Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Improvement Report

Edition 1
April – July 2017

Vision:
Leading in partnership
to improve health and well-being by providing high quality care

Experience based design project delivers an improved quality of service at Upton Lea (see page 20)

Care • Well-being • Partnership

Welcome to CWP's first *Quality Improvement Report* of 2017/18

These reports are produced three times a year to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. We are required to formally report on our quality improvement priorities in the annual *Quality Account*.

CWP's *Quality Account* and *Quality Improvement Report*s are available via:

http://www.cwp.nhs.uk/our-publications/reports/categories/431

Reporting on the quality of our services in this way enhances involvement of people by strengthening our approach to listening and involving the public, partner agencies and, most importantly, acting on the feedback we receive.

At CWP, we are starting to look at ***quality*** in more detail to better demonstrate where we are making real improvements, with the aspiration to achieve **equity** of care through ***quality improvement***. We are using international ways of defining quality to help us with this aim. This edition will focus in more detail on other areas of quality such as the **accessibility**, **affordability** and **sustainability** of care.

QUALITY					
Patient safety	**Clinical effectiveness**			**Patient experience**	
Safe	**Effective**	**Affordable**	**Sustainable**	**Acceptable**	**Accessible**
Achieving **Equity** and **Person-centred Care** through **CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES**					
Delivering care which minimises risks	Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs	Delivering care in a way which maximises use of resources and minimises waste	Delivering care that can be supported within the limits of financial, social and environmental resources	Delivering care which takes into account the preferences and aspirations of people	Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs
"Being treated in a safe environment"	*"Receiving care which will help me recover"*			*"Having a positive experience"*	
"Being protected from harm and injury"	*"Having an improved quality of life after treatment"*			*"Being treated with compassion, dignity and respect"*	

This report is just one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance.

This *Quality Improvement Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide. It also provides examples of **quality improvement** projects.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

Improving the effectiveness of pre-admission assessments has reduced lengths of stay by an average of 2 days
➲ see page 4

Central and East Substance Misuse Service has worked on preventing drug related deaths by training carers and other agencies in the use of naloxone
➲ see page 9

Falls prevention programme is reducing the risk of harm from falls on our inpatient wards
➲ see page 10

Winsford CAMHS are working with families to support the emotional well-being of the children and young people accessing their services, as well as building resilience for care givers
➲ see page 12

Croft ward are improving collaborative working with secondary care to provide enhanced access to medical input for frail older patients
➲ see page 16

An experience based design project has involved both staff and patients to improve initial mental health assessments in Chester Adult CMHT
➲ see page 20

Lime Walk are increasing the involvement of carers to aid the recovery of patients accessing their services
➲ see page 22

An explanation of terms used throughout this report is available on the Trust's internet:
http://www.cwp.nhs.uk/reports/1628-quality-reporting-glossary

IMPROVING QUALITY

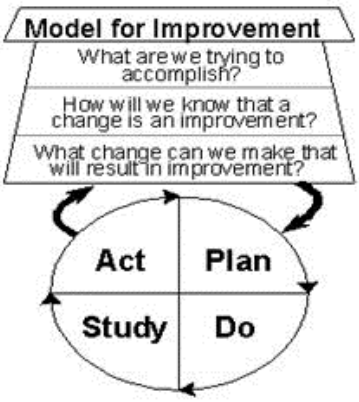
Improving the effectiveness of pre-admission assessments

Background:

People in acute mental health crisis have often been admitted to acute psychiatric hospitals without a clearly articulated rationale of how the admission plans to help them. Sean Boyle, (pictured right), lead practitioner in Wirral Crisis Resolution Home Treatment (HT) team, attended a **Patient Safety Leader** course facilitated by AQuA, and has completed a project to improve the 'gatekeeping' process undertaken by his team. Working with Rachel Fay, the team's administrator, Sean analysed all admissions to Lakefield and Brackendale wards at Springview Hospital. Gatekeeping is a process whereby the HT team assess whether a patient who is experiencing an acute episode of mental illness needs an inpatient admission, or support and treatment at home. This assessment details the reason for the admission, what the treatment aims to achieve, and the estimated length of stay on the ward.

What did we want to achieve?

It was hoped that by improving the gatekeeping process, highlighting reasons for admissions and estimating the length of that admission, that patients would have a clearer idea of how they were going to be treated. This would potentially reduce confusion and delays of how and when patients returned to their original place of residence, thus focusing the admission. An additional benefit would be improved flow of patients through acute inpatient beds, which have been reduced by 60% in number over the past 10 years, following the move towards better community based care.



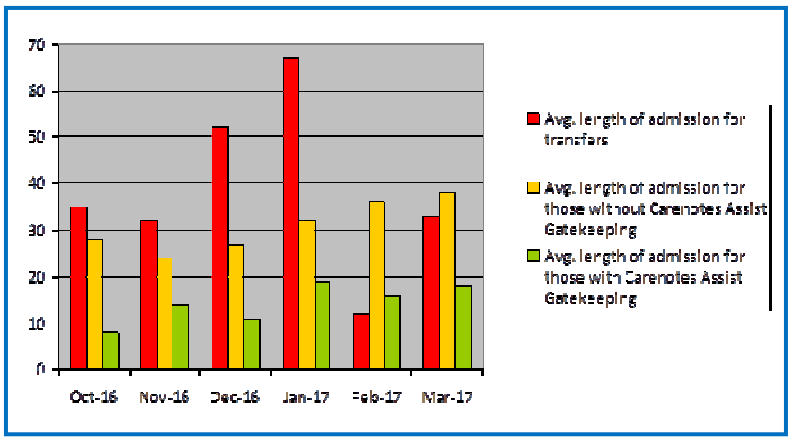
What we did:

We used the **Plan, Do, Study, Act (PDSA) model for improvement**. We wanted to ensure that all admissions to an acute mental health bed on Lakefield and Brackendale wards had an enhanced gatekeeping assessment tool completed on CAREnotes Assist, which is part of the Trust's electronic record system.

Results:

Utilising the PDSA cycle has led to increased usage of the assessment as highlighted in the results below. One result has been a **reduced length of stay** for those patients who have been gate kept via the new tool. Flow has improved and this may mean patients admissions are more focussed and discharges are without delays.

The graph, right, shows the reduction in length of stay following increased use of the new Gatekeeping Assessment tool. This tool has now been introduced in both the West and Central & East localities. Analysis of data in West also demonstrates a reduction in length of stay, with a median of 16 days when the tool is used, and 18 days when not.



This is one example of many in the Trust that shows how our staff are embracing our Zero Harm campaign, which is about **supporting people to deliver the best care possible.** This project demonstrates how staff are using their training in **quality improvement methodology** to deliver **high quality care** which **maximises use of resources.**

For further information, please contact Sean Boyle on 0151 482 7854

Custodial Partnership Groups promote continuity of care

Prison may not always be an appropriate environment for those with severe mental illness, and custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide. In addition, recent studies of mental health services for prisoners suggest that there is still some way to go in achieving equivalence with mental health services in the community. This project exemplifies how we are achieving **equity** and **person-centred care.**

Key statistics

Since June 1995, the prison population in England and Wales has increased by 60%, or more than 30,000 people, to reach record levels. Figures for July 2017 put the prison population at 86,253.

Background:

Gordon Leonard, Specialist Forensic Lead for CWP (pictured left with Brendan O'Hare, *National Probation Service*), has been working on a project to develop a **Custodial Partnership Group** to address and **improve pathways for patients with mental health problems or a learning disability in prison**, and provide planned support when they are released. The Cheshire and Merseyside Forensic Support Service noted that some patients were being released from prison with no support in place, or at very short notice, consequentially CWP teams had very little time to assess the patient prior to prison release. We considered this to be unacceptable, and that there needed to be a mechanism that identified the patient's needs six months prior to their release, prompting care services to get involved early to ensure an appropriate clinical pathway for each individual.

What did we want to achieve?

Working together, across agencies, criminal justice services needed to join up their thinking and tackle the issues of mental health and learning disabilities through multi agency approaches, so that as individuals go through the system they are treated both consistently and fairly. To achieve this aim, we wanted to:

- Explore ways of working better with the *HM Prison Service*.
- **Improve communication** between prisons and NHS staff.
- Enable sufficient time to undertake effective assessment of an individual's mental health.

What we did:

We set up a Custodial Partnership Group with four local prisons: Risley, Thorn Cross, Altcourse and Styal. We are also working to develop links with the new Berwyn prison in Wrexham.

A meeting is held every 6-8 weeks to discuss new cases we are concerned about. At these meetings we discuss cases where prison staff feel there is a requirement for mental health or learning disability support via CWP services. Following the identification of a vulnerable individual, we identify if he or she is already known to CWP services, or identify the most appropriate Single Point of Access (SPA) team and enable an assessment prior to their release from prison.

Results:

The project has resulted in **integrated working** with the *Prison Service*, through information sharing and pathway identification. There is **improved multi agency public protection** (MAPPA) and **improved support** for individuals leaving prison locally. Following some initial problems with getting attendance from local prisons to the meetings, the group is now working towards improved attendance and currently revising its terms of reference. A number of cases have been highlighted and subsequently supported more effectively when leaving prison because of this initiative.

