NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Quality Improvement Report

Edition 2
June – August 2020

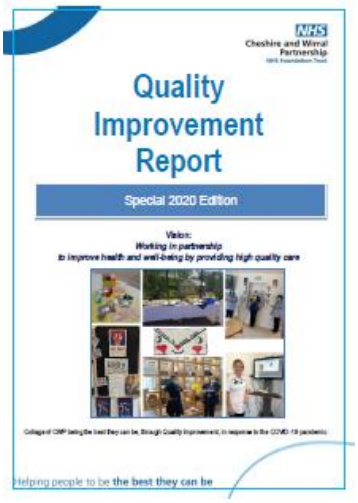
Vision:
Working in partnership
to improve health and well-being by providing high quality care

Tissue Viability Service's innovative training aids support the delivery of high quality care
(see page 11)

Helping people to be **the best they can be**

Welcome to CWP's second *Quality Improvement* Report of 2020/21

These reports are produced three times a year, this being the second edition of 2020/21, to update people who access and deliver our 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*.



At CWP, we look at **quality** in detail to better demonstrate where we are making real improvements, with the aspiration to achieve **equity** of care through **Quality Improvement (QI)**. We are using international ways of defining quality to help us with this aim.

CWP's *Quality Account* and *Quality Improvement Report*s are available via: http://www.cwp.nhs.uk/resources/reports/?ResourceCategory=2335&Search=&HasSearched=True

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.

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 in a way which increases safety by using effective approaches that mitigate unwarranted 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

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 we provide. It also provides examples of **Quality Improvement (QI)** projects.

Implementation of our new Quality Improvement strategy commenced in April 2018. Phase 1 of the strategy stretches across three years and describes how our people and teams who deliver and support the delivery of our services will work together to create a culture where QI can flourish.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

QUALITY IMPROVEMENT PRIORITIES

The following table provides details of our quality improvement priorities for **2020/21** that were agreed by our Quality Committee. These priorities reflect our vision of **"working in partnership to improve health and well-being by providing high quality care"**. These new QI projects are in line with our strategic objectives. We make a commitment in our annual *Quality Account* to monitor and report on these goal driven measures in our *Quality Improvement Reports*.

The **patient safety** QI priority identified for this year is:

Improvement in team level patient safety systems and culture, as rated by the people who deliver our services

We want to:
At least a 10% improvement in the percentage of survey participants grading their team as excellent or very good.

The following describes our achievements in progressing with this priority:

- ✓ One of our organisational priorities is on the Trustwide implementation of positive behaviour support (PBS) across services, both clinical and non-clinical, which is being supported through an evidence-based training programme which commenced in 2019/20. Three further cohort coaches' programmes have been scheduled, in addition to the delivery of another senior managers' training one.
- ✓ A 'team around a team' approach is currently being progressed on one of our rehabilitation wards, supporting staff in developing an holistic, PBS environment.
- ✓ Qualitative surveys have been conducted with patients and staff to look at how improvements can be made, establishing a baseline, which will be revisited once the PBS model has been further embedded on the rehabilitation ward.
- ✓ Learning from this approach will be used to further strengthen our approach to our Patient Safety Improvement Review programme of work with our teams and their Patient Safety Leaders.

For more information, please contact Katherine Evans, Head of Quality Assurance & Improvement, at katherine.evans9@nhs.net

The **clinical effectiveness** QI priority identified for this year is:

Improved and consistent recording and use of outcome measures across inpatient, community, EI, CAMHS and perinatal services

We want to:
Reduce the gaps and variation in the current recording, reporting and use of outcome measures.

The following describes our achievements in progressing with this priority:

- ✓ Work is underway with the Perinatal service and the Business and Value team to ensure that outcome measures used within the service are accurately coded, recorded and reported to the national 'Mental Health Services Data Set' in order to address any data quality issues.
- ✓ Baseline compliance is being identified and monitored to establish any further improvement work required in the recording of paired outcomes (recording of measures at the beginning and the end of an intervention in order to track improvement across the intervention). An outcomes framework comprising of outcome measures, process measures and balancing measures has been developed to inform the development of a dashboard to further enhance the monitoring and use of data within the service.
- ✓ Work is currently underway to develop an outcome measures e-learning package to improve the recording and use of outcome measures to inform practice, with an initial focus on the 'HoNOS' outcome measure. This will soon be launched alongside a share learning bulletin to improve access to information, training and support around HoNOS.

