NHS
Cheshire and Wirral Partnership
NHS Foundation Trust








BIG BOOK OF BEST PRACTICE 2021







BIG BOOK OF BEST PRACTICE 2021

Contents

4. Playing Together with Words: Early intervention through parent-child interaction
5. Quality improvement project of improving the quality of documentation
6. Quality improvement project of improving the quality of documentation
7. Supporting the delivery of safe and effective online psychological interventions during the pandemic
8. Piloting the High Intensity User (HIU) approach across health care services in Cheshire West
9. To provide packages of care for patients medically optimised in the hospitals during COVID-19 in January to February 2021
10. Estates Statutory Compliance Dashboard
11. Staff Survey - *'You said, We did'*
12. Use of video consultations during the pandemic to avoid long patient waiting times and reduce risk of breaching 18-week pathway
13. The implementation of increased sensory based interventions within a specialist dementia care setting
14. *Come Dine With Me*
15. COVID-19 did not stop therapeutic intervention for young people in Chester and Winsford
16. Development of a bereavement guide for parents of children and young people with severe learning disabilities
17. Project to increase the uptake of annual health checks for people with learning disability aged 14-17 in Wirral
18. Implementing the National Early Warning Score 2 (NEWS2)
19. Equipment Refresher Training - Integrated Working with Mental Health and Physical Health Services
20. Establishing autism hubs to support autistic people pre and post diagnosis
21. Maintaining provision of autism hub sessions during the pandemic
22. To co-produce a health passport for children and young people with learning disabilities that enhances communications and access to services
23. Sharing learning and best practice from reviews of care, complaints and HR investigations
24. A new discharge information leaflet for Beech Ward service users
25. CYP Intensive Support Function (ISF)
26. Dynamic Support Database - Clinical Support Tool online training
27. *Feel Good Friday Shout Out* - celebrating and thanking people in our teams each week
28. Formation of Chester therapy WhatsApp to support therapists and other Care Community team members
29. Wirral Wide Crisis Response meeting
30. Working in partnership with multi-agencies to manage the risk of stalking and serial domestic abuse
31. Ancora House Nursing Preceptorship Package
32. *CHECK!* A resource to support CWP staff to work more effectively with autistic people
33. Joint Specialist Perinatal Midwifery Care
34. Hospital at Home Service expansion and transformation of Advanced Clinical Practice during COVID-19 Pandemic
35. Using iPads to support interaction and engagement for people with dementia in hospital
36. New pathway implementation within Complex Needs Service Wirral: Intensive Case Management
37. Youth Justice Service health team lead the way in trauma informed practice
38. Developing a running group at Bowmere Hospital
39. Adapting physical exercise for service users on Eastway during COVID-19 pandemic
40. Flexible approach to clinical working
41. The *Living with Emotions* Group
42. Development and delivery of an online Compassion-Focused Therapy Group for Eating Disorders
43. Provide flexible and open access to training during COVID -19 for parents/carers and early years settings to support children's Speech and Language development
44. Invitation only Breast-Feeding Support Group

This year sees the return of our *Big Book of Best Practice,* post pandemic. In this ninth edition it showcases best practice across our services and celebrates the most exciting and innovative work our teams have achieved during the past few years.

Once again, our people have gone above and beyond to adapt and continuously improve to ensure we are delivering the best outcomes to the population we serve. I am immensely proud of the work #teamCWP continue to do - we are always striving to ensure our care is as compassionate, effective and safe as possible. Our focus continues to be on continuous improvement, in partnership with others, so that we can be the best we can be in providing high quality services.

NHS services have had an incredibly challenging 24 months, and this is a fitting tribute to the work that colleagues have undertaken to deliver care for the people who access our services. Thank you to everyone who submitted an entry, competition for a spot was fierce and we really do wish we could include all the submissions we get.

The case studies submitted show how Quality Improvement is bedding into the fabric of CWP and indicates how committed our staff are to deliver high quality care. I encourage you to take your time and read through the wonderful examples of innovation which took place during the pandemic, including the use of technology to reduce waiting times, provide psychological therapy, deliver children's speech and language training to parents and carers as well as support family interaction for those living with dementia.

I am proud to see the expansion of the Hospital at Home Service as well as the development of a bereavement guide for parents of children and young people with severe learning disabilities. Partnership working has enabled us to manage the risk of stalking and serial domestic abuse alongside increasing the uptake of annual health checks for people with learning disability aged 14–17 in Wirral.

Like me, I am sure you will find yourself inspired by our *Big Book of Best Practice.*
If you would like more information, please feel free to get in touch via email at:
anushta.sivananthan@nhs.net

Best wishes,

Dr Anushta Sivananthan,
Consultant Psychiatrist and Medical Director

Care Group: Children, Young People and Families
Team Name: Paediatric Speech and Language Therapy

Playing Together with Words: Early intervention through parent-child interaction

What did we want to achieve?

Our aim was to provide early intervention for young children with delayed or disordered speech, language and communication to support parents to implement the appropriate strategies - resulting in better outcomes for the children.

What we did:

This pathway begins with a playtime assessment for children age three and under to identify whether the child has delayed or disordered speech, language and communication. We created several videos containing advice, which parents, carers and education settings are signposted to prior to the assessment.

We then work with parents and carers through a therapy intervention called *'Playing Together with Words',* sharing strategies which are known to support interaction and language skills. There is then an eight-to-12-week period for the strategies to be implemented consistently at home before a face-to-face appointment is arranged to review the child's progress.

Results:

- A reduction in the time children wait for therapy and review appointments
- A greater success in engaging with more difficult to reach families, such as those with English as an additional language and parents with additional needs
- By offering one-to-one appointments, we can work at the pace of the parents/carers
- There has been a lower rate of appointments which have not been attended as there is some flexibility in days/ times appointments can be offered.
- There has been an increase in the attendance of both parents, although this may have related to parents working from home during lockdown, we have noticed a greater engagement in both parents and more dads attending the sessions
- The speech therapist/assistants running the *'Playing Together with Words'* intervention report increased job satisfaction as children are receiving a greater quality of therapy from us because it is personalised.

We regularly receive positive feedback from families, including:

"You have given me so much confidence and reassurance that he will get there with time and a little extra encouragement."

Next steps:

We intend to keep using *'Playing Together with Words'* as a video and one-to-one intervention. We have been able to still see the same number of children and the quality of our service has improved - this is felt by the therapists, assistants, nurseries and our parents and carers.

Contact: susanne.bowden@nhs.net

Care Group: Specialist mental health
Team Name: Maple ward

Quality improvement project of improving the quality of documentation

What did we want to achieve?

Our aim was to improve the quality of patients' clinical documentation, for the clinical entries to be more meaningful and for the patient to be more involved and supported to document their perception of their own mental health daily.

What we did:

A pilot study was carried out on Maple Ward where it became routine for several patients to write their own clinical entry for the shift. They were supported by staff to do this and fed back that they found it therapeutic, helpful and a good way to communicate their thoughts and feelings to the multidisciplinary team. Staff would support and supervise patients to either write these notes on Microsoft Word or straight onto Care Notes where appropriate.

Results:

One patient was able to use his skills to write his four weekly medical review and care plans (which were of an excellent standard).

We received positive feedback from patients, including:

"Typing my own notes helped me think about how I was feeling and what I had achieved. It also gave a channel of communication for me to share these things with the team looking after me."

"I was able to write notes, clinical reviews and participate in risk reviews, which helped to promote independence and restore my confidence. I now have a volunteering role with CWP!"

Next steps:

The pilot project continues and has been rolled out across the rehabilitation units. Several patients continue to enjoy participating in writing their own clinical notes. This also gives patients and staff the chance to work collaboratively, rather than staff sitting in the office documenting about patients.

Contact: debbie.williams35@nhs.net

Care Group: Clinical Support Services
Team Name: Education CWP

Clinical Coaches

What did we want to achieve?

On receiving funding from Health Education England (HEE) to develop registered practitioners, we wanted to do something that would allow us to reach as large a clinical staff group as possible. We knew coaching was an effective tool for development and we also knew it can be hard for clinicians to leave their practice to access coaching, so we developed a project to take the coaching to them.

What we did:

We recruited coaches with significant clinical, managerial and staff development experience across all care groups. Coaches adopt a coaching approach, which supports the individual to come up with their own solutions rather than being 'given' the answer. This leads to increased problem-solving skills and greater autonomy for practitioners.

Working with senior leaders, we identified targets for the coaches to focus on. Coaches worked alongside clinical teams for 12 weeks using a combination of coaching, role modelling, reflection and training to support the staff in achieving sustainable improvements.

Results:

Each project had an agreed outcome measures document which sets the aim of the intervention and the underpinning objectives. These objectives have quantitative and qualitative measurements starting with a baseline measure, then mid and end point interval targets and finally a measurement at three months post intervention to determine if the improvement has been sustained.

Coaches have been able to evidence an improvement in all clinical areas, including reduction of restraint in an inpatient ward, increase in reflective practice after incidents, use of 'team around the family' tools and an increased understanding of effective leadership processes.

In addition to the measured improvements, staff have reported increased confidence and problem-solving skills as some of the additional benefits of working with a coaching approach.

Next steps:

Coaches continue to take on clinical support projects and we are keen to hear from clinical teams who would like to work with a coach to deliver sustainable support in any areas of their practice, from embedding clinical tools to developing an effective clinical leadership team.

Contact: anna.beaver@nhs.net

Care Group: Specialist mental health
Team Name: Wirral Complex Needs Service

Supporting the delivery of safe and effective online psychological interventions during the pandemic

What did we want to achieve?

Our aim was to develop guidance to ensure the safe and effective delivery of remote psychological therapy within adult community mental health services at CWP during the COVID-19 pandemic.