Next steps:

The group are developing further information sharing agreements and looking at developing links with private sector prisons. Gordon is currently working with one of CWPs Assistant Clinical Psychologists, Felicity Watkin, on an opinion paper, to **recommend national adoption of this process to support continuity of care**. Mike Beasley (Forensic Practitioner CWP) has also worked on this initiative, and supported the chairing of the Custodial Partnership Group meetings.

For more information, please contact Gordon Leonard, Specialist Forensic Lead 01625 862414

Trafford Autism team working in partnership to support independent living

Background:

The national Autism Strategy defines autism as a lifelong condition that affects how a person communicates with and relates to other people. Many people with autism struggle to move on from their family home because they are not a priority for social housing, and often do not qualify for supported living options. Services are generally focused on responding when there is a crisis but struggle to work when a "preventative" approach is needed.

What did you want to achieve?

We worked in partnership with a local social housing provider and *Trafford Council* to support people with autism to move into independent living.

What we did:

Initially, this project involved running focus groups, meetings with families, *Trafford Council* and housing providers to identify the needs of adults with autism.

Individuals are referred to the project by professionals working across different agencies. Once referred, their application is discussed at a housing panel and if accepted they are placed on *Trafford Housing Trust*'s (*THT*) internal transfer list. When suitable properties come up, they are offered to people on the list. If additional social care support is needed, the person can be referred for a social care assessment. By acting as the link between people and families, *THT* and *Trafford Social Services*, we have been able to **provide homes and person-centred social care** support for 12 people with autism who would otherwise not have had the opportunity to move out of their family home.

Results:

This project provides an example of agencies working together **within existing resources without additional staffing costs**. This project relied on the recognition of unmet need and a willingness of agencies to work together **sharing resources, skills and knowledge.** Those involved committed additional time, energy and enthusiasm within their existing job roles to initiate and maintain the project.

Case study:

John (38 years old) moved into a flat reserved for people over 50, but the flat had been empty for some time. Without this project, John would not have been considered for this property

"I felt ready and wanted to see if I could cope. I had been on the waiting list with HOST for ages and hadn't made any progress. There is less strain in the relationship I have now with my parents."

John's mother had this to say:

"I wanted him to begin living independently while we were still well enough to provide background support. I felt that if he lived with us until this was no longer viable, and then had to manage on his own, he may have found himself suddenly filled with regret that he hadn't tried while he was younger."

Next steps:

We will continue to work with *THT* and social services to support people to access independent living and the appropriate social care support. We will also work with other housing providers to identify future ventures, and have already presented at a

regional event and a local housing provider forum. We hope that other housing providers will recognise this as an example of good practice.

For more information please contact Jane Forrest, Autism Support Coordinator on 0161 912 2807

Winsford 0-16 CAMHS Team supporting young people to raise awareness about mental health in schools

Background:

The initial catalyst for the project was the 'Takeover Challenge' which took place in November 2016. Takeover Challenge is an annual event, which sees organisations across England invite children and young people to 'take over' their job roles and be involved in decision making, and raise issues that are important to them. As part of this year's 'takeover', young people requested that they be supported in visiting local schools and other agencies to discuss their experiences of mental health. (Pictured left and below are some of the young people who took part in the project.)

What did we want to achieve?

The project's aims were to:

- Raise awareness of 'real life' mental health issues
- **Decrease the stigma** around mental health
- Encourage schools and agencies to 'rethink' their approach to mental health
- Increase staff's confidence in having conversations around mental health
- Empower the young people to reflect on their journey and share their experiences
- Increase the young people's confidence and give them a sense of 'giving back'

What we did:

A variety of young people attended four school meetings and a CAMHS team meeting as part of the pilot project. This was supported by a Tier 3 mental health practitioner. Five young people took part in the project, and were given autonomy to decide what they wanted to discuss, the messages they wished to portray, and their hopes for the project. The young people volunteered their own time to participate in the project as it was something they felt passionate about.

Results:

Feedback was received from the 34 teaching staff who attended talks given by the young people. Using thematic analysis, the main themes which were prevalent in the feedback were grouped together and analysed.

Next steps:

The young people have expressed clearly that they would like to continue going into schools to do these talks, as they feel it benefits them as well as the professionals involved. The project has already been approached by other services and agencies to request input and to request talks. It is hoped that the school staff who have attended this training will take the lessons and information supplied to build on the mental health information and education in their schools. This will also help to support young people in developing awareness and management of mental health difficulties early on in their journey rather than waiting until things have escalated. The feedback from young people suggests that the project is **helping them as part of their therapeutic journey**, suggesting that this project is an important part of the service.

For more information, please contact Rebecca Kinnear, Mental Health Practitioner on 01606 565240

QUALITY SUCCESS STORIES

We have set three **Trustwide quality improvement priorities** for 2017/18, which reflect our vision of "**leading in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

We have made a commitment in our *Quality Account* to monitor and report on these in our *Quality Improvement Report*s. This year, the common focus across all the priorities is **reducing unnecessary avoidable harm** to help reduce avoidable variations in the quality of care and to improve outcomes.

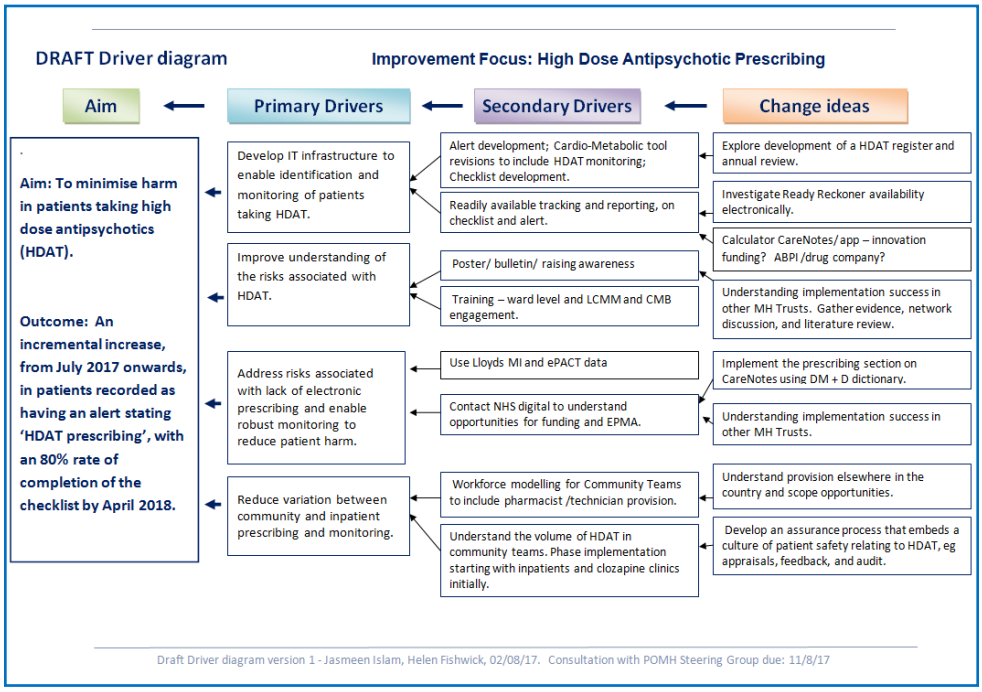
This year, as well as setting a number of areas for overall continuous quality improvement, a number of goal driven measures aligned to the dimensions of our **safety management system**, and to the Trust's forward operational plan for 2017/18, have been set. These are an increase in the identification and monitoring of patients taking high dose antipsychotics (see below); an improvement in the average bed occupancy rate for adults and older people (see page 4 and page 12); and improvement in embedding a person-centred culture across the Trust (see page 19).

Patient Safety Improvements

Goal driven measure for patient safety

CWP *Patient Safety* improvement priority for 2017/18
Increase in the identification of patients taking monotherapy or combination antipsychotic treatment, in which daily doses exceed the recommended maximum limits (according to the British National Formulary) to improve monitoring of the associated risks

At the start of 2017/18, we set a goal to minimise harm in patients taking high dose antipsychotic treatment (HDAT). There are greater risks, including serious physical side effects, when antipsychotic drugs are taken in high dose or in combination.

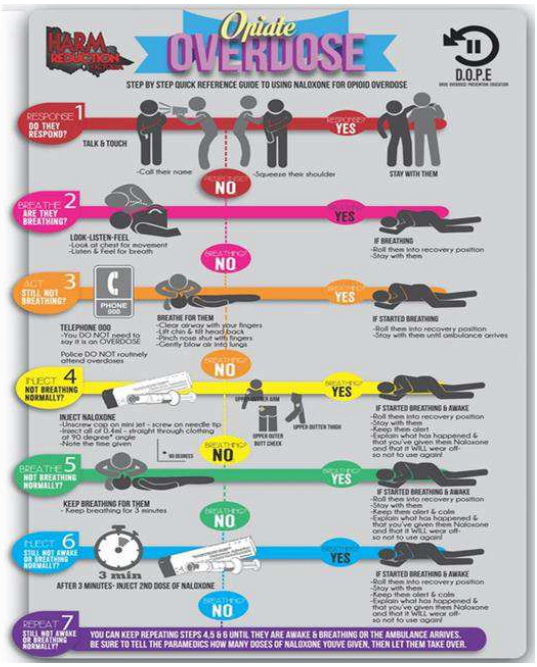


This project aims to increase the identification of patients on this treatment so that we can **improve monitoring of the associated risks**. The driver diagram, left, details the range of quality improvement activity being developed to achieve this goal. These include:

- A checklist and an alert have been produced to assist clinicians in monitoring the risks associated with HDAT.
- We are developing the IT infrastructure so we can flag and monitor patients at risk.
- Raising awareness through bulletins and posters.
- Developing training provision.