For more information, please contact Tracey Collins, Head of Effective Services, at tracey.collins10@nhs.net

The **patient experience** QI priority identified for this year is:

Improvement in asking people who access our services about their experience of care, and learning from what they tell us to make changes to our services and improve their experience

We want to:
Promote the revised Friends and Family Test (FFT) survey, in addition to using a variety of opportunities to 'Ask, Listen, Do' in relation to what people say matters to them. Services will report changes they make as a result of feedback they receive from people by publishing posters.

The following describes our achievements in progressing with this priority:

- ✓ People with lived experience are involved in a research project that is striving to understand people's experience of care during the restrictions associated with the COVID-19 pandemic.
- ✓ A number of services have taken a positive and proactive approach to asking people if they require any adjustments, with care being delivered in different ways that include with remote care.
- ✓ We have procured some iPad devices and will be able to implement the survey on our inpatient wards to gain people's experience of care.

For more information, please contact Cathy Walsh, Associate Director of Patient and Carer Experience, at cathy.walsh1@nhs.net

QUALITY IMPROVEMENT PROJECTS

Patient Safety Improvements

Delivering *Safe* care

The following projects show how CWP teams are delivering care which increases safety by using effective approaches that mitigate unwarranted risks.

QI project simplifies the referral process to CART

Background:

The Crisis and Reablement Team (CART) began using EMIS as the patient health record and to schedule visits in December 2019. Previously, the team had used a Council 'application' to record information, which did not share that information with the community care teams (CCTs).

In the past, community staff would have to ring the CART team and verbally pass over the person's details required, then write a careplan and leave it in the person's house.

As a consequence of this, patient information was limited and patient history, together with risk assessments, could not be viewed; therefore additional visits were being undertaken by professionals to take a careplan to the person's home.

What did we want to achieve?

Our aim was to simplify the referral process to CART, promoting ease of access, reducing administration time and elimination of unnecessary or additional visits by referrers. The provision of additional information – patient history, medication and risk assessments, **promote person-centred care** and **safety of patients and staff.**

What we did:

We worked with Ruth Wallis, EMIS specialist, to produce a referral form which supplied essential information, and had the ability to self-populate information from the patient record into the referral form. Our care coordinator produced several standard operating procedures (SOPs) complete with images to guide professionals through the referral process. This eliminates the requirement to involve additional staff in the referral process, streamlining it and reducing the time spent completing administration and freeing up time to care.

During the emergency response to the COVID-19 pandemic, in order to reduce footfall into people's homes, we looked at our referral criteria (face-to-face assessment on the day of referral) and agreed that, whilst the team was working in business continuity mode, we would accept referrals from health professionals without a face-to-face assessment on that day as long as the person was known to the community care team and had been seen in the last week. The aim of this was to:

- ✓ Improve referral times
- ✓ Reduce footfall into people's homes
- ✓ Reduce unwarranted and potential exposure to people with COVID-19

Results:

An 'SBAR' communication tool was created and presented at the team managers' monthly Business and Governance meeting. Adaptations were approved by the group and subsequent verbal feedback from CCT staff has been positive.

Using EMIS has meant that CART have been able to **improve mobile working**. This has resulted in a reduction of time spent by staff travelling, creating **more time to deliver care**. The long term goal is to reduce mileage incurred, but as staff have to

travel in separate cars, at present, due to COVID-19 guidelines, this will not show in our results until this requirement has been lifted or adapted.

Next steps:

- Evaluate results by gathering information from CCTs and specialist teams with regard to the process.
- Create a questionnaire or experience feedback form for distribution to CCT staff and specialist teams.
- Visit staff in their bases when the response to COVID-19 allows to discuss any issues and solve any problems raised by staff.
- Audit available patient time by using EMIS referral information.
- Audit mileage claims and measure against previous mileage claims pre changes and post the response to COVID-19 as restrictions on travel ease.