What we did:

Practitioners from the Wirral, West and East Complex Needs Services, Eating Disorder Services, and the Chester Step 4 Psychology Service formed a working group early in the pandemic, taking into consideration potential practical and psychological barriers, including digital poverty, access for people with disabilities and neurodiversity. We reviewed documents from key UK regulatory and advisory bodies, and experience from colleagues and clinical supervisors.

The final document, titled 'Providing psychological therapies in a post-coronavirus context in primary, secondary and specialist community adult mental health settings', provides guidance on assessing clients' appropriateness for remote working, including issues of risk, adaptations to consider, as well as delivering therapy in person with infection control measures in place. User-friendly handouts for clinicians and clients to support remote working were also created.

Results:

- Teams were able to commence delivery of a range of evidence-based therapeutic interventions safely and more confidently via video; enabling clients to have access to therapies that had stopped abruptly when the pandemic hit.
- We have since delivered the therapies online consistently each week ever since, in place of supportive telephone calls that, whilst helpful in many ways, had not been part of the client's treatment plans for evidence-based therapy.
- Moving therapy groups online enabled the Complex Needs Services in Wirral and West to re-start dialectical behaviour therapy (DBT) and mentalisation based therapy (MBT) programmes. These interventions have been described as life-saving interventions due to their focus on understanding and managing emotions safely in place of self-harming or other risk behaviours.

Next steps:

We considered the potential benefits of maintaining some online therapies in the longer term. The Specialist Mental Health Business and Governance Group are in the process of exploring whether to formally adopt the guidelines for use more broadly across the Trust, and how we can better use online platforms to help people who might otherwise be excluded from in-person psychological therapies, such as those with physical disabilities, agoraphobia or caring responsibilities.

Contact: dulcie.cormack1@nhs.net

Care Group: Neighbourhood-based Care
Team Name: High Intensity User Service/Support Access Service

Piloting the High Intensity User (HIU) approach across health care services in Cheshire West

What did we want to achieve?

Our aim was to help people who were relying on unplanned healthcare services to access planned community resources to meet their ongoing needs, reducing their need for and use of unplanned services.

What we did:

We used Clinical Commissioning Group data to identify the most frequent service users across Cheshire West. We connected with these individuals and services around them to fully understand why they had come to be in urgent and emergency care services so often. From there we helped them to understand their own presentation better, explaining specialist knowledge and applying it in the context of their lives. We helped them identified areas of their lives they wished to change, available support, and supported them to access these.

Results:

Comparing the rate clients used services with the three months before we started working with them, we have seen attendance reductions of:

- A&E 43%
- GP appointments 64%
- 111 calls 67%
- 999 calls 42%
- Non-elective admissions 46%
- Mental health attendances 33%
  (although this is actually higher as many of these contacts were with the high intensity user programme)

The estimated financial cost saving to these services over the first six months was £66,000.

Feedback:

"I was really impressed with the level of support and innovative ways of working with a group of people who can often fall through the gaps in services. I felt like the service user finally had someone who understood his needs." – Psychologist

"He has not had a drink since early September. He is applying for jobs and is also having counselling. You played a major part in getting him to this point."
– Client's father

Next steps:

CWP has invested in the permanent continuation of the current single post. One practitioner is able to work in this way with around 50 individuals a year. We have identified around 250 people a year across Cheshire West using services to a similar degree.

The Cheshire and Merseyside Integrated Care Partnership and CWP mental health transformation programme are exploring opportunities for additional practitioners with other system partners. We hope that all teams will see things in the model that they can use to improve engagement and outcomes with their patients.

Contact: timothy.hughes6@nhs.net

Care Group: Neighbourhood-based Care
Team Name: All Care Community, Podiatry, Continence and Palliative Care Teams within the Neighbourhoods Care Group

To provide packages of care for patients medically optimised in the hospitals during COVID-19 in January to February 2021

What did we want to achieve?

During the COVID-19 pandemic, patients who were medically fit for discharge within the hospital and awaiting a care package were unable to return home. The ask of the teams was to provide packages of care to support discharge and free up hospital beds.

What we did:

As Care Community teams (CCTs) we changed our working patterns to enable us to provide packages of care seven days a week between the hours of 8am and 8pm. This involved all members of the team including nurses, therapists and specialist teams in providing the care.

Results:

- Patients were successfully discharged from hospital with a safe transfer of care form, indicating the level of need and package of care required by patients. Packages of care ranged from one to four calls a day and double and single handed. Some patients were optimised within the six weeks and no longer required a care package
- Having therapists and therapy assistants undertaking care calls meant that patients received assessment and exercises that allowed them to become self-caring. With the specialist teams also supporting we were able to address continence and podiatry issues at the point of contact
- Staff were able to undertake all care required within a visit and reduced the number of professionals entering the house
- There were no issues with communication that can sometimes occur when care agencies are involved.

Next steps:

This was a positive experience and the staff felt that there were benefits to working alongside each other to support patient at home. This is something the teams would love to provide with the adequate staffing and skill mix needed, especially in some areas were care packages take a long time to start.

Contact: elea@nhs.net

Care Group: Clinical Support Services
Team Name: Estates Department

Estates Statutory Compliance Dashboard

What did we want to achieve?

The estates statutory compliance dashboard was developed to provide assurance to the Trust that its legal duties relating to the estate such as asbestos, fire, electrical issues and legionella, were being met. A system was required that would close the loop from inspection through to remedial actions being closed and that would generate concise reports for a non-technical audience.

What we did:

We felt that most off-the-shelf estate compliance systems did not provide the adequate level of assurance to the Trust with focus on the inspection element of compliance and little regard to the remedial works arising.

Through a project led by Stacey Jones, statutory compliance support officer, we developed a system (and supporting processes) that would evidence the whole process from inspection, analysis of findings, raising of works orders though to sign off.

The front-end dashboard graphically reports an overall compliance percentage with a breakdown by inspection and remedial works for each statutory compliance subject.

Results:

At the click of a button we can report when a Trust asset was last inspected, whether it required any remedial works and provide either the purchase order or internal job reference for when the works were completed. Through the dashboard we can view the live compliance status for each compliance subject.

This system is now the cornerstone of operational estates operations. This performance data is reviewed monthly by the operational estates teams and a quarterly report is produced for the infrastructure subcommittee.

The dashboard has been developed completely in house with no set up or recurrent costs. The system was recently audited by Merseyside Internal Audit Agency (MIAA) and was deemed to provide substantial assurance to the organisation.

Next steps:

The dashboard has been a product of continual improvement and has been through several iterations over the past 18 months. We expect that the system will continue to evolve however, a specific area of improvement will be the development of compliance on a page. This will be an infographic that could be shared Trust wide and with people that access our services.

Contact: daniel.allmark@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury
Team Name: Eastway Assessment and Treatment Unit

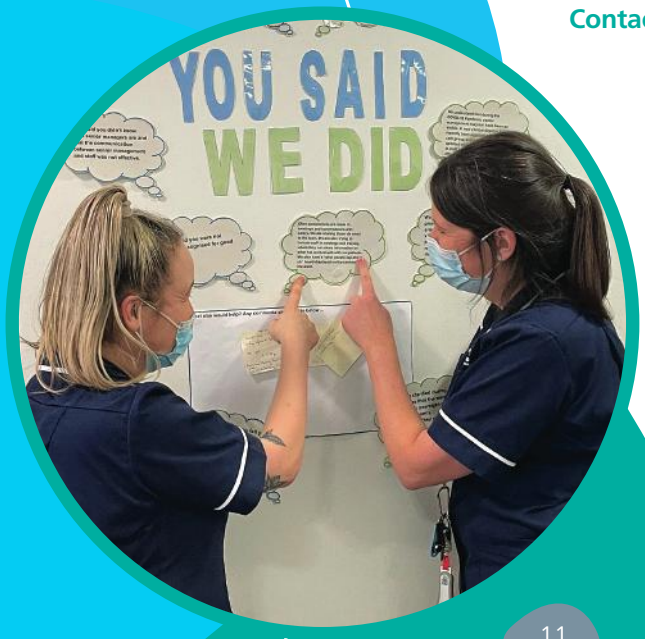
Staff Survey - 'You said, We did'

What did we want to achieve?

To work together to identify new ways of working in relation to the results from the staff survey. The purpose was to pull together key themes identified within the staff survey and how they could be rectified to allow staff to feel accomplished in their role within the workplace.

What we did:

We pulled together a piece of work to identify the key themes that came from the staff survey. Through this we identified what could be done in relation to the themes. The themes were summarised into a supervision format, where the team were given an opportunity to informally discuss ideas that could be used to address outcomes from the staff survey. From this a 'you said, we did' board was developed and placed where handover is given so staff have the opportunity to discuss any further ideas.



Results:

- Staff feel like they have more input into decisions made on the ward
- Staff reported that sessions or ideas that have come from the staff survey have made them feel like they have gained new knowledge in relation to patient's conditions, as well as being able to apply this to practice, which in turn benefits the patients
- Staff feel like they have more input into patients care and feel they make a difference, with new knowledge learnt and discussions held on interventions to support patients, and they feel more involved in the day to day running of the ward
- Staff have a greater understanding of the patient journey and individual roles within the multi-disciplinary team, which enables them to support the patients more effectively
- Staff feel like they can speak up to discuss new ways of working

Next steps:

The you said, we did board has an option for staff to write confidentially any comments and to include if anything else they think would help. This will be reviewed monthly and then discussed at handover. This will keep the momentum going and enable staff to feel supported.

Contact: amy.wixey@nhs.net

Care Group: Neighbourhood-based care
Team Name: Podiatry

Use of video consultations during the pandemic to avoid long patient waiting times and reduce risk of breaching 18-week pathway

What did we want to achieve?