For more information, please contact Jasmeen Islam, Acting Chief Pharmacist on 01244 397380

Central and East Substance Misuse Service work on preventing drug related deaths



Background:

The *NHS Substance Misuse Provider Alliance*'s inaugural conference was held in Prestwich on 25 April. CWP is a member of the Alliance and this was a fantastic opportunity for our staff to share good practice, innovative ideas and to network. The conference topic was **'Preventing Drug Related Deaths'** which are disappointingly on the increase nationally. The purpose of the conference was to provide an insight into what is causing so many of the people who access Substance Misuse Services (SMS) to die early through what are often avoidable deaths.

Professor John Strang OBE, who delivered the keynote speech (below), talked about the need for better action in preventing opioid deaths – a call to arms for the sector in responding to where the risks are, and applying a broad range of remedies, including the use of naloxone. Naloxone is a prescription medicine that blocks the effects of opioids and reverses an overdose. Professor Strang reported that most people are in the company of others when they overdose, and by being given training, and a take home pack of naloxone to carry with them, this will **inevitably save lives**. Research has shown that with basic training, non-medical professionals, such as friends or family members, can recognise when an overdose is occurring and give naloxone.

What did we want to achieve?

We wanted to **prevent avoidable deaths** from opioid overdose by providing training in the use of naloxone, and to cascade this training to others involved in the care of service users at risk of an overdose.

What we did:

All SMS staff have been trained, including how to train people accessing SMS services, family, friends and carers to use naloxone. This enables individuals to administer naloxone in the case of an opiate overdose in the community. In addition, training has been rolled out to the staff at a community housing project (*Emerging Futures*). All their current staff have been trained, and a supply of naloxone has been provided to each accommodation site.

Key statistics

A national overview of the impact of drug related deaths highlighted that although the majority of these deaths are of males, deaths of females are also steadily rising. Where deaths are not directly related to the use of a substance, a person using substances over the age of 45 is 27 times more likely to die by homicide than someone in the general population, and the risk of suicide was also significant.

Next steps:

We will continue to monitor, support and train people. In addition, we will be looking to continue to promote with other agencies and hold an event during *Overdose Prevention Week* in August, in which we will offer further training and naloxone supplies to family, friends and carers.

National data presented at the conference will be used to compare with CWP data on drug related deaths to enable us to identify further opportunities to learn and improve.

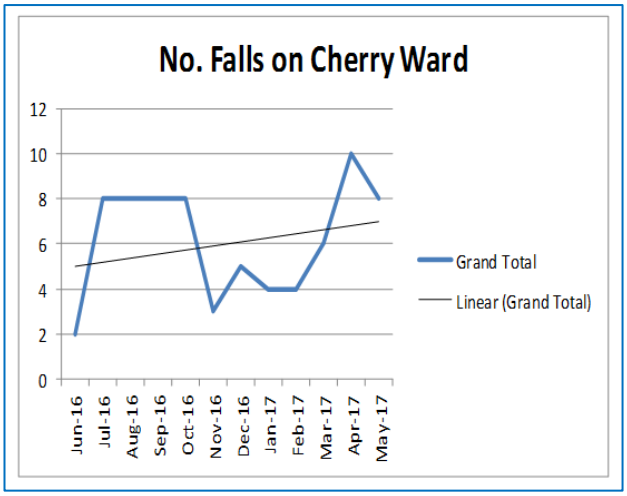
For further information, please contact Suzanne Jones, Substance Misuse Service Lead on 01625 712000

Reducing the risk of harm from falls on our inpatient wards

Background: The Trust has a focus on investigations when things go wrong, or when we have an incident, to be able to identify what we can do to improve our care in the future. In line with the Trust's Zero Harm strategy, this project is also trying to learn from good care so we can **spread best practice**. The review below is a brief summary of the care and interventions to a patient on Cherry ward who was at a very high risk of falling; however, as a result of the interventions from staff, **there have been no falls with this patient**. Risk factors included: age, frailty, physical health co-morbidity, and previous fall prior to hospital admission, intermittent confusion, and patients not always wanting to wear appropriate footwear or use their walking aids. The quality improvement project on Cherry ward follows a successful pilot project on Croft ward, which also successfully reduced the number of falls. Sarah Townson, ward manager, and the Cherry ward team are pictured right.

Why focus on falls?

- Patients' incidents of falls are high on the older adult wards.
- Our aim is to reduce all falls, but especially those which cause the most harm.
- We aim to distinguish between avoidable and non-avoidable harm.



Outcomes we wanted to achieve:

- Reduce harm from falls.
- Test pathways to inform policy.
- Improve communication re falls.
- Improve overall knowledge of falls.
- Provide data for analysis.
- Promote involvement.

Learning from good practice - how did we keep one patient safe who was a very high risk of falling?

The 6Cs are the values CWP has adopted to underpin everything we do. We applied the 6Cs to review the care provided to prevent falls for this patient.

Care: included multifactorial interventions, detailed care planning and risk assessment, toileting plan including urinalysis, medication review, review of risks at multidisciplinary team meetings, taking lying and standing blood pressure, and assessment of fear of falling.

Competence: Comprehensive assessments and care plans ensuring they detailed call bell at hand, the wearing of appropriate footwear, glasses due to sight problems, and hearing aid due to hearing problems.

Communication: Communication plan in place ensuring patient and family were aware of all the risks and their responsibilities.

Compassion: A caring and trusting relationship was built with the family and patient, open and honest discussions were evidenced.

Courage: The team showed courage as they asked for further training and support. They recognised that there was an increase in falls and a serious injury from a fall made them question their assessments, management and interventions in relation to falls. The patient was not sleeping and had a long term issue with this, although other interventions were also used to aid sleep, the pharmacist and team worked with patient and family and agreed a regime with increased input and observation for night time.

Commitment: The team is fully committed to reducing falls. Furthermore to reduce harm from any fall. They wish to provide the best care that they possibly can for their patients.

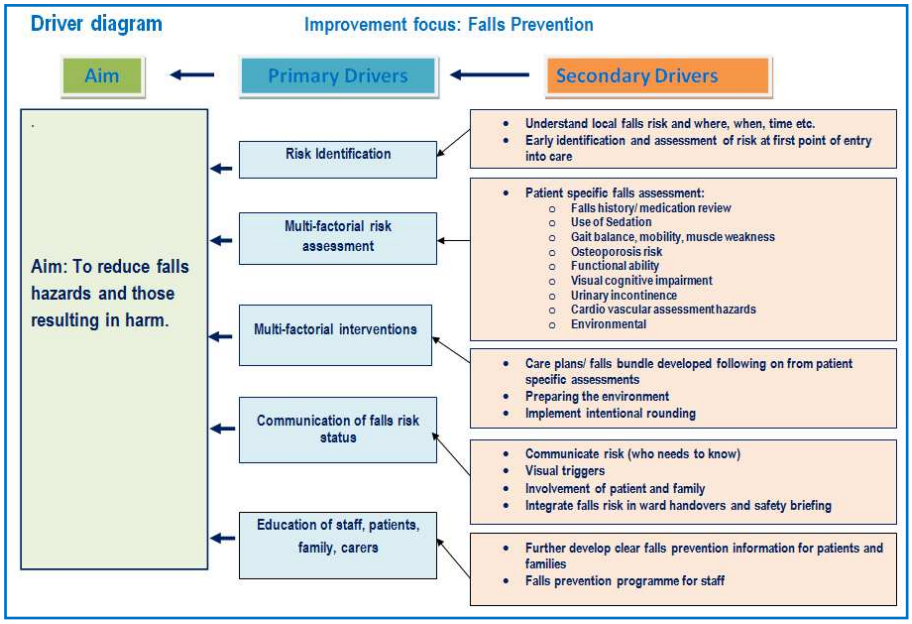
Baseline data	Number of falls Time and place of falls Number of falls that cause serious harm Number of potential avoidable vs unavoidable (PDSA is currently underway to test this methodology)		
Ongoing measurement			
	Phase 1	**Phase 2**	**Phase 3**
Ongoing measurement	Engage with staff (including whole MDT) Discuss and agree project and plan with timeframes Communicate plans including roles and responsibilities	Collect baseline data and design data collection methodology Pilot multifactorial: risk assessments - PDSA intervention plans - PDSA Safety Huddles – PDSA Plan education for ward staff	Review data and compare to baseline Review impact of learning (audit of staff) Evaluate the individual PDSA Cycles and make changes to documentation prior to next ward Amend and roll out to next ward Policy development in light of feedback from both pilot sites

A 90 day quality improvement plan and driver diagram (below) has been developed to ensure the project is implemented in a timely and robust way.

