot.

Promoting equal awareness and equal access to training

As part of this evaluation the research team discussed access to training with two mental health wards that were part of the overall project. Both these wards were based at the same location however one ward manger, when discussing training, shared many examples of their staff team participating in training. The other ward manager however shared their frustration of not being able to find or access training for their staff team.

This unequal awareness and access to training is something that is often identified both within statutory services and in VCSE organisations. Opportunities and access to training should be more equitable and not just down to which managers know and which ones don't.

Taking a trauma-informed approach in healthcare

The Office for Health Improvements in working definition of Trauma (November 2022) describes trauma-informed practice as:

> "It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing."

Within this pilot there were many examples of the development of “safe services that people trust” examples of “collaboration and partnership” and examples of service users being able to “make choices about their health and wellbeing.”

Not only is a trauma-informed approach the right approach to take in terms of trying to reduce health inequalities, but it is also an approach that can potentially lead to cost savings and an approach that should be actively used by all organisations involved health care.

Brief summary and conclusions

The original project proposal identified the following priorities:

1. **To recruit a sensory champion to support this work across the pilot sites in Leeds and Bradford. This role will be evaluated to determine its impact in promoting and embedding the benefits of sensory skills within all MH inpatient services.**

   This worked well, with lots of evidence demonstrating positive changes that had been made to both the physical sensory environments of mental health wards and an increased awareness amongst staff around the needs of Autistic adults and adults with Sensory needs. Many of these positive changes have been imbedded into mental health inpatient services.

2. **To create routes for people with lived experience to feed into inpatient environmental sensory assessments through creating training and toolkits.**

   Autistic adults were supported through training and support to successfully take on roles as ward checkers and used their lived experiences to make recommendations around making mental health wards more autistic and sensory friendly. While this evaluation identified that not all of these recommendations had been implemented (yet), it also showed that many of the recommendations had been positively responded to.

3. **Alongside this we want to develop and test an e-learning sensory training package that will skill up staff to undertake low level sensory needs assessment.**

   Evidence in this evaluation clearly demonstrates the difference that training has made in increasing awareness around the needs of Autistic adults and adults with sensory needs. Evidence also shows that as a result of this training staff now felt more confident in the things they could adapt to better support autistic adults and adults with sensory needs.

4. **To bank an element of funding to purchase bespoke sensory aids to support individuals who have had a sensory assessment e.g. weighted blankets, calm at night packs.**

   Having an element of funding to be used to purchase bespoke sensory needs aids and to equip and set “Make It Your Own Space” room was a positive element. Good consultation was undertaken with service users in helping to identify the type of equipment and aids that would contribute “positive change”. This model of having service users involved in identifying resources that they felt should be prioritised for purchase, worked and provided value for money.

Homui threshold is an image reflecting difference in neurological threshold that can contribute to sensory differences