In April 2020, most of the routine podiatry clinical work ceased due to the fluctuating circumstances associated with the pandemic. Our biomechanics caseload is the service which gains the highest number of referrals, so our biomechanics lead attempted to do some baseline assessments via video to avoid a huge backlog post COVID-19 and reduce the number of patients waiting longer than 18 weeks.

What we did:

Lucinda Mercer, the podiatry biomechanics lead, set up the Accurx software on her iPad. Patients were then contacted inviting them to a video consultation if they wished. If they did not want a video consultation, they were offered a telephone consultation. This took place between April and July before we started to invite patients back to our clinical sites for face-to-face assessment.

Results:

Within this period, we were able to maintain our 18-week key performance indicators and did not breach on any waiting lists. This meant patients were still able to commence treatment in a timely manner. Insoles were prescribed and exercise regimes given remotely to support patient care. Prior to the pandemic, our technology would not have supported this, so the fact that we were issued with iPads to support the Care Community teams made this doable.

Next steps:

The use of video technology is something to consider longer term and how this could be utilised across services. We have further upgraded technology since, so have more scope for development. In the future, we would like to create some online training videos for use in prescribing exercise regimes to patients within biomechanics/diabetic foot and wound care.

We would also like to develop videos for our minor surgery clinic for anyone who has learning disabilities to be fully informed of the clinical environment and procedure prior to visiting our clinics. We have recently introduced a text messaging system to remind patients of their appointment time using the same software - we hope this will reduce our service 'did not attend' rate.

Contact: emma.gallagher2@nhs.net

Care Group: Specialist Mental Health
Team Name: Silk Therapy Team

The implementation of increased sensory based interventions within a specialist dementia care setting

What did we want to achieve?

Our aim was to provide a number of interventions that would benefit a greater proportion of our service users, many of whom lacked the cognitive ability to engage in many of our regular interventions.

What we did:

In order to be more person-centred we began to facilitate a greater number of sensory based interventions that would benefit a large number of service users on the ward and enhance engagement in therapeutic services.

Interventions included regular food themed events including fish and chip lunches, roast dinners and afternoon tea. These sessions were designed to provide sensory stimulation that promoted reflection on memories, leading to a sense of wellbeing.

Increased gardening sessions were also facilitated, providing a multi-sensory experience for our service users and providing a number of benefits including a sense of purpose and independence as well as having a calming effect and providing a distraction from agitation or distress. Music sessions were also enhanced to evoke positive memories, thoughts and feelings.

Results:

Adapting the therapeutic programme to better suit the needs of the service user group on the ward led to increased engagement with occupational therapy services. This meant we were able to positively impact greater numbers and see increased benefits upon health and wellbeing for our service users.

Staff also benefited from the programme adaptation, engaging with the therapy team in many of the sessions. In the midst of staffing and COVID-19 pressures, this greatly boosted staff morale and the team received positive feedback regularly from staff around this.

Next steps:

The team are now looking to expand the range of sensory interventions available to service users on Silk Ward. Personalised sensory boxes are being researched with the aim of providing person centred interventions that can help reduce distress and behaviours of concern often associated with dementia. This will feed into the positive behavioural support approach championed by the trust.

Contact: michelle.martin16@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)
Team Name: Acquired Brain Injury

Come Dine With Me

What did we want to achieve?

To use cooking skills and learn new ones and to involve families and friends in a pleasant experience on the unit. During the COVID-19 pandemic, having a meal with staff and enjoying a conversation over a meal the patient had cooked.

What we did:

The initial activity was done before COVID-19 restrictions came into place. We discussed with the patient who they would like to invite to share a meal with them. Invites were then created and sent to the chosen guest. We decided on a three-course menu, then went shopping for items we needed. Menus were printed out and the patient took part in decorating and printing these. The patient assisted in getting the visitors room ready and set the table.

The patient then served the meal and enjoyed eating with their chosen guest. During COVID-19 restrictions this activity was not able to go ahead with family and friends but we adapted this so they could invite a staff member to come dine with them - preparing the meal and enjoying one to one time with a staff member.

Results:

To promote positive relationships between patients and staff as well as family and friends. Service user feedback included:

"I was really excited and enjoyed the cooking and eating with a staff member and I was glad they ate it.' Another patient said "it was nice sharing a meal with a family member instead of the usual visit".

Next steps:

To continue with *Come Dine With Me* with staff and hopefully with restrictions being lifted to be able to invite family and friends once again.

Contact: amanda.pearson9@nhs.net

Care Group: Children, Young People and Families
Team Name: Chester and Winsford Child and Adolescent Mental Health Service (CAMHS) Dialectical Behavioural Therapy Team

COVID-19 did not stop therapeutic intervention for young people in Chester and Winsford

What did we want to achieve?

Chester and Winsford CAMHS teams' skills group component of the Dialectical Behavioural Therapy (DBT) programme for young people aged 0-19 had to stop due to COVID-19 restrictions, however staff within the team worked creatively to enable these to continue utilising multimedia resources.

What we did:

In March 2020 the CAMHS skill group (DBT informed) was initially taught using YouTube. Practitioners recorded themselves demonstrating the skill for that particular module. Young people were encouraged to watch the YouTube videos and then were telephoned by a practitioner for an individual session to go over the material and reinforce the learning.

Practitioners had to adapt to managing high levels of risk in this way, working remotely and discussing suicidal ideation and self-harm. In September 2020 Microsoft Teams was approved for use and so the group was moved onto this platform.

Results:

At a time of uncertainty young people had to draw on this new provision to learn ways to regulate their emotions, increase their self-awareness and attentional control. The tools were to enable them to reduce impulsivity and accept reality as it is - a difficult challenge in the face of a global pandemic.

Young people were taught strategies to maintain or improve their family relationships and reduce conflict. Being locked down and not able to utilise other forms of resilience impacted negatively on their mental health.

Existing group members were able to complete the modules and a high percentage were discharged from the service. New referrals were accepted, reducing the waiting list. Family input was also provided. One young person gained employment, passed her driving test and noted that she had found the programme to be life changing.

Next steps:

Chester and Winsford 0-16 online groups merged due to staffing pressures. The long-term aim is to grow the group provision in both Chester, Winsford, Crewe and Macclesfield, with funding identified to train further practitioners in DBT in other areas of Cheshire CAMHS. A psychology assistant is going to work with the DBT team to audit this time period and gain a clearer understanding of outcomes.

Contact: jane.white20@nhs.net

Care Group: Children, Young People and Families
Team Name: Children and Young People's Learning Disability Service - Wirral Child and Adolescent Mental Health Service (CAMHS)

Development of a bereavement guide for parents of children and young people with severe learning disabilities

What did we want to achieve?

To develop a resource specifically for parents/carers of children with severe learning disabilities who have been bereaved. The guide would provide information to help parents/carers understand their child's grief, build their confidence in responding to this and offer a range of practical strategies to support them through the process.

What we did:

We reviewed current research and resources that offered support for bereavement and adapted this advice to be more appropriate for children and young people with severe learning disabilities who cannot easily rely on verbal strategies or communication skills.

Dr Jacqui Wood recognised that whilst some of these strategies could be helpful to non-verbal young people, they often needed adapting or simplifying to be appropriate and accessible, and it might be difficult for families to make these adjustments themselves. Therefore, the aim was to produce a guide that could be used by parents, carers and wider services to feel more confident in supporting bereaved young people with severe learning disabilities.

Results:

Professionals, parent carer forums, and key stakeholders provided feedback, praise and thanks for the guide. Parents have said how great it is to have access to it. The electronic version of the resource means we can gather data on how many times it is accessed. The bereavement guide has been accepted by the World Health Organisation Collaborating Centre for Public Health Nursing, Midwifery and Allied Health Professions as an example of good practice.

Next steps:

The guide is freely available. Next steps are to share the guide further with services including schools, respite services and social services, parent carer groups and the Special Educational Needs and Disabilities (SEND) network.

Contact: tracey.hartley-smith1@nhs.net

Care Group: Children, Young People and Families
Team Name: Children and Young People's Learning Disability Service - Wirral CAMHS

Project to increase the uptake of annual health checks for people with learning disability aged 14-17 in Wirral

What did we want to achieve?

CWP and Wirral Clinical Commissioning Group (CCG) have partnered together to become one of nine new NHS England champion/exemplar sites in learning disability care with a focus on increasing the uptake of annual health checks available to people with learning disabilities across the area.

What we did:

The specific aims of the Wirral annual health check exemplar/champion site project were to increase the uptake of annual health checks available to people with learning disability aged 14 to 17. This will be achieved by:

- Developing understanding of the barriers to accessing annual health checks through collaboration with partner agencies, self-advocacy groups, young people's forums and parent/carer forum
- Increasing awareness of annual health checks for children and young people with learning disabilities in Wirral
- Establishing pathways with primary care and child health colleagues to ensure access to annual health checks and health action plans.

Results:

This project and the Champion site status has enabled us to work alongside Wirral CCG to reduce health inequalities for people with a learning disability. We have had the privilege of driving forward approaches to improve care, through a focus on increasing the uptake of annual health checks amongst 14 to 17-year-olds with a learning disability.

Through engagement with parents and carers we now have a greater understanding of why the uptake has historically been low. We have developed resources and undertaken promotional and publicity work with primary care and health colleagues, special schools, parent/carer and children and young people representatives.

There is evidence that the interventions are effective and the number of 14 to 17-year-olds accessing an annual health check in Wirral is increasing; in previous years the number accessing their annual health check was around 27% in Wirral. Following the initiatives to raise awareness this has increased to 53% (May 2021).

Next steps:

I will continue to be part of the Wirral project team and work alongside primary care colleagues to continue this work and develop further regarding health action plans.

Contact: tracey.hartley-smith1@nhs.net

Care Group: Neighbourhood-based care
Team Name: Neighbourhood Integrated Teams

Implementing the National Early Warning Score 2 (NEWS2)

What did we want to achieve?