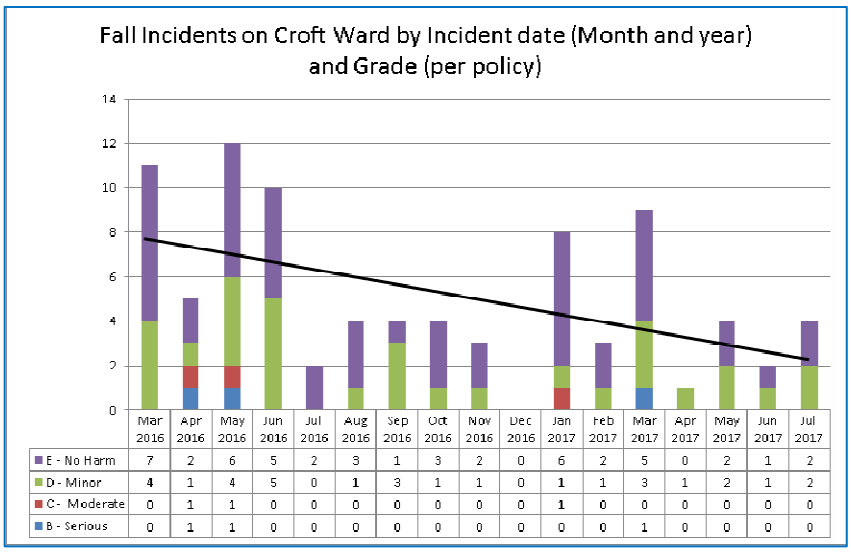
Results: Throughout the project, there was ongoing measurement and data analysis to monitor improvement. We conducted PDSA (plan, do, study act) cycles to evaluate progress as illustrated in the project plan above.

What have we learnt so far?

- We have teams who are committed to drive improvements for patients and to **reduce avoidable harm**.
- Falls prevention is more successful delivering quality improvements through a multi-disciplinary approach.
- Relatives and patients need to be active partners in the prevention of falls.
- All staff need to be engaged with the completion of the multifactorial risk assessments and interventions.
- Staff need updates on falls prevention.
- **Ward teams are preventing falls and harm from falls every day, this needs to be celebrated.**



The graph below demonstrates the reduction of falls on Croft ward since the implementation of the falls work; the next stage is to identify how many of the falls that have occurred were avoidable. This methodology is currently being tested.



	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017
E - No Harm	7	2	6	5	2	3	1	3	2	0	6	2	5	0	2	1	2
D - Minor	4	1	4	5	0	1	3	1	1	0	1	1	3	1	2	1	2
C - Moderate	0	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
B - Serious	0	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0

This project is one of many that demonstrate how CWP's teams are **using quality improvement methodology to improve patient safety, and applying the 6Cs values to the care they provide.**

Next steps:

We are planning to roll out this project to other wards across the Trust, the policy will be finalised in September to include the tools used within the pilot.

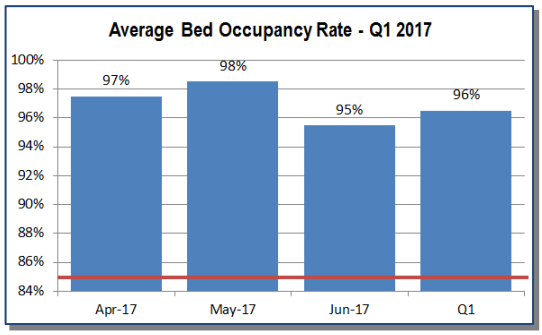
For more information, please contact ward managers Sarah Townson, Cherry ward 01244 397304, or Maurice Egan, Croft ward 01625 663060

Clinical Effectiveness Improvements

Goal driven measure for clinical effectiveness

CWP *Clinical Effectiveness* improvement priority for 2017/18
Improvement in the Trustwide average bed occupancy rate for adults and older people

Very high bed occupancy rates can affect the quality and safety of patient care. We have set ourselves the target of reducing the average Trustwide bed occupancy rate to 85% by the end of December 2017 on our adults and older people's inpatient wards. This target is taken from the *Royal College of Psychiatrist*'s research into the optimal level of bed occupancy *(Looking Ahead – Future Development of UK Mental Health Services, 2010).* Bed occupancy rates are a main driver of inpatient care standards, and a rate of 85% is seen as optimal.



CWP has identified a centralised 'bed hub' to optimise use of our bed stock and ensure everyone needing an inpatient bed is in the best bed for their needs that day. The graph, left, demonstrates our bed occupancy rates for quarter 1 against the 85% target, shown by the red line. A number of projects are underway to support a reduction in our bed occupancy levels. These include:

- 'Red and Green days' improvement project – which identifies and reduces internal and external delays to improve flow.
- Improving use of the 'Gatekeeping Assessment form' (see page 4) – this project has identified reductions in patients' length of stay resulting from a detailed assessment of each patient's need.
- Detailed investigation and analysis of our bed occupancy data is being undertaken and is looking in detail at the number of patients sleeping out from their wards; comparisons between admission and discharge data for different wards; comparisons in bed occupancy between the localities; and the number of transfers between wards, and the reasons behind these.

In addition, an **Acute Care Away Day** was held on 31 July; this was an opportunity for staff working in our acute wards to share best practice and learning from the number of quality improvement projects underway. Approximately 50 staff from across the Trust attended, drawn from multidisciplinary teams in the acute inpatient wards, Home Treatment teams, and Community Mental Health Teams. Dr Anushta Sivananthan, Medical Director, opened the event and presented CWP's vision for acute care, and Dr Ian Davidson, Clinical expert champion for Zero Harm, gave a presentation on risk management. The event also provided an opportunity for Sarah Quinn, General Manager – Wirral, to update staff on the work of the centralised bed hub and the quality improvement projects that are in progress, such as:

- Zero out of area placements for acute admissions.
- No patient requiring acute admission to wait longer than 4 hours to be allocated a bed (from request to bed manager).
- Acute care pathway is safe and effective.
- Optimal flow is achieved through the acute care system.
- Bed occupancy of 85%.
- Exploring income generation opportunities.

For further information, please contact Sarah Quinn, General Manager on 0151 488 7444

Winsford CAMHS supporting the emotional wellbeing of young people

Background:

In June 2017, Winsford CAMHS set up a pilot group to support the emotional wellbeing of young people, called "Youth Connect." "Youth Connect 5" is a course that was developed with *Merseyside Youth Association*, who then trained various professionals throughout Cheshire and Merseyside to deliver the course to parents.

What did we want to achieve?

Our aim was to support families within CAMHS with supporting and managing their children and young people as well as building their own resilience as caregivers. It was hoped that the course would help families to feel more supported and the course skills would help parents and their children to **achieve their goals** within CAMHS at an earlier stage.

What we did:

One mental health practitioner from the team was trained and recruited participants from within the CAMHS service. The course was delivered to a cohort of 6 caregivers during the initial pilot in July, and ran for 5 consecutive weeks.

Throughout the course, parents requested more of a mental health focus and wished to focus on certain issues such as self-harm or bullying. As this was not written into the course content, it was agreed that time would be put aside to try and cover these areas and that the facilitator would offer resources to address some of the questions and topics parents wished to cover. Additionally, parents were directed to use the duty service within CAMHS or speak to their child's clinician. Sessions included topics such as:

- Defining and understanding what is mental health
- Looking at risks and resilience
- Seeing things from a teenager's point of view – e.g. pressures
- The teenage brain
- Seeing the positives

Results:

Parents/ carers (some are pictured above) were asked to complete a session evaluation sheet each week which asked whether they enjoyed the session, found it useful, how much they thought it would help them to support their child, and how confident they were feeling. The majority of the session evaluation forms rated the sessions as either "really useful" or "invaluable" and that they felt the session had "helped them" to support their child. Feedback from one parent said:

"Invaluable meeting other parents "in the same boat" as me and sharing ideas and experiences"

Next steps:

It is hoped that the course will continue to run within Winsford CAMHS, and possibly extend to West Cheshire CAMHS, with some of the parents/ caregivers from this cohort co-facilitating the next group alongside the mental health practitioner. This project exemplifies how CWP teams are **promoting accessible and affordable solutions** to improve the quality of their service, by working together with those who access our services.

For more information, please contact Rebecca Kinnear, Mental Health Practitioner on 01606 555240

Speech and Language Therapy team in Central and East ensure good communication standards are in place

Background:

Most people with learning disabilities have some speech, language and communication difficulties. The *Royal College of Speech & Language Therapists* published a report in 2013 called "Five good communication standards". It was written to highlight what reasonable adjustments to communication that people with a learning disability and/ or autism should expect when they are an inpatient in a specialist hospital or residential setting.

Advanced Speech and Language Therapist (SLT) Natalie Hewitt, and Specialist SLT Leanne Veale have conducted two audits of communication

5 Good Communication standards

1. *There is good information that tells you how best to communicate with someone.*
2. *People are helped to be involved in making decisions about their care and support.*
3. *Others are good at supporting someone with their communication.*
4. *People have lots of chances to communicate.*
5. *People are helped to understand and communicate about their health*

practice in Greenways and the Alderley Unit to assess communication standards and make recommendations for improvement.

What did we want to achieve?

We wanted to ensure that we were meeting the 5 good communication standards, and that our patients at Greenways and Alderley Unit received the best possible support to express their needs.

Results: The two audits demonstrated high levels of compliance with the 5 good communication standards at Greenways and the Alderley Unit. Now the audit is complete, it has highlighted the need for continuously overseeing good communication standards, and this will be one of the main roles of a new SLT post for inpatient units in East Cheshire.

Next steps: One of the key themes was the provision of communication training for staff working in learning disabilities, and discussions are taking place to improve this.