Our aim was to implement the National Early Warning Score 2 (NEWS2) - a standardised communication tool which can be used in any care setting where people may be at risk of deterioration and sepsis to establish a baseline for a patient's vital signs and identify sepsis quickly.

What we did:

In February 2021, training commenced. This was a refresher session on sepsis recognition, high risk sepsis patients, the introduction of NEWS2 and escalation of deteriorating patients.

These sessions generated important clinical discussions and reflection around our complex caseloads, admission avoidance and appropriate escalation routes. Clinicians were encouraged to use NEWS2 to demonstrate a deterioration or improvement in a patient's condition. This training further raised awareness and understanding of the *Hospital @ Home/REACT* team and encouraged teams to contact them for advice or referral.

Results:

The sepsis refresher training supported discussions and reflection on clinical observations in the home environment and was well received. We have discussed at length the frequency of observations on home visits for patients.

A number of clinicians identified that they had previously struggled to escalate deteriorating patients in the community. NEWS2 now supports communication to evidence a deterioration and potential sepsis.

Our advanced clinical practitioners quickly noticed an increase in phone calls from community teams to the *Hospital @ Home* triage line for advice and referrals. All levels of staff are engaging with the use of NEWS2, which is enhancing assessments, supporting treatment plans and keeping patients safe.

Next steps:

- NEWS2 is discussed and reflected on in the care groups Clinical Quality Assurance and Improvement Group each month.
- Monthly audit is ongoing to understand the recording and use of NEWS2 on EMIS
- Sepsis and NEWS2 training continue for our new starters and staff returning from absence
- Therapists are looking at a traffic light system to prompt them in identifying when observations and NEWS2 should be recorded during therapy assessments in the home environment.
- Sessions for Occupational Therapists around clinical observations are being facilitated by CWP Education
- Some GPs have identified that they would like some additional training on using this tool.

Contact: c.jones19@nhs.net

Care Group: Neighbourhood-based care
Team Name: Chester Central Care Community Team (Community Therapies)

Equipment Refresher Training - Integrated Working with Mental Health and Physical Health Services

What did we want to achieve?

To provide colleagues working in different areas within CWP with updated training on prescribing equipment for patients. To help colleagues increase their confidence and competencies in assessing patients at source and providing relevant intervention. Thereby, aiming to reduce unnecessary referrals to community therapies and longer waiting times.

What we did:

Virtual refresher training was provided for colleagues, focusing on assessing for and prescribing basic equipment. This aimed to provide a smoother pathway for patients requiring equipment to complete daily activities. Equipment can make activities safer, increase independence and improve quality of life.

Training also included education for colleagues on the role of community therapies and when it is appropriate to refer a patient on for more targeted input. Increased communication between mental health and community therapies was also encouraged to further increase confidence when prescribing equipment.

Results:

Verbal and written feedback from colleagues who attended the virtual refresher training was positive, with colleagues advising they felt more confident in assessing for and providing basic equipment to patients, rather than automatically referring them on to community therapies.

Colleagues also confirmed they felt more reassured knowing they can contact Community Therapy staff in 'real-time' to discuss the specific needs of patients and determine whether they can be treated in-service or need referring on to Community Therapies.

The training has the potential to have a positive outcome for all; colleagues within mental health services should have increased confidence with providing equipment, as such patients needs should be addressed more promptly and in turn, community therapy staff save valuable clinical time, freeing them up to assess more urgent cases in the community.

Next steps:

The workshop was recorded on Microsoft Teams and is now available as a link online at any time for colleagues to refresh their knowledge. Colleagues have requested a future practical training session face-to-face with equipment on hand to practice with. Requests have been forwarded on to management for consideration.

Contact: heather.coan@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)
Team Name: Adult Autism Spectrum Disorder (ASD) Service

Establishing autism hubs to support autistic people pre and post diagnosis

What did we want to achieve?

Autism hubs are third sector led in local communities and provide advice, information and support from support and peer workers. They offer early intervention and provide a support network to minimise risks associated with isolation, social anxiety and depression. The hubs support a person with autism to access health and social care.

What we did:

Following a successful co-produced bid, we worked with third sector establishments and created autism hubs. We undertook autism assessments from the hubs so people were more comfortable accessing support through the hub.

We enhanced provision through the hubs by providing a clinician led monthly topic-based group to enhance knowledge and strategies; monthly one-to-one advice sessions; advice/mentoring to hub staff and we helped bring other services into the hub such as the Department for Work and Pensions.

We have three hubs in East, Wirral and West, all at different stages of development. NHS England and Improvement (NHSEI) is now showcasing this model as an' exemplar and we were a finalist at the Northwest innovation's awards.

Results:

"I feel as if I don't have to hold back from being myself. I particularly enjoy meeting others just 'like me'. I would be lost without this service."

"The hub is the only environment where I can express concerns about life and obtain information from other adults with a late diagnosis of autism and life experience."

"They've transformed my life. I have felt much better about myself."

Next steps:

We are further developing our hub provision to enhance it by listening to autistic people and seeing what services would be helpful to access through the hub. We are developing by responding to feedback and reshaping provision. We are being used as a model service by NHSEI and recommended nationally.

Contact: k.arnison@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)
Team Name: Adult Autism Spectrum Disorder (ASD) Service

Maintaining provision of autism hub sessions during the pandemic

What did we want to achieve?

Autism hubs were set up offering a monthly topic-based hub session and one-to-one advice sessions for autistic people. We identified the need for support to continue during the pandemic, responding to feedback about the best way members could access support.

What we did:

Member's feedback indicated that a hybrid approach of virtual sessions, emailed information and access to an increased number of advice calls (due to uncertainty caused by the pandemic) would be helpful. We facilitated this and moved our hub sessions to Skype and provided a newsletter each month of helpful current and topic-based information and increased advice call provision.

We saw a threefold increase in these, and the caller needed more time for support which we responded to. Several people said this had prevented them going into crisis. By setting up hub sessions using Skype we also enabled members to connect with each other outside of the hub sessions for peer support.

Results:

"I love how free I feel on the sessions. I feel as if I don't have to hold back from being myself. I particularly enjoy meeting others just 'like me'. I would be lost without this service."

"The really interesting information, connection with other autistic people and their shared knowledge and experiences."

"Easy to access support as less pressure than attending face to face."

"Kindness, non-judgemental. Tips to cope and the overall support and warmth is a life changer."

Next steps:

We are currently evaluating our hub plans as membership has increased and the groups are large which is off putting for some. We are seeking advice from hub members as to how best to provide provision going forwards and how best to provide monthly topic-based group sessions and advice calls. We are also looking at peer mentor roles within a future model.

Contact: k.arnison@nhs.net

Care Group: Children, Young People and Families
Team Name: Children and Young People's Learning Disability Service - Wirral Child and Adolescent Mental Health Service (CAMHS)

To co-produce a health passport for children and young people with learning disabilities that enhances communications and access to services

What did we want to achieve?

Health passports are designed to support and facilitate effective communication and shared understanding between people with learning disabilities, families and professionals who are providing care and support. A review of the current available passports revealed that there is a clear need for co-produced local information, local links and meaningful engagement across NHS trusts.

What we did:

The Queens Nursing Institute's Fund for Innovation 2020 (with funding from the Burdett Trust) is focussed on nurse led projects to improve health outcomes for people with learning disabilities. Our team submitted an application and were successful. We:

- Scoped national guidance, good practice and current available health passports
- Established a working group with parent/carer participation, children and young people representation, learning disability liaison nurse
- Developed and published a co-produced health passport for children with learning disabilities in Wirral
- Raised awareness and use of this child focused and local health passport amongst families of children and young people with learning disabilities and health professionals

Results:

- The project has been a wonderful example of co-production; The Positivitree, our Special Educational Needs and Disabilities (SEND) Youth Engagement Officer, Wirral University Teaching Hospital and CWP have worked together to develop a local child, young person and family-centred health passport which will be a wonderful asset in Wirral
- An initial poll of parents and carer's awareness of Health Passports revealed that most people who responded had never heard of a health passport
- Feedback on the draft copy of the passport was overwhelmingly positive; parents, carers and professionals were really impressed with the clarity and comprehensiveness of the passport. The viewed it as a highly valuable resource
- Presented at clinical network events, Queens Nursing Institute (QNI) events, Health Promotion Community of Practice, SEND networks.

Next steps:

The passport will be available electronically as well a high-quality paper document.

Contact: tracey.hartley-smith1@nhs.net

Care Group: Specialist Mental Health
Team Name: Wirral Place-based Services Investigating Managers

Sharing learning and best practice from reviews of care, complaints and HR investigations

What did we want to achieve?

Trustwide learning reports can lose context between the event and the learning. We wanted to share local learning and best practice examples from reviews of care, investigations of complaints and HR matters in a way which more easily enabled reflection and discussion by adult community mental health teams on Wirral.

What we did:

Investigating managers undertake reviews following clinical incidents, unexpected deaths, complex complaints and HR investigations. The care team involved will have had individual feedback, but we wanted to find a more direct way to share learning with all our local teams to improve services across the portfolio.

We devised a simple Excel spreadsheet, which supports identification of the incident/complaint (but not staff involved) whilst protecting confidentiality. It includes the learning and good practice elicited and the outcome for the patient, where relevant. It is presented six-monthly at the local business and governance meeting and can easily be shared at individual team meetings.

Results:

Investigation reports are lengthy and service pressures mean colleagues will not always have time to read through them. A simple spreadsheet detailing highlights from local reports allows team managers and the head of clinical services to consider themes and demonstrates where actions from one team impacted on another.

The report supports reflection and further professional discussion, initially between team managers at our local governance meeting. It can then easily be shared as a whole, at clinical team meetings, and/or filtered to allow more nuanced discussion and sharing of learning and good practice with individual team members involved.