For more information, please contact Natalie Hewitt, or Leanne Veale on 01625 509013

Service Improvement Forums

Background:

Service Improvement Forums were established towards the end of 2016 to facilitate networking and collaboration across inpatient and community teams, with the aim of **reducing variation**, and **improving services and outcomes across CWP**. Inpatient and Community Service Improvement Forums are led by Gary Flockhart, Associate Director of Nursing & Therapies, with support of the Service Improvement Team and the Safe Services Department, and include staff from a range of specialties meeting every 6 weeks to discuss issues, **identify improvements** and **share learning and knowledge**.

What did we want to achieve?

We aimed to develop a forum which supported the **sharing of best practice, facilitated engagement with operational staff** of key issues being faced, and provided an opportunity for problem solving and **initiating improvements**. The forums aim to support **improvement in quality and efficiency within services**, as well as resilience of staff through peer support.

What we did:

Presentations are given to share data analysis or initiatives across the Trust, with staff then engaged through workshop sessions in order to gather their views to inform developments. A recent example is focused work undertaken on self-harm. This was raised as an issue following an analysis of available incident data and an ensuing discussion regarding the management of self-harm within CWP. The 'Unconference' approach that was used to explore the issue of self-harm began with the 'burning question' of "How do we reduce and manage self-harm within CWP?"

Results:

The Service Improvement Forums have enabled **improved communication and engagement** within and across inpatient and community teams, through the provision of information and updates regarding new initiatives, or the sharing of data and best practice, as well as the gathering of feedback on key issues raised such as *NICE* guidance compliance, outcome measurement and the management of self-harm. Following the self-harm 'Unconference', and further work undertaken with the Inpatient Service Improvement Forum, the key issues have been collated to enable further exploration and implementation. The Service Improvement Forums continue to strengthen, with **positive feedback** from attendees:

"Unconference went very well, very good opportunity to be creative and think out of the box"
"Loved the Unconference"
"Good to have thinking and talking time with colleagues, also interaction with executive and corporate services"

For more information, please contact Safieh Fraser or Lauren Connah, Service Improvement Managers, on 01244 397386

Croft ward working with East Cheshire NHS Trust to facilitate seamless services for dementia patients and their carers

Background:

Admission to hospital is exceptionally difficult for people with dementia. Illness or injury, loss of familiar surroundings and routine, and a busy environment can all worsen the symptoms of dementia. Figures from the *Department of Health* estimate that people with dementia account for around 3.2 million bed days a year. Common reasons for admission to an acute trust include falls, hip fractures, urinary and chest infections. Staff from Croft ward have been working with colleagues at *East Cheshire NHS Trust* to **improve care** for patients with dementia and their carers.

What did we want to achieve?

The aim was to strengthen staff networks, improve knowledge and **share best practice** between the two trusts who provide care for the same group of patients, with complex needs, requiring a combination of treatments from physical and mental health services, so that they receive the **best possible care.** Pictured above are Kate Chapman, Matron, and Maurice Egan, Ward Manager on Croft ward, with members of their team and staff from *East Cheshire NHS Trust*.

What did it involve?

Celebrating 'Nurses Day' and 'Dementia Awareness Week,' CWP and *East Cheshire NHS Trust* facilitated a number of events to share knowledge and best practice. Staff from both trusts were involved. Information was provided on falls prevention; improving the care environment; helpful therapies including music, sensory, art, occupational and physiotherapy; 'John's Campaign'; 'Dementia Friend' sessions; ensuring individualised end-of-life care; use of one-page-profiles; accessing continence services; tissue viability. The two trusts pledged to continue to jointly foster **high quality, person-centred care**.

Results: The initiative has highlighted much common ground between physical and mental health care and strengthened relationships between teams; staff reported how valuable they found it, describing that they felt more confident dealing with problems which were not within their specialty and more able to seek specialist advice from partner organisations. Building positive relationships between the trusts has **ensured that patients are treated in the place best suited to their primary needs**, with ongoing support and expert consultation from the partner trust. This helps treatment continuity, benefitting and reassuring patients and carers. The initiative empowered staff by giving them the knowledge that allows them to signpost patients in an effective way, **providing seamless transitions** between the two trusts. 37 people attended Dementia Friends sessions; including 4 carers, 19 staff from the acute trust and 14 staff from Millbrook; one carer said "the session inspired me to become more involved raising awareness about dementia". Pictured right are the Croft team meeting carers who attended the event.

Next steps:

CWP and East Cheshire NHS Trust have pledged to continue to work together to improve the experiences of patients living with dementia and carers. Clinical expertise will be shared to ensure that patients receive **the best possible healthcare**; strategically the two trusts continue to work together through an operational dementia steering group.

For more information, please contact Maurice Egan, Ward Manager, or Kate Chapman, Matron on 01625 663060

Improving access to medical input for our frail older patients

Background:

Croft ward frequently works with frail older adults with dementia who have multiple physical health problems. Patients with dementia are vulnerable and they are highly susceptible to environmental change. It is imperative, therefore, that there is good access to physical health care on our ward, and that we can prevent several transfers for patients so that they don't become unsettled unnecessarily.

What is frailty?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. (Clegg, A et al, *Frailty in elderly people*, Lancet, 2013)

What did we want to achieve?

Our aim was to predict what care needs a person has more accurately, plan to prevent problems, and plan future care following discharge. We also aimed to:

- Reduce unnecessary moves, and unnecessary treatments (polypharmacy), involving our patients.
- To improve management of physical healthcare needs for our patients on the ward.

What we did:

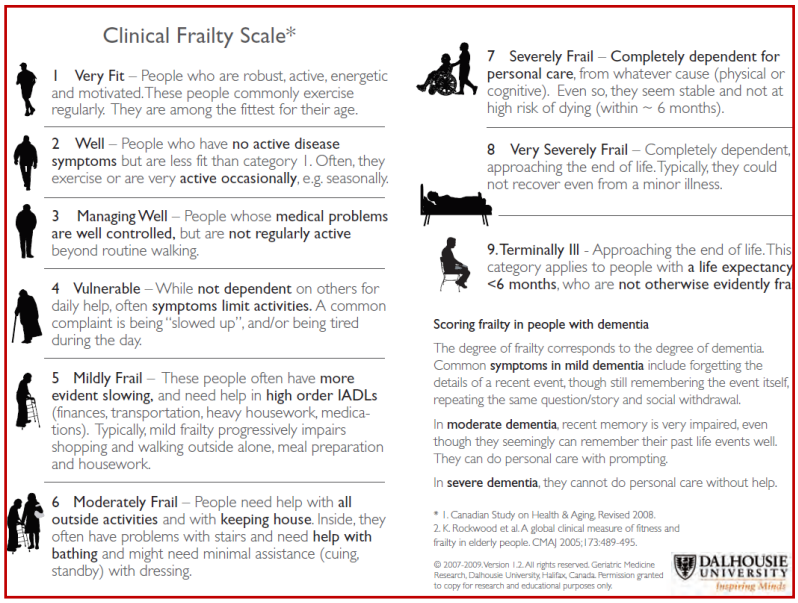
Croft's Consultant, Dr Sadia Ahmed (pictured left with Kate Chapman and Maurice Egan) identified a "Clinical Frailty Scale" (see below) that is currently being used in the community to indicate what stage a patient is at. This was a useful tool to score a patient's level of frailty upon admission, and then again at discharge planning stage. It provides a great indication to recognise when patients are declining in their health, but also helps to assist us in establishing what care setting is going to be appropriate at discharge.

The ward Consultant and Matron attended the 'Frailty Groups' held at East Cheshire NHS Trust, and arranged for a GP Specialist, Dr Dawn Moody, who works within their Frailty Team, to offer her expertise once a week for patients with acute medical issues on Croft ward. This **joint working** role provides advice on pending medical issues, in order to avoid potential admissions or transfers to the medical wards, and to limit polypharmacy. This extra medical support for our patients is important due to their complex medical needs.

Outcome:

Staff are now using the frailty scale each week to comment on patients' assessments. It's a simple tool and takes seconds to complete. This happens when the patient is admitted in their first ward round and then again when planning discharge. This process has been cascaded to all staff on the ward to ensure frailty is planned for.

This project demonstrates the benefits of **working together**, **sharing best practice**, and **placing the patient and carers at the heart of practice**. This project also exemplifies how quality of care can be improved in an **affordable** and **sustainable** way, as it has been achieved at no additional financial requirement.



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently fra**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

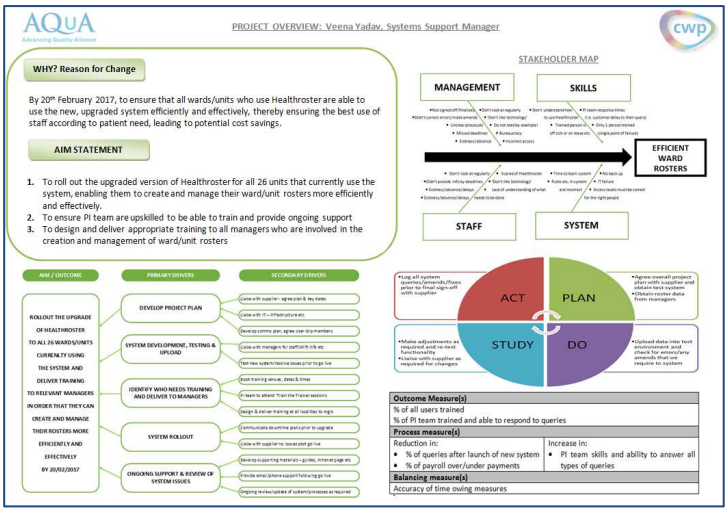
DALHOUSIE UNIVERSITY *Inspiring Minds*

For further information, please contact Dr Sadia Ahmed, or Kate Chapman on 01625 663021

Introduction to Improvement Training

Background:

The Service Improvement Team, based within Effective Services, works across the Trust to help build capacity and capability for **continuous improvement** and support services to be well-led, with **effective and efficient pathways** and **delivering high quality care**. The team facilitates improvement through responding to data, supporting teams with improvement projects, facilitating and leading projects via strategic groups and developing and delivering improvement training, coaching, advice and support to staff at all levels within the Trust.