Next steps:

Our system relies on dedicated investigation managers carrying out all reviews of care in a locality, which does not happen uniformly around the trust. Business and governance leads are looking into the possibility of DATIX providing the information to allow the Wirral place-based system to be replicated Trustwide.

Contact: sarah.carroll10@nhs.net

Care Group: Specialist Mental Health
Team Name: Beech Ward, Bowmere Hospital

A new discharge information leaflet for Beech Ward service users

What did we want to achieve?

It was identified that there was not an organised system of giving service users information at the point of discharge. The purpose of the project was to develop an information leaflet to be handed out at the point of discharge that would provide useful information around follow up services and ideas to promote recovery. The aim was to help the discharge process to be as efficient, supportive and safe as possible.

What we did:

The discharge planning leaflet was developed as a collaborative project between:

Sally-Anne Atkinson, Beech Ward specialist occupational therapist

Aoife Coyne, Beech ward manager

Dr Sumita Prabhakaran, Beech consultant psychiatrist

Vicki Ashford, Home Treatment team clinical lead

Kim Taplin, Principal clinical psychologist

The team wanted the leaflet to include follow up appointment information and emergency contacts, as well as wider information that would be helpful to service users during their recovery. Several drafts of the leaflet were created, with an emphasis on having a person centred, easy to use resource. Once finalised, the leaflets were placed on the ward for all staff to be able to give to service users as part of the routine discharge process.

Results:

The leaflet is called *Beech ward - your recovery and moving on.* It includes personalised information about follow-up appointments (such as with the Home Treatment Team) and contact names. It uses plain language and is set out with colours and pictures to make it easy to understand.

The leaflet has a moving on checklist to prompt around key practical considerations pertinent to discharge such as having house keys and food/drink at home. The leaflet gives information about the Trust urgent mental health helpline and also websites, apps and phone numbers for mental health support, such as homeless services, Age UK, Mind and Stay Alive app.

The leaflet has been routinely given out on Beech ward since February 2021. Staff have felt the leaflet helps the discharge process to be more organised. The leaflet can also be shared with carers/family.

Next steps:

The leaflet could be adapted to be used on other wards. It would be useful to do an evaluation of the perspectives of service users and carers on how they have found the leaflet useful.

Contact: maria.yuen@nhs.net

Care Group: Children, Young People and Families
Team Name: Wirral CAMHS/Learning Disability (LD) CAMHS - Children and Young Peoples Intensive Support Function (CYP-ISF)

CYP Intensive Support Function (ISF)

What did we want to achieve?

The CYP ISF sits alongside CAMHS and learning disability CAMHS as an enhanced function providing intensive support to children and young people with learning disabilities and/or autism, who display behaviours of concern who are:

- Frequent attenders at A&E
- Experiencing a self-defined crisis and in need of support
- At risk of tier four admission or out of area placement
- At risk of delayed transfer of care from tier four

What we did:

The CYP ISF works directly with families, while bringing together a professional network focused on providing community-based multi-agency support. Established care pathways respond to escalating need benefitting young people, families and professionals.

The CYP ISF attend Care, Education and Treatment Reviews (CERTs), Tier 4 Care Programme Approach (CPA) meetings, chair monthly tracker meetings attended by CCG/social care aimed at monitoring and responding to escalating risk, as identified by the CYP dynamic support database.

CYP ISF contribute to a weekly multi-agency teleconference call, convened by the clinical commissioning group, to discuss young people accessing tier four services, the purpose being to prevent delayed transfer of care and interagency working.

Results:

In proactively identifying escalating needs and responding in a timely manner, the CYP-ISF aims to reduce the emotional costs to young people and families and economic costs associated with tier four admissions, delayed transfer of care and out of borough placements.

Since the CYP ISF has been established tier four admissions have reduced, as identified by NHS England transforming care data sets.

Initial findings from CYP ISF evaluation have highlighted that following interventions families and professional networks are able to understand and manage young peoples' distress within the community. Thereby promoting positive outcomes for young people and their families after CYP ISF interventions cease.

"The team are committed to person-centred care. Their robust response to potential crisis situations has been invaluable."

Next steps:

Tier four admissions were reduced following introduction of CYP-ISF. Savings on beds can be re-invested and reduction in acute attendance allows resources to be utilised elsewhere.

CYP ISF established a North West best practice and peer support forum to share good practice regarding intensive support services, thereby promoting access to innovative community-based provision.

Contact: Lisa.Thompson24@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)
Team Name: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI) - not team specific

Dynamic Support Database - Clinical Support Tool online training

What did we want to achieve?

NHS England requested training materials for the CWP created tool the *'dynamic support database - clinical support tool'*. An hour-long online training course is now available. The training is promoted and supported on the NHS England website and can also be accessed within CWP and on the CANDDID website.

What we did:

We were asked by NHS England to develop an online training resource that could be accessed nationally for anyone interested in using the CWP developed tool. Ceri Woodrow, Faye Bowden, Mizla Manandhar and Matthew Crouch (with support from many others) developed the training for clinicians. The training has videos, clinical scenarios and practice examples as well as plenty of information on the transforming care agenda.

Results:

NHS England supported all Trusts to access the training and we had 183 people from around England access it. The response was extremely positive with a satisfaction rating of 4.71 overall (on a 0-5 scale with 0 being 'not at all satisfied' and 5 being 'extremely satisfied').

Comments on what was useful included:

- An explanation on how to use the tool
- Use of case studies
- Examples used in training helped with practical application and assessment
- Knowing the training is evidence based and understanding the proactive nature of the tool

Next steps:

NHS England have asked for the continuing support of CWP in relation to dynamic support registers. We continue to offer the online training. We have also been asked to lead on national network events on the topic.

Contact: ceri.woodrow1@nhs.net

Care Group: Neighbourhood-based care
Team Name: Neighbourhood Integrated Teams

Feel Good Friday Shout Out - celebrating and thanking people in our teams each week

What did we want to achieve?

It was important for us to recognise, value and celebrate the excellent teamwork and patient care within our care group. All of our teams have worked incredibly hard during the pandemic, continuously adapting and flexing to meet the needs of our local population.

Community services have been the unseen frontline army during COVID-19, supporting highly vulnerable people to have safe care in their own homes. They have enabled consistent patient flow system wide, taking huge pressures away from the hospital and facilitating services in innovative ways out in the community. We wanted to raise the profile of physical health community teams by 'shouting out' every Friday a huge thank you via email.

What we did:

Staff were asked to nominate a team or person in writing each week for their outstanding contribution, hard work and commitment to physical health community services. It could be a simple act of kindness in the office, compliments from patients, academic achievements, exemplarily teamwork or high quality, person centred outcomes.

It was important to the care group that we celebrated everyone, at every level within our teams. This also included our students who continue to be active and contributory members of our teams.

Results:

Since April 2021, everyone in the care group has been involved nominating colleagues and students each week. A colourful celebratory email has gone out every Friday afternoon. These shoutouts have raised the profile of so much fantastic teamwork and patient care that is consistently happening every day. It has highlighted collaboration between teams and outstanding interventions for particularly complex community cases. Registered clinicians and our students within the care group have been able to use these shout-outs for professional portfolios and revalidation.

In April 2021, our evenings and nights community nursing team leader died very suddenly. In the weeks to follow the neighbourhood teams used the shout out email as a dedication and tribute to her. Staff shared stories and fond memories of working with her over many years. It was important to everyone to pay tribute to her commitment, passion, warmth and leadership within community nursing. We were able to send a copy of the tributes to her family.

Next steps:

The engagement in the weekly shoutout and nominations is continuing with great enthusiasm. We will continue to think of ways to celebrate and thank our teams within the care group and further raise the profile of our innovative physical health community services.

Contact: c.jones19@nhs.net

Care Group: Neighbourhood-based care
Team Name: Chester South Care Community Team

Formation of Chester therapy WhatsApp to support therapists and other Care Community team members

What did we want to achieve?

To utilise time effectively whilst shielding, due to health reasons, during the COVID-19 pandemic. When therapy assistant Deborah was unable to fulfil her normal duties, it was decided that she could assist with completing all admin tasks which would be normally carried out by individual therapists.

What we did:

To have a single contact point using WhatsApp, email and telephone calls, where therapists within Chester (and other community care team staff as capacity allows) can pass over admin duties, such as ordering equipment (Rosscare), completion of MA1 (home assistant hub), wheelchair referrals, orthotic referrals, follow-up telephone calls to service users and other services/agencies, complete audits, ensuring all patient registration details are correct.

Results:

The feedback from the therapists has been extremely positive as they have been able to concentrate on their clinical role as the therapy assistant's support, completing admin tasks, has freed up their clinical time. This has been particularly valuable when dealing with patients in crisis and needing to get equipment delivered to the house within four hours, as therapists have been able to contact the therapist assistant from the patient's home, request what is needed and designate the ordering of equipment to them.

Next steps:

Moving forward it has been agreed that therapy assistants will continue to support the team with this role on a rota-based system.

Contact: deborah.davis7@nhs.net

Care Group: Specialist Mental Health
Team Name: Wirral Crisis Response Meeting

Wirral Wide Crisis Response meeting

What did we want to achieve?

To promote a collaborative responsibility to risk management and safety planning for patients that have multi-agency contact. Proactively improving relationships between teams and across organisational boundaries that supports a reduction in duplication for the patient, creating a care plan that results in a timely person-centred response that promotes the diversion from emergency departments and demonstrates utilisation of services provided by a range of organisations to support the person at the right time in the right place.

What we did:

Over the past two years experienced senior leads, responsible clinicians and psychologists from the Crisis Resolution Home Treatment Team, Community Mental Health Team, Clinical Nurse Specialist Team, Liaison Psychiatry Team, Community Learning Disability Team, North West Ambulance Service (NWAS), Police, Wirral Ways to Recovery Service and Quality Surveillance Specialists have met for 1.5 hours every month to share information and review a previously identified patients journey through services at a time of crisis.