What did we want to achieve?

The aim of the *Introduction to Improvement* (*i2i*) training is to increase capacity and capability across the Trust through improving the knowledge, skills and confidence of staff in using improvement methodologies. Applying new improvement skills throughout the course empowers staff to make improvements that will bring about **positive change** and **improve outcomes for patients.**

What we did:

The Service Improvement Team has been running *Introduction to Improvement* (*i2i*) training for staff over the last 12 months. This 3.5 day training programme has been developed in conjunction with AQuA (the North West Quality Observatory), and has recently been tailored and targeted to the needs of CWP staff following the Improvement Survey that provided a snap shot of the skills and competencies across the Trust. All members of the Service Improvement Team are fully equipped with the knowledge and skills to undertake improvements and to deliver this training to staff.

Results:

Over the last 12 months, a total of 42 people have completed the *i2i* course, equipping staff with a thorough knowledge and understanding of improvement methodologies. An example of an improvement project which has been supported includes rolling out the upgraded version of "HealthRoster" (an e-rostering solution) for all 26 units that currently use it, enabling them to create and manage their ward/ unit rosters more efficiently and effectively. Posters are submitted to present the outcomes of the projects and we have more than doubled the number of submissions of posters (22 in total) over the last few months (see example above). As of September 2017, all attendees will also work through their projects via *Life* QI (software designed to support and manage quality improvement work) and become Improvement Champions, providing additional resource within services to offer advice and support. This network of Improvement Champions will be supported by the Service Improvement Team to ensure their skills are further developed and refreshed in order to assist them in their role. The retention rate, and percentage of attendees completing the course, remains high at almost 100%. Feedback also continues to be positive, with one delegate saying:

> ***"Excellent, the space to think, plan and reflect. Has improved my motivation and focus on service user need and not resource led. Everyone would benefit from this no matter their role."***

Next Steps:

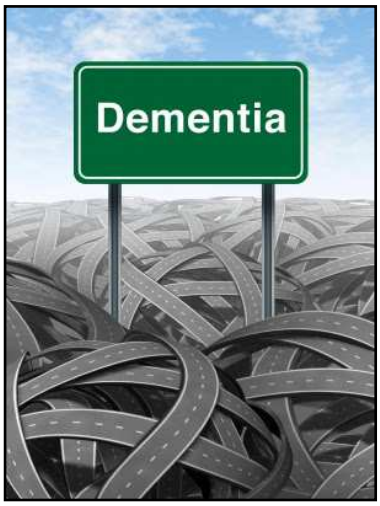
Cohort 4 of the *i2i* training will commence in September 2017, with high demand for the 3.5 day course. Three cohorts of the *i2i* training course will be provided each year. We have also developed a broad training and support offer, including one to one improvement coaching, bespoke improvement activities for teams, improvement surgeries and bite size improvement modules. We are also developing an e-learning module, and considering a level 2 improvement practitioner course in collaboration with AQuA, in order to build on the content of the *i2i* course at a higher level.

For more information, please contact Safieh Fraser or Lauren Connah, Service Improvement managers, on 01244 397386

Central and East Older people's CMHT work on improving the Dementia Pathway

Background:

With a rapidly expanding population of older adults, caseloads within the older people's teams have grown significantly over recent years; it was therefore imperative that we look towards a more **streamlined and more integrated approach** within the Memory Service. Our approach was to redesign the existing pathway, in line with current *NICE* guidelines, in order to **create efficiency through the reduction of duplicated activity**, and as a result, improve the rate of diagnosis and treatment initiation in a timelier manner, and provide increased support to people who with dementia.



What did you want to achieve?

As a result of burgeoning caseloads, and growing waiting times, we set out to **redesign the pathway** whilst **reducing waste through duplication** and to work more closely with our primary care colleagues as part of the '*Caring Together*' transformation programme and the development of '*Primary Care Homes*'.

What we did:

- A workshop was held for the whole team to explain the current financial position across health and social care, and the system wide transformation plans that were being developed in response. The team identified ways in which they could work differently in line with current *NICE* guidance, together with ideas for new developments.
- The consultant psychiatrists and team manager have met with key GPs within the two prototype *Primary Care Homes* to redesign the clinical pathway and to develop new ways of working together.
- The team are active members of the multi-disciplinary team (MDT) process within nursing and residential homes.
- The consultant psychiatrist now holds her clinics within GP practices, with full access to the primary care clinical records. Nursing staff have access to hot-desking office space alongside health and social care colleagues within the local area.

Results:

This programme of work is still at an early stage, but the results are already beginning to show that:

- Caseloads have started to reduce due to more people's care and treatment being managed by primary care services, **creating space and capacity** for the team to begin to work differently with primary care services.
- **Waiting times for assessment and diagnosis have reduced** from 9 weeks to a maximum of 5 weeks and involve fewer appointments for the person to attend, which means less travel for older people across a large semi-rural geography.
- Communication between the GPs and the team has significantly increased.
- Costs for the team have been reduced as clinic rooms within GP practices have been offered free of charge.

Next steps:

- Update the service specifications and formalise the revised clinical pathway with commissioners.
- Extend the current urgent response to people up to 8pm Monday – Friday.
- Extend the input into the other three Primary Care Homes being currently developed across Eastern Cheshire.
- Share the learning with the Central Cheshire team.

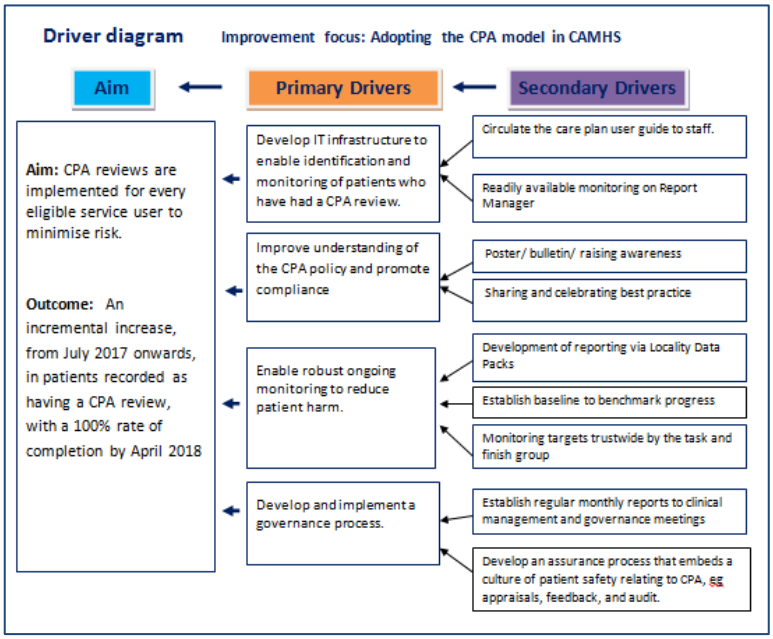
This project demonstrates how CWP teams are undertaking quality improvement initiatives which provide **accessible and affordable care**. It exemplifies how a team can **increase efficiency** and **reduce duplication** of effort in order to enable system **sustainability.**

For more information, please contact Josie Worthington on 01625 505611

Adopting the Care Programme Approach in Community CAMHS teams

What did we want to achieve?

The Care Programme Approach (CPA) is a way that care is assessed, planned, co-ordinated and reviewed for someone with severe mental health problems or a range of related complex needs. Following the Trustwide *Care Quality Commission* inspection, it was established that CAMHS teams needed to improve patient safety by adopting the CPA. Although bulletins had been circulated, it was recognised that there needed to be a **more sustained approach to implementation**, which included raising awareness, and ongoing monitoring, to ensure all patients received a CPA review where appropriate.



What we did:

At the Trustwide CAMHS Transformation Data meeting held in Winsford in July, it was agreed that a standardised approach was needed to ensure implementation of CPA within community CAMHS. A multidisciplinary task and finish group (Dr Rachel Mcloughlin, Dr Steve Earnshaw, Nicky Robinson, Dave Hedges, Sophie Holt, and Clare Cooper) has now been set up and have planned a series of meetings to discuss, plan and implement this Trustwide project.

Results and next steps:

A small group of patients are now on CPA, and this is **steadily expanding** as the project progresses. We have established a baseline report via the Trust's Performance & Information team and will monitor further progress through regular reporting. We will work with the Quality Surveillance Analysts in the Safe Services Department to ensure that the Locality Data Packs for CAMHS teams accurately reflect compliance.

For more information, please contact Nicky Robinson on 0151 488 8143

Patient Experience Improvements and *patient feedback*

Goal driven measure for patient experience

CWP *Patient Experience* improvement priority for 2017/18
Improvement in embedding a person-centred culture across the organisation

At the start of 2017/18, we set ourselves a goal to demonstrate that 90% or more of our staff are able to respond positively in the *NHS Staff Survey* that they are able to deliver a person-centred approach in their practice/ delivery of care. Following the successful implementation of the person-centred framework, CWP has put in place the following measures to enable us to meet this goal. These include:

- A dedicated page on the Trust's intranet.
- Face to face training sessions facilitated by the nurse consultant for learning disabilities and the participation and engagement lead. Three sessions have been held to date and **over 100 mental health staff have attended.**

The *NHS Staff Survey* is an annual event and will take place during September and October 2017. Results are expected in spring 2018, and a further update will be reported in Edition 2 of the Quality Improvement Report.

Experience based design improves initial mental health assessments in Chester Adult CMHT

Background:

Experience Based Design (EBD) is a methodology for working with patients, families, carers and staff to improve services together. EBD allows teams to gather insight into how services are experienced, based on the patient's emotional response to the interaction. It helps teams to challenge assumptions and perceptions about what they think the patient or carer feels and needs. Using the insights that are captured, patients, families and staff work together to **'co-design' improvements to services**. Chester Adult CMHT has used EBD to improve initial mental health assessments. This exemplifies CWP's commitment to **co-production in designing and improving services to meet our patients' needs.**

What did we want to achieve?

We wanted to use this co-design approach to ensure that improvements we made truly added value, and ensuring that the services we provide meet the needs of those who access them, and those who provide them.

What we did:

A small project team was formed and included Lesley Gledhill, Participation and Engagement Practitioner, Carl O'Loughlin, Lived Experience representative, Jim McCafferty, service user volunteer and Heather Dutton Clinical lead. The project team attended a master class, providing training on the EBD approach.

The project team chose the initial mental health assessment as the focus for the project, based on discussions with the wider community team. Using flowcharts and process mapping, they were better able to understand the stages of the initial assessment. As the EBD approach places equal emphasis on patient and staff perspective, the project team then went on to interview groups of both patients and staff, and to map their experience.

Results:

The project team identified quotes from patient and staff experience at each stage of the process of attending for an initial assessment. They then mapped the associated emotions connected to these quotes. Consistent themes of experience emerged based on the responses from both staff and patients, enabling the project team to identify key recommendations for improvement.

Next steps:

The EBD project identified a number of improvements which have been completed, including redesigning patient letters and leaflets, improving the reception area and signage, volunteer 'welcomer'. The project team has developed an action plan and is working through further improvements such as training opportunities for staff.

Jim McCafferty, (pictured on the front cover) who was part of the EBD project as a volunteer, and who captured the service user feedback, said:

"I cannot think of many times I have felt valued in my life, if any. To be involved in a project that recognises success, but also gaps in service provision in order to benefit people with same lived experience as myself, was truly rewarding for me. In an emotional investment, and practical sense way, I cannot thank AQuA and CWP enough for the opportunity to be involved in this invaluable project".

For more information, please contact Lesley Gledhill, Participation & Engagement practitioner on 0782 5522489

Improving Access and Support for Veterans

Background: On 11th July staff from across the Trust came together at Sycamore House to learn more about the armed forces covenant, and CWP's commitment to support our veterans. Many of the staff attending had a personal interest as members of their families were serving in the armed forces, or were veterans. Staff listened to presentations from representatives from the Royal British Legion and the role played by the Transition, Intervention and Liaison Service. There was very positive feedback from those who attended, particularly around the range of support that they could signpost patients, who had served in the forces to.

Key statistics:

- There are 2.6 million veterans in the UK, many aged over 75 (many are ex national service)
- The northwest is one of the largest recruitment centres in the country
- 20% of recruits are from the northwest, even though the northwest accounts for only 11% of the population
- Forensic history is high amongst veterans

Pictured right are Jamie Holmes, High Intensity worker IAPT; Adam Gillett, Royal British Legion, Independent Living Lead (North); John Henstock, Transition, Intervention and Liaison; and Julia Cottier, Service Director, and CWP armed forces champion.

Some of the problems faced by veterans were highlighted in the presentations; these included:

- High incidence of mental health problems, and unlikely to seek help
- Struggle to adjust to civilian life, and families also suffer
- Self-medicating, drug and alcohol abuse
- Young men prone to increase risk of suicide

What did we want to achieve?

We wanted to raise awareness of the range of support that veterans can access, and CWP's commitment to the Armed Forces covenant which we signed up to in June 2017. Avril Devaney, Director of Nursing and Therapies, is pictured below signing the covenant. Members of the Armed Services may face many challenges, particularly when returning to civilian life, which is why CWP has signed this Covenant. Julia Cottier, Service Director, in the Central and East Locality is CWP's named officer for military veterans. The Armed Forces Covenant is a voluntary statement of mutual support between a civilian community and its local Armed Forces community. The aims of the covenant are to:

- Encourage local communities to support the Armed Forces Community in their areas
- Nurture public understanding and awareness of issues affecting the Armed Forces Community
- Recognise and remember the sacrifices made by the Armed Forces Community
- Encourage activities which help to integrate the Armed Forces Community into local life
- Improve access and priority treatment

Next steps:

The *Defence People Mental Health Wellbeing Strategy 2017 – 2022* has now been launched, and distributed to all staff who attended the awareness session. We are arranging for the Royal British Legion to provide further sessions for mental health staff in Macclesfield and Crewe. We are also arranging for the *Veterans in Minds* and *Working Well* Talking Therapies, delivered by GMMHT to deliver an information session to staff from across the trust. CWP has signed up to the *Step into Health* programme which is to support veterans who may have transferable skills relevant to vacancies in NHS.

For more information, please contact Julia Cottier, Armed Force Champion 01625 508542

Involving and supporting carers at Lime Walk to aid recovery

Background:

Lime Walk offers assessment, rehabilitation and therapies for mental health patients from across Cheshire. Our patients can be treated here for many months so involving and supporting their families and carers is really important.

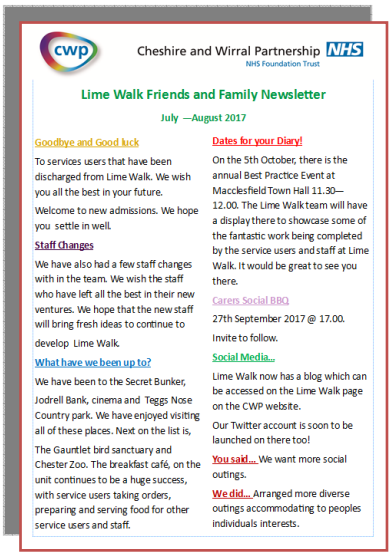
What did we want to achieve?

We wanted to increase carer involvement within an individual's recovery, and we wanted their carers to be more aware of the daily activities that were happening on the unit.

Pictured right are occupational therapists, Megan Burns and Bethan Woodcock, and Sarah Edge, Specialist Occupational Therapist. They were supported by Jane Vincent – Occupational Therapy Assistant.

What we did:

Questionnaires were devised and sent out to ask from carers when it would be best for them to attend events. Events were planned based on the outcome of their feedback. A monthly newsletter, collaboratively created by the occupational therapy team and the service users, has been developed (see right) and sent out to carers. Carers have also been involved in the development and improvement of a carer information pack.



Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Lime Walk Friends and Family Newsletter

July —August 2017

Goodbye and Good luck

To services users that have been discharged from Lime Walk. We wish you all the best in your future.

Welcome to new admissions. We hope you settle in well.

Staff Changes

We have also had a few staff changes with in the team. We wish the staff who have left all the best in their new ventures. We hope that the new staff will bring fresh ideas to continue to develop Lime Walk.

What have we been up to?

We have been to the Secret Bunker, Jodrell Bank, cinema and Teggs Nose Country park. We have enjoyed visiting all of these places. Next on the list is, The Gauntlet bird sanctuary and Chester Zoo. The breakfast café, on the unit continues to be a huge success, with service users taking orders, preparing and serving food for other service users and staff.

Dates for your Diary!

On the 5th October, there is the annual Best Practice Event at Macclesfield Town Hall 11.30—12.00. The Lime Walk team will have a display there to showcase some of the fantastic work being completed by the service users and staff at Lime Walk. It would be great to see you there.

Carers Social BBQ

27th September 2017 @ 17.00.

Invite to follow.

Social Media...

Lime Walk now has a blog which can be accessed on the Lime Walk page on the CWP website.

Our Twitter account is soon to be launched on there too!

You said... We want more social outings.

We did... Arranged more diverse outings accommodating to peoples individuals interests.

Results:

Rearranging the timing of events had led to an increase of involvement and attendance by carers. Service users are also closely involved in the preparation of events including planning, shopping, cooking, and budgeting. Their feedback has been really positive, with many saying how much that they enjoy their involvement in the events, particularly preparing it for their family and friends. A Recovery Festival held in July (see picture abve) was particularly successful, with more than 50 people joining service users and staff for the event. This was the unit's third annual festival and featured live music and a BBQ. The event raised £540 for charities chosen by patients on the unit.

The events give staff, patients and carers the opportunity to all meet as one and work together, and they enable staff to explore ideas, concerns and expectations of carers. Another benefit is that carers are able to meet one another at the event and gain support from each other. One carer said:

"….it's great to attend the events, sitting chatting with my son like this, seems so much more natural than just the usual visiting."