Expertise is shared to support the development of a collaborative care plan that is then shared with the group and with the patient. Care coordinators or primary workers of the patient are invited to the group to explore support from wider services such as NWAS and the Police that is resulting in improved relationships.

Results:

The Crisis Response meeting continued to meet throughout COVID-19 via Microsoft Teams. It has evidenced improved dialogue between organisations, receiving positive feedback from NWAS relating to patient experience. One example was where a patient was warmly handed over to Wirral Home Treatment Team (HTT) and diverted away from A&E.

NWAS has worked on a memorandum of understanding and clinical pathway that is progressing through the urgent care review. This will enable NWAS to contact the crisis line directly and divert known CWP patients away from the emergency departments. Working together, the safety plan for patients has improved and is reducing incidents of the patient falling between services and organisations. There is potential for this group to work more closely to provide timely appropriate responses that supports the collective responsibility approach as opposed to one team/ organisation trying to manage the risks presented. This results in a wraparound approach for the patient that is consistent and supportive.

Next steps:

The crisis response meeting will continue and will explore shared training opportunities across organisational boundaries, supporting the development of standard operating procedures between organisations and creating more cohesive working relationships that support safety planning for people in crisis.

Contact: glenda.bryan@nhs.net

Care Group: Specialist Mental Health
Team Name: Harm Reduction Unit

Working in partnership with multi-agencies to manage the risk of stalking and serial domestic abuse

What did we want to achieve?

The aim is to provide preceptees with a consistent approach and detailed structure to facilitate their learning and development within clinical practice, to improve preceptees experience to attract and retain nurses within inpatient services, and to enhance the skills and knowledge of the workforce to improve patient experience.

What we did:

The Harm Reduction Unit (HRU) is a collaborative, risk management service delivered by Cheshire Constabulary, the National Probation Service (NPS), CWP and Mersey Care NHS Foundation Trusts across Cheshire. We:

- Identify, assess and manage risk in stalking and serial domestic abuse cases
- Provide case consultation within Cheshire Constabulary, NPS, CWP and Mersey Care NHS Foundation Trusts
- Specialist victim's advocates will provide practical support, safety-planning and advocacy to victims of stalking and serial domestic abuse
- Support our multi-agency partners in the management of risk in cases of stalking, serial domestic abuse, fire setting, sexual violence and querulant behaviour
- Health practitioners will provide bespoke, short term, individual therapeutic interventions for some individuals when it has been deemed safe, therapeutically viable and the individual is genuinely motivated to address their behaviour
- Liaise with other specialist mental health services in the management of stalkers and serial domestic abuse perpetrators where appropriate
- Provide specialist training to police and partners
- Raise awareness of stalking and domestic abuse.

Results:

Since the HRU became fully operational in March 2021, we have received over 70 referrals into the unit through the legal process, police units and partners. In over half of these the health component has been involved in offering consultations regarding assessment of risk and management of individuals who engage in stalking or domestic abuse behaviours. We have also been able to carry out a large number of initial assessments to determine whether an individual is motivated to address their stalking or domestic abuse behaviours.

"The team provided valued input and expertise into the discussion around risk assessment and management plans. They were knowledgeable and approachable, and this support was appreciated by the team."

"I just wanted to pass on my sincere thanks for coming in to meet me today. It was fantastic to hear about what goes on in your team and all the great work you do and it really helped me get my head around things. I really appreciate your time and the brilliant job you all do."
– Assistant Chief Constable

Next steps:

The next step will be to continually develop, evaluate and improve the service. We will continue to collect evidence and data to demonstrate there is a clinical need for CWP practitioners to remain a part of the HRU in the years to come.

Contact: daniel.naden@nhs.net

Care Group: Children, Young People and Families
Team Name: Ancora House

Ancora House Nursing Preceptorship Package

What did we want to achieve?

The Ancora House Nursing Preceptorship package been devised to supplement the standard Trust Preceptorship programme. It has been designed to support newly registered nurses to make the transition from learner to autonomous practitioner, while developing in confidence and proficiency within the specialist clinical area. The aim is to:

- Provide preceptees with a consistent approach and detailed structure to facilitate their learning and development within clinical practice
- Improve preceptee's experience to attract and retain nurses within inpatient services
- Enhance the skills and knowledge of the workforce to improve patient experience

What we did:

We established current preceptees and preceptor's experience of utilising the standard Trust package. This highlighted inconsistencies in approach and a lack of detail regarding how competencies could be achieved.

We created a task and finish group and utilised a PDSA approach to consult with key stakeholders to design the package. The Ancora House nursing preceptorship package was presented trust-wide at the modern matron forum and inpatient service improvement forum. The package has been disseminated to all inpatient areas.

Results:

Data from the questionnaire completed by preceptees demonstrated an increase in confidence and understanding as follows:

- 100% of people rated their understanding of standard preceptorship as 'reasonable' with 75% rating their confidence in understanding as 'reasonably confident'
- 100% of people rated their understanding of the Ancora package preceptorship as 'very confident' with 100% rating their confidence as 'very confident'
- 50% of people rated their understanding of what they need to submit as evidence for the standard preceptorship as 'reasonably good' whilst 100% of people rated their understanding of what they need to submit as evidence for the Ancora Package as 'very good'.

The document was positively received by the modern matron forum, the inpatient service improvement forum, practice education facilitators and the associate director of nursing and therapies, for mental health and learning disabilities.

"Having a structure is so much better, I feel more confident already!" – Preceptee

"Ensures a consistent approach that we would like to replicate across the Trust."

Next steps:

The package is to be adopted trust-wide across all care groups, with adaptations to meet the needs of the specific specialist areas. We are currently updating and developing additional documents and guidance to support preceptees and new starters including a staff welcome pack, staff local two-day induction and a ward resource file.

Contact: r.sevillano@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)
Team Name: Adult Autism Service

CHECK! A resource to support CWP staff to work more effectively with autistic people

What did we want to achieve?

COVID-19 has been particularly hard for autistic people who already face substantial barriers to accessing and engaging with health services. As the 24/7 urgent mental health helpline was implemented, a resource was required to help practitioners understand and intervene effectively with autistic people, especially in distress, to improve outcomes and user experience.

What we did:

The CHECK poster was developed with clinicians and autistic adults. It informs what practitioners need to consider when interacting with autistic people in distress and suggests what to ask to inform reasonable adjustments.

The information was then transformed by a marketing company into a poster, free of charge and the adult autism team details were added to remind staff that the team can advise and support anyone working with an autistic person. The posters were disseminated to the urgent mental health helpline and more widely across CWP teams and services.

Results:

The CHECK poster has been used across the organisation and shared outside of CWP. It was incorporated into autism training both internally and across the UK by professional bodies/agencies and CWP staff have reported that it has reminded them of the needs and potential reasonable adjustments for autistic people.

It has been noted that the design has ensured the poster stands out on notice boards and that whilst autism training is useful, having a visual reminder of what to consider, especially when an autistic person is in distress, has been really helpful. The CHECK poster equips staff to improve health outcomes and offer individualised care, improving efficiency and experience.

Next steps:

The CHECK concept is now being developed into a framework encompassing further resources for carers, GPs and specialist autism services providing post diagnostic support.

Contact: clair.haydon@nhs.net

Care Group: Specialist Mental Health
Team Name: Specialist Perinatal Mental Health Service

Joint Specialist Perinatal Midwifery Care

What did we want to achieve?

The purpose of this work has been to provide specialist perinatal mental health expertise to the maternity services so that best practice evidence-based care can be delivered which is accessible and convenient for expectant mothers. It has also served the purpose of building closer working relationships between services and reduced waiting times to access specialist care which also ensures staff in maternity services are well supported in delivering their role.

What we did:

A joint venture where mental health practitioners from the Specialist Perinatal Service run clinics alongside maternal mental health midwives across the CWP footprint, in the Countess of Chester Hospital, Leighton Hospital and Macclesfield District General Hospital. We provide specialist input to the midwifery triage meetings at Wirral University Teaching Hospital.

Out team established relationships with the specialist midwives in each of the maternity units we serve and approached them about how we can support them and provide 'forward facing' care to ensure we reach the women in their service that may need us.

Once we established their requirements, clinics were identified and relevant practitioners from the service were chosen to support these clinics. Women are triaged to attend these joint clinics in advance and the specialist service then jointly assesses them with the midwives to draw up a collaborative care plan.

Results:

This initiative has allowed for closer working relationships between different professionals across perinatal services and reduced time to access specialist services as women are booked into the joint clinics after triage by the midwives. The service is greatly appreciated by the midwives as they feel supported in their role. It has supported the growth of our service and access rates.

Next steps:

There will be further expansion of this service to offer joint working with third sector partners such as Koala North West in Wirral and joint health visitor clinics. We wish to evaluate the existing service in more detail through patient satisfaction surveys.

Contact: bhairavi.sapre@nhs.net

Care Group: Neighbourhood-based care
Team Name: Hospital at Home Service

Hospital at Home Service expansion and transformation of Advanced Clinical Practice during COVID-19 Pandemic

What did we want to achieve?

COVID-19 increased the need for remote consultations, which impacted on demand for Community Advanced Clinical Practitioners (ACPs) face-to-face acute home visits. ACPs joined Hospital at Home to expand the community service offer. This new model resulted in the safe delivery of hospital inpatient interventions within the comfort and familiarity of the patient's home.

What we did:

The aim was to deliver acute, urgent (within two hours) clinical assessment and delivery of inpatient hospital level interventions within the patient's home, reducing the need for unnecessary A&E attendances and hospital admissions. Community ACPs embraced new ways of working and developed new and existing skills to provide more acute care delivery whilst continuing to deliver holistic patient centred care. This enabled patients to remain in their preferred place of care.

All staff engaged with training and development which was integral to the success of the new service delivery. Clinicians led service changes and community ACPs worked together as one team rather than as individuals.

Results:

- COVID-19 shaped, defined and accelerated the implementation of an expanded Hospital at Home team, which achieved significant benefits to patients
- Seven-day working has improved continuity of care and provided a more equitable service
- Delivery of patient centred care that reflects what matters most to patients
- Working collaboratively with primary, secondary and tertiary services to enhance patient outcomes
- All the above impacts on reducing the risks of hospitalisation to the individual which include deconditioning, delirium and healthcare associated infections
- Availability of medical support from the Hospital at Home GPs and the availability of step-up beds in Ellesmere Port have enhanced the provision of supportive care.'

Next steps:

Continue to offer support and role-model advanced practice across the four pillars of advanced clinical practice (Leadership and management, Research, Education and Clinical Practice) to further support our colleagues in the community. To continue to develop the acute visiting service and North West Ambulance Service admission avoidance work. In particular, the service aims to deliver on NHS England and Improvement's mandated two-hour urgent community response.

Contact: clairejames5@nhs.net

Care Group: Specialist Mental Health
Team Name: Meadowbank Ward

Using iPads to support interaction and engagement for people with dementia in hospital

What did we want to achieve?

To support regular and enhanced communication between patients and their friends/relatives whilst in hospital, via video calls, whilst strict visiting restrictions were in place during the pandemic. To also develop further opportunities for meaningful engagement for patients through the use of technology.

What we did:

During the pandemic, we were fortunate to be provided with an iPad for the patients on Meadowbank to use. This was being used for FaceTime calls so patients could maintain contact with their loved ones whilst there were strict visiting restrictions in place.

Having experienced the benefits of this, one relative went on to coordinate fundraising to purchase additional iPads for Meadowbank. We then received a donation of ten iPads for the ward, to ensure that all patients could have access to an iPad to use when needed. An occupational therapy technical instructor took the time to set up the iPads ready to be used on the ward and downloaded some dementia-friendly apps on the iPads.

Results:

The iPads were used regularly for FaceTime calls between patients and their loved ones, enabling patients to maintain contact. The use of video calls allowed patients and relatives to be able to see each other whilst chatting, which can provide much needed reassurance. FaceTime calls have also been beneficial for patients with more advanced dementia, who would be unable to communicate verbally on the phone but have been able to maintain contact with loved ones through video calls.

Carers have given positive feedback around the use of iPads, including it being helpful to be able to speak to their relative, being able to see how their relative is when visiting wasn't possible and in helping to brighten a patient's mood, as well as that of the relative.

As well as being used for FaceTime, the iPads were used to support meaningful engagement for patients on a one-to-one basis. This allows interactions to be tailored to individual patient need.

Next steps:

Whilst visiting restrictions have eased, the iPads are still being used regularly for FaceTime calls. We plan to continue to support patients to complete video calls, to enable better interactions with loved ones in between face-to-face visits. This will also enable relatives who are unable to visit, perhaps due to living further away or abroad, the opportunity to maintain contact with their relative and enjoy these interactions.

Staff are continuing to support patients to use the iPads on a one-to-one basis around their interests. We are continuing to explore apps and other ways in which the iPads may be beneficial for the patients on Meadowbank.

Contact: rachael.osullivan@nhs.net

Care Group: Specialist Mental Health
Team Name: Complex Needs Service Wirral

New pathway implementation within Complex Needs Service Wirral: Intensive Case Management

What did we want to achieve?

The purpose was to evaluate the impact of Intensive Case Management (ICM) on client outcomes and service utilisation. We have compared pre-recorded data from 5 months prior to commencement onto the ICM programme and compared that to data for the first 5 months of the intervention.

The data to be analysed includes: A&E presentation, contact with police/street triage/section 136, time spent on general/psychiatric inpatient wards, crisis intervention (home treatment/crisis line), mental health act assessments, Criminal Justice Liaison team and Community Mental Health team input.

What we did:

We have developed a new treatment pathway within Complex Needs Service (CNS) Wirral. This was set up in February 2021. The treatment pathway is called ICM, also known as enhance structural management, and is a newly designed therapeutic intervention that aims to target individuals with complex personality disorders.

This piece of work involved allocation of cases, intensive psychotherapy supervision as part of the model but more importantly we trained up staff with very little experience to facilitate treatment in a new therapeutic intervention We believe that this innovative model of care has improved not just the quality of care of the patients but also is to be cost saving for the Trust.

Results:

- The reduction of overall hospital stays (number of days) reduced from 482 to 248 which is a 49% reduction of local inpatient days usage. If translated to financial savings, this represents £100,440 saving in five months
- We've analysed the data for each patient contact with A&E, Home Treatment Team etc.
- We calculated a net saving of £90,426 (this is because the A&E contacts and Street-car-triage increased slightly).

Next steps:

We will continue to evaluate the impact of ICM, we will collect that data comparing 12 months before and 12 months after the inception of ICM. After this we will complete a two-year comparison before and after the inception of ICM, this is because ICM is a two-year treatment and will be interesting to complete the evaluation when therapy have come to an end.

Contact: kathia.sullivan@nhs.net

Care Group: Children, Young People and Families
Team Name: Youth Justice Service Health Team

Youth Justice Service health team lead the way in trauma informed practice

What did we want to achieve?

To provide specialist input and lead the development of the internal trauma informed working group. This has included developing a base line around trauma informed practice and vision across the Youth Justice Service (YJS). The key goal has been to raise awareness among all staff about the wide impact of trauma and to prevent re-traumatisation of the young person in service settings, in addition to adapting policies, practices and procedures.

What we did:

Four CWP Child and Adolescent Mental Health practitioners and a CWP speech and language therapist became trauma ambassadors within the YJS. A workshop was facilitated to attain practitioners view of the vision of YJS trauma informed services. This information was collated and subgroups formed with identified action. A trauma-informed action plan was devised looking at strategic objectives, action, success criteria and identified risks.

Results:

- A training pack was developed by the health team and is being delivered to YJS staff, volunteers and services involved with the young person. This training focusses on 'what has happened to you' and guides practitioners to look at the underlying needs behind behaviours.
- The health team have formulated a crib sheet based on an acronym 'THINK TRAUMA' for staff to have as an aide memoir when engaging with the young person.
- The outcome of the subgroups has been communicated to the service via trauma corner a new feature in the monthly service newsletter. Notice boards in office spaces have also been updated with information about trauma informed practice.
- Specialist training was funded by YJS for the healthcare team in interventions such as Eye Movement Desensitisation and Reprocessing, Dialectical Behavioural Therapy and mindfulness. These interventions are being used with young people within the service.
- YJS practitioners are reassured that specialist care can be provided from the health team colleagues. YJS practitioners are able to directly access trauma informed consultation, assessment and interventions in addition to reflective group supervision.
- YJS policies and procedures have all been reviewed and adapted to ensure that trauma focussed language is being used.

Next steps:

YJS health team has made a commitment to influence a broader culture of trauma informed practice across the Cheshire footprint. This will look at inter-agency working and identifying training needs. In service training is ongoing with volunteers that are part of the panel process whereby decisions are made regarding the content of the young person's order. This includes adapting communication styles, enabling access to services and ensuring that the voice of the child is clearly heard.

Contact: jane.white20@nhs.net

Care Group: Specialist Mental Health
Team Name: The Fitness and Wellbeing Team

Developing a running group at Bowmere Hospital

What did we want to achieve?

Allowing inpatient service users access to running outdoors with support from trained fitness instructors to help improve physical and mental health. This form of aerobic exercise is known to help reduce stress, improve heart health, and help reduce symptoms of mental health disorders such as depression.

What we did:

Prompted by service user requests, we worked alongside the occupational therapy department and wider team to develop a running group, where service users could take part in running to improve their physical health, mental wellbeing and for enjoyment. We have scheduled running group sessions, where service users can be trained by or run alongside a qualified fitness instructor. To reach the objective of running outside an initial assessment and an introduction to running was first done using the treadmill in the gym setting.

We have found safe routes within the area close to the inpatient hospital grounds where service users can run a distance from 1k to 5k. We have also created a running resource pack highlighting where each of the distances would be met alongside a 'couch to 5k' workout and the benefits of running.

Results:

Service users have been able to increase their physical health and some within a rehab setting have made it a regular part of their weekly regime. All service users taking part in the sessions have said they enjoy them and show enthusiasm for continuing when discharged.

Some have taken it upon themselves to go for runs outside of the fitness and wellbeing scheduled sessions. One individual has completed over 100 runs since being a part of this initiative and has stated how much he values going for the runs and will treasure a certificate he was presented with for his achievement.

"Those service users who have taken part in the running group have commented how much they enjoy it and are really proud of their achievements. Not only has it had an impact on their physical health but their mental health is also improved by simply taking part." – Occupational Therapist, Rosewood.

Next steps:

We plan to look into creating greater partnership links within the community so that service users can continue to enjoy running when discharged from hospital. We also want to introduce service users to fun run events where they can enter for enjoyment or as a competitive hobby.

Contact: donna.cain@nhs.net

Care Group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)
Team Name: The Fitness and Wellbeing Team

Adapting physical exercise for service users on Eastway during COVID-19 pandemic

What did we want to achieve?

To continue to provide accessible fitness resources to those with learning disabilities, so that they can continue to gain basic awareness of the benefits of enjoyable physical exercise and improve their physical and mental wellbeing.

What we did:

We worked alongside the Eastway multi-disciplinary team to provide service users with the opportunity to engage in physical exercise during their inpatient stay whilst being unable to attend the gym due to COVID-19 restrictions. By introducing and adapting the variety of equipment and exercise programmes we offer we have been able to ensure that individuals isolating have still been able to take part in meaningful exercise tailored to suit them.