Next steps:

Building on the success of previous events held, we are holding another Recovery Festival for the service users and carers to attend. We are also:

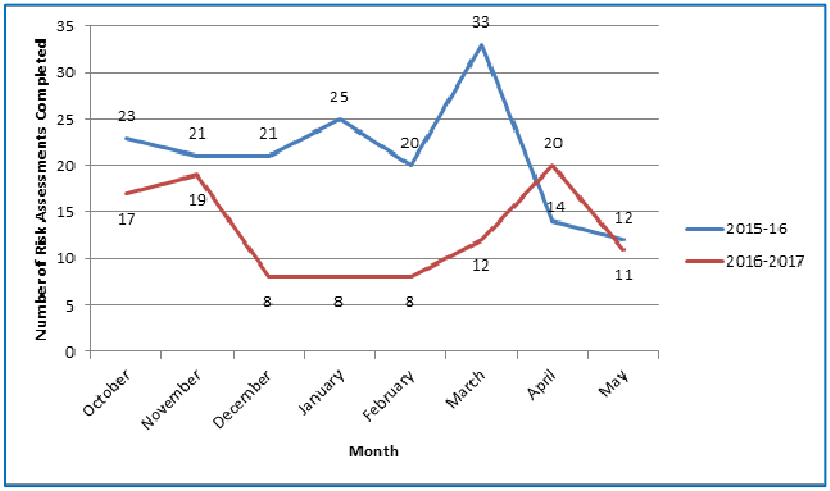
- Planning a BBQ for service users and carers in September
- Setting up a twitter account linked with the unit, that carers will be able to access
- Continuing with the development of the monthly unit newsletter (see previous page)
- Continuing to engage carers
- Starting a patient led blog

For more information, please contact Bethan Woodcock, Occupational Therapist on 01625 505 662

Wirral CAMHS improve access to advice and support

Background:

Wirral CAMHS launched their response to the *Future in Mind* (FiM) transformation plan in October 2016. As part of this response, there was a transformation of the existing Primary Mental Health (PMH) team and model. The new team's aim is to provide specialist mental health support via a training and consultation model, to all the agencies supporting young people's emotional health and well-being on Wirral. Amongst a variety of **transformative quality improvement developments**, the Service and Duty Line has been introduced. This provides a single 'front door' to a CAMHS duty worker that enables people (including parents, carers or healthcare professionals) to **access advice or support** before referring a young person into the service.



What did we want to achieve?

The last FiM survey indicated that schools would like **better communication** with CAMHS.

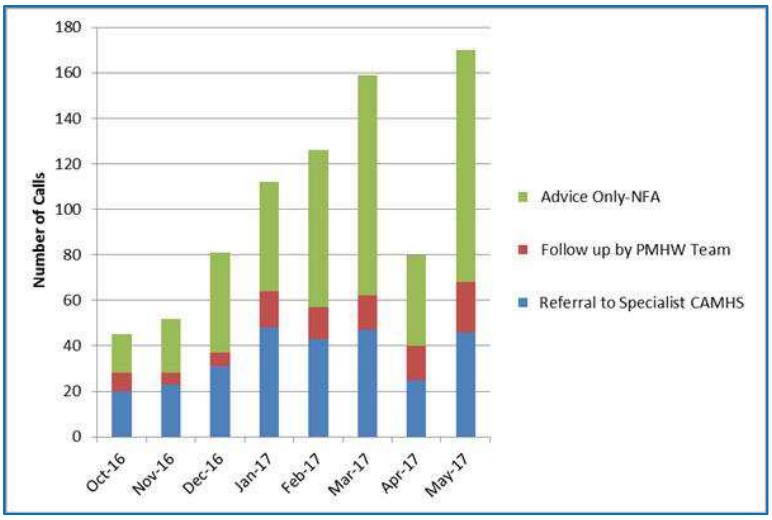
What we did:

The entire Wirral CYP workforce, along with parents and including referrers, can now access specialist mental health advice from our team via the telephone Advice and Duty line, 9 – 4:30, Monday to Friday. The line was set up in November 2016. If needed, this phone call can also act as the referral into CAMHS for the young person. Pictured below, the Advice and Duty line team.

Results:

- 825 phone consultations have been completed since October 2016.
- 34% of these went on to be referred into specialist CAMHS.
- 12% were followed up by the PMH team.
- 53% were given advice only.

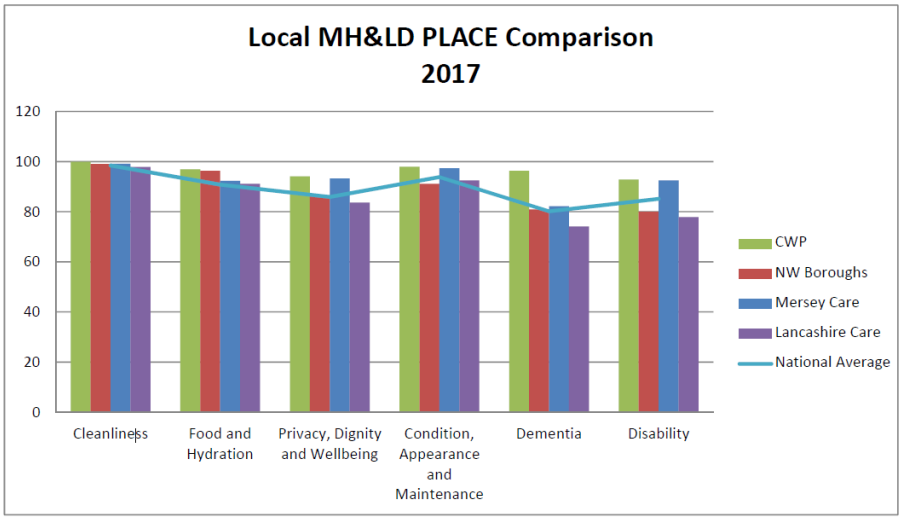
Although we can't draw causal correlations, since the introduction of the advice line, deliberate self-harm risk assessments for under 16s, and therefore admissions for assessment via A&E, are **40% less between October – May 2017,** compared to the same period the year before. We are also beginning to see a reduction in referrals into CAMHS, though we must be cautious about interpreting our data at this early stage. Evaluations from callers are **overwhelmingly positive.**



This project exemplifies CWP's commitment to **person-centredness and co-production**. Following a recent visit to the team, the Chief Executive described the team as: **"absolutely inspirational… this brilliant but simple idea has led to less immediate pressure on the clinical service while providing an effective and meaningful new offer to our community. The team is a fantastic example of what can be achieved if we work hand in hand with those who access our services, their carers and families, using a learning and reflecting approach".**

For more information, please contact Dr Helen Taylor, Stephanie Ireland, Rachel Nunn or Vicki Dunham on 0151 4888450

High quality standards of care and facilities for CWP patients



Patient-led assessments of the care environment (PLACE) are an annual appraisal of the non-clinical aspects of NHS and independent/ private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50% patient assessors.

Assessments of CWP sites took place between March and June 2017, and provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. CWP has scored **higher than the national average**, and **higher than our neighbouring mental health trusts** in each of these categories (see above). Furthermore, our scores **have improved from previous visits last year** (see table below).

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
2016	99%	92%	92%	97%	95%	89%
2017	99.8%	96%	94%	98%	96%	93%

For more information, please contact David Pearson, Senior Facilities Manager on 01244 397273

Between April and July 2017, CWP formally received 822 ***compliments*** from people accessing the Trust's services, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received:

CWP East

"Virtually every day we noticed improvements and the staff (on Bollin ward) were helpful in allaying our worst fears. Very soon after the start of treatment, our son improved in leaps and bounds. The atmosphere provided was tremendously beneficial for him, and a combination of great carers, experienced staff, proper medication, and a healthy calming environment all contributed to the near complete rehabilitation of our son within 12 days. Watching so many carers channel their energy into helping the patients was delightful. The care they displayed was very obviously genuine, and we are forever grateful for that. We were allowed to visit often and call every two hours to check on his condition. The staff showed flexibility, sympathy, and were uniformly superb."

"It was a place where I could be open and I was never judged. I've picked up some handy ideas for the future and I've learnt a lot."

"I would just like to express on behalf of myself and my family our heartfelt thanks to all your staff that looked after my mum whilst she was with you. I witnessed great care and dedication to duty every time I visited her, and I too was made welcome which was lovely."

"Words alone cannot express how grateful we are for their service. They gave us our son back, and I cannot praise the staff highly enough."

CWP West

"My therapist has been a great support during my sessions, encouraged me to reflect on my thoughts and never made me feel judged. I feel like I have the right tools to carry on outside of session."

"We would like to thank all the team who looked after (patient), during his last days, with kindness and care. Without your help it would not have been possible for us to grant (patient) his wish to spend his last days at home."

"I just wanted to say thank you for everything and for all your support while I have been on the ward, I really appreciate it. I honestly can't thank you enough for how lovely and kind you have been and it means so much. You have given me hope that it is possible to get through this."

CWP Wirral

"I felt listened to and felt that the people I spoke to knew the best course of action to help me."

"I just feel the support is fantastic, and I actually felt like someone cared about how I was feeling. Brilliant service; proper in depth counselling which helped me to really pull apart my problem. Staff supportive, caring, and very pleasant."

"The support was great and we feel optimistic on the future support our daughter will get."

Share your stories

We welcome your best practice stories and Quality Improvement successes; please share your work via the Safe Services Department using the Best Practice and Outcomes page on the intranet or contact the Healthcare Quality Improvement Team on 01244 393138

Look out for more about Quality Improvement in Edition 2 2017/18 of the *Quality Improvement Report*