Sessions have been on a one-to-one basis, so service users had exclusive access to a qualified member of the Fitness and Wellbeing team. Pictorial cards were also created to help explain how to do the activity or as a motivational aid tailored to suit individual needs, all of which allowed more accessibility to people with autism or cognitive difficulties to maintain their physical health and improve their mental wellbeing.

Results:

- Many of the service users have been able to engage in meaningful physical exercise whilst being in hospital and having limited access to community activities
- All service users taking part in the sessions have said they enjoy them or show enthusiasm for the activities
- Ward staff have seen the benefit of additional input and welcomed the support from other departments.

"Our service users have really valued the additional input; it has been so important to ensure they have been able to keep physically active during the pandemic restrictions." – Occupational Therapist, Eastway

Next steps:

Continue to work with the occupational therapy and wider team at Eastway to develop further ward-based opportunities. We also want to look into creating greater partnership links within the community so that service users can continue to enjoy meaningful physical exercise when discharged from hospital.

Contact: donna.cain@nhs.net

Care Group: Neighbourhood-based care
Team Name: Cardiac Rehabilitation

Flexible approach to clinical working

What did we want to achieve?

To look at the impact of the reduction in face-to-face contact and clinical assessments for patients referred to cardiac rehabilitation during COVID-19 between March 2020 and June 2020 and to see if this reduction in the clinical patient interface would impact on readmission rates /bed days for cardiac admission at the Countess of Chester Hospital (COCH).

What we did:

- Changed elements of service/patient interface to include more remote monitoring (home blood pressures)
- Maintained face to face review for the at risk
- Offered a highly individual plan of care and follow up that was supported with additional telephone lifestyle and secondary prevention coronary heart disease (CHD) clinics
- Offered a one stop shop clinics for nurse prescribing, clinical assessment and exercise capacity tests (for occupational return to work/function and symptom management)
- Rapidly adopted 'new' platforms for virtual cardiac rehab delivery in keeping with evidence-based medicine.

Results:

Despite the COVID-19 restrictions and total loss of facility and base, we were able to adapt to more agile way of working within the community at a new temporary clinical location and maintain the most important elements of clinical practice for patients with CHD and heart failure.

- 27% of cardiac rehab patients readmitted to COCH with the first four months of national lockdown
- When cardiac rehab face to face resumed readmission for patients reduced to 15% (12%) reduction
- 70 bed days per month on average were cost saved when face to face resumed
- Projected that normally when all staff are patient facing the readmissions will be average 5% if staff have a permanent base.

Service user (tearful after cardiac surgery) said:

"You are the only person that has seen me face-to-face. I can't thank you enough, I haven't been able to see anyone, not even my GP."

Next steps:

Continue the audit to benchmark against readmissions comparing pre COVID-19 and during COVID-19 and the impact of reduced face to face contacts and lack of clinical space compared to pre-COVID-19. Continue the virtual cardiac rehabilitation component in additional to home visits for appropriate patients who require specialist follow up.

Contact: sophie.mcintosh@nhs.net

Care Group: Specialist Mental Health
Team Name: Birkenhead Adult Mental Health Service/Wallasey and West Wirral Adult Mental Health Service

The Living with Emotions Group

What did we want to achieve?

The purpose of the project was to run an emotional regulation group across two community mental health teams.

What we did:

The assistant psychologists from the Birkenhead Adult Mental Health Service and the Wallasey and West Wirral Adult Mental Health service co-facilitated an 8-session emotional regulation group for participants under the care of the respective teams.

The group focused on the development of skills and drew on therapeutic models such as Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Compassion Focused Therapy.

The group was initially held face-to-face but was moved to a virtual format to allow for higher participant numbers and to maintain the safety of our service users during the COVID-19 pandemic.

Results:

This project allowed service users across two community mental health teams to gain swift access to psychology through a group intervention. This had a positive impact on waiting lists for both teams. Delivering the group virtually via Microsoft Teams allowed people to access psychology despite the restrictions associated with the COVID-19 pandemic.

After completing the intervention, one service user reported:

"I have learned that I need to become more aware and accepting of my emotions and acknowledge them in a compassionate way."

Another service user reported that she enjoyed the group and was keen to engage in any other groups that the team(s) may offer in the future.

Next steps:

The next step is to run another virtual cycle of the living with emotions group.

Contact: katie.kavanagh6@nhs.net

Care Group: Specialist Mental Health
Team Name: Wirral Eating Disorders Service

Development and delivery of an online Compassion-Focused Therapy Group for Eating Disorders

What did we want to achieve?

To provide an alternative evidence-based intervention and modality to the current pathways in the service in order to enable more patient choice and to have a different intervention to suit their particular needs. Further, to provide time efficient option to help support the waiting list.

What we did:

Dr Clare O'Grady wrote and delivered (with the support of Meeta Singh) a Compassion-Focused Therapy Group for Eating Disorders (CFT-E) programme, which drew upon the evidence base, but was adapted to fit the needs of the group members.

This involved promotion of the group across the different eating disorder services in the Trust, development of inclusion/exclusion criteria, and approval from the service to run the group.

Following this was invitation letters to suitable clients, assessment and formulation of all of the group members, development of power-point slides, letters, course materials, outcome measures and post-group reviews. Finally, there was an evaluation of the group.

Results:

Overall, there was a reduction in clinical symptoms of eating disorder and an improvement in self-compassion and self-esteem scores. Engagement in the group was very good, with 80% of those who started the group completing it and 75% being discharged following the group due to good outcomes.

The following is some of the feedback given:

"I've learnt and continue to learn that by slowing down and considering mindful action (with practice) can make a real difference to my habits. I've also learnt that compassion for myself, allowing myself space and kindness when it does, and doesn't go to plan is also vital."

"As a group your warmth, honesty and sense of togetherness has made me feel equal and worthy of this time to explore my relationship with my emotions and diet."

Next steps:

The group is being adapted in other eating disorder services across the Trust and this new pathway is being more formally developed by the clinical network of Eating Disorder services in the Trust.

Contact: clare.ogrady@nhs.net

Care Group: Children, Young People and Families
Team Name: Children's Speech and Language Therapy Department

Provide flexible and open access to training during COVID -19 for parents/carers and early years settings to support children's Speech and Language development

What did we want to achieve?

We have delivered a training package to introduce parents to the early communication development that children require before starting on the Speech and Language Therapy Department pathway.

Training has been made very flexible to fit around people's home and work life during COVID-19 and was only introduced due to the COVID-19 restrictions and lockdown.

What we did:

We 'up skilled' ourselves to be able to transfer the training from face to face to Microsoft Teams. This also involved putting together packs to be sent home for the parents to take part in the interactive parts of the session and videos to watch. It also involved us doing research in confidentially issues when inviting parents to an MS Teams training course.

Results:

Parents verbal feedback included that they are much more engaged when therapy starts. It has also been made more accessible for families to attend who don't have childcare and /or transport.

"I am a single parent that doesn't drive so having the training delivered by teams is the only way I could have accessed the training."

"I found the workshop really useful and it helped me understand what I need to do before the therapy started."

"I wouldn't have attended a face to face session as I get anxious talking in front of other people however I was able to turn my camera off and be fully engaged without the fear of being judged."

Next steps:

Due to the success, we will be continuing with the training in this format due to the feedback provided from parents.

Contact: a.burns1@nhs.net

Care Group: Children, Young People and Families
Team Name: Infant Feeding Team

Invitation only Breast-Feeding Support Group

What did we want to achieve?

Pre-COVID the Starting Well Service provided three infant feeding drop-in groups which were facilitated within three Districts: Northwich/Winsford, Chester and Rural and Ellesmere Port and Neston. Due to COVID restrictions the groups were suspended and support provided virtually, however, it was acknowledged that there are significant benefits from face to face support and peer support which the virtual offer could not replicate.

The Infant Feeding Leads, through discussion with the Starting Well Nurse Consultant and in line with CWP and Government Guidance in relation to COVID-19, developed a bespoke invitation only breast-feeding group.

What we did:

Three groups were run each week, one in each district, across Cheshire West and Cheshire. A cohort of six mothers and infants were invited to attend each group for five sessions.

Results:

- Anxiety in relation to feeding in public reduced
- Mothers felt supported in relation to breast feeding and this resulted in the continuation of breast feeding for their infants
- An invitation only group reduced the anxiety of attending groups knowing that everyone was attending for the first time
- Social isolation was prevented, and mothers indicated that the group supported their emotional health and well-being
- Friendships have developed and contact numbers exchanged which has led to informal ongoing support within the wider community setting

The Starting Well 0-19 service has seen a steady increase in the continuation of breast-feeding rates at 6-8 weeks over the past year through investment in workforce development, the development of an Infant Feeding Team and the re-shaping of the Breast-Feeding Group offer. A selection of comments from attendees:

"I plan on contacting the other mothers and keeping in touch. Thank you so much for this free service, it has been so valuable, and you have all been lovely."

"Having a relaxed environment with mums in similar situations where we could freely ask any question and get support without judgement. The tips and tricks I picked up in terms of fitting expressing and breastfeeding times around my already full life were invaluable."

Next steps:

A huge investment has been made in relation to workforce training and development with the implementation of a comprehensive audit programme. The audit programme is providing evidence to demonstrate that the workforce is educated and are utilising evidence-based interventions to support new parents, as well as adhering to the Baby Friendly Standards.

The training offer has been attended by all *Starting Well* Staff and offered to all our *Bosom Buddies.*

Contact: clairemaidment@nhs.net

BIG BOOK OF BEST PRACTICE 2021

To find out more about our Care Groups please visit our website:
www.cwp.nhs.uk

Cheshire and Wirral Partnership NHS Foundation Trust
Trust Headquarters Redesmere
Countess of Chester Health Park
Liverpool Road
Chester CH2 1BQ

Tel: 01244 397397

@cwpnhs