For further information, please contact Sue McGuigan, team manager, at sue.mcguigan@nhs.net

New Dynamic Support Database Clinical Support Tool improves identification of people at risk of admission

Background:

As part of the national Transforming Care agenda, the Care and Treatment Review (CTR) policy requires that commissioners hold a local database of people with a learning disability, autism, or both, who are at risk of an inpatient admission. As commissioners are tasked with holding the local database and keeping this information active and dynamic, they need support from clinicians in the community teams to know who is at risk of admission. The Dynamic Support Database (DSD) clinical support tool was developed in collaboration within all CWP Learning Disability services to support the flow of information to commissioners in a standardised and consistent manner. As well as providing standardisation in relation to levels of risk of admission, **the tool also provides support to clinicians and guidance on the structure of support.** The piece of work they were referred for would be completed with support plans and risk assessments completed as usual.

What did we want to achieve?

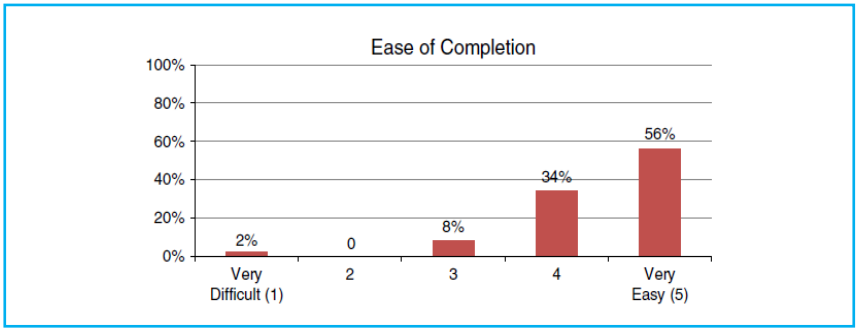
The aim of the project was to develop a dynamic register to enable local services to **meet the needs of people with a learning disability and/ or autism (or both)** and who display behaviour that challenges or are at risk of displaying behaviour that challenges.

What we did:

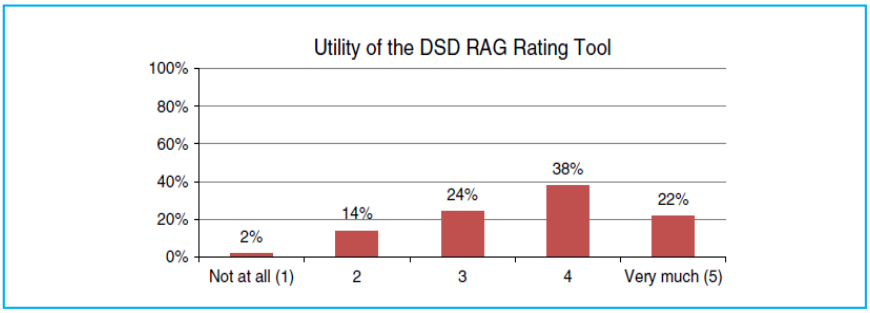
A clinical support tool was created with the purpose of supporting clinicians to identify the level of risk of admission for those people with intellectual disabilities. A child and adult version of the tool is available. The tool consists of 19 items that were derived from the factors that may place a person at risk of admission listed in the CTR policy. Examples of these risk factors include significant life events, problems with behaviours that challenge, unstable or untreated mental or physical health condition/s. The items are weighted depending on their influence on admission. Once completed, the tool gives clinicians a "red", "amber" and "green" (RAG) rating where "red" would indicate someone is at immediate risk of admission, "amber" would suggest significant deterioration in the community, and "green" would indicate that someone is more stable but may have an unmet health need that could be supported by the team within the community without the need of an inpatient admission. A pilot of the tool was first conducted within an adult community intellectual disability team. Improvements were made following their feedback and then the tool was rolled out across three adult community intellectual disability teams. Feedback was again collated and adaptations to the tool were made before its wider dissemination. Further alterations to the tool were made 18 months after the wider dissemination of the tool from feedback gained when delivering training across the North West region. Alterations to the clinical support tool will continue to ensure that the tool is **reflecting the needs of individuals and their risk of admission.** The clinical support tool has been implemented within the community intellectual disability teams within the CWP for approximately three years.

Results:

An evaluation of the tool has been conducted and showed the practically, utility and face validity of the DSD clinical support tool was positively rated. See graphs 1 and 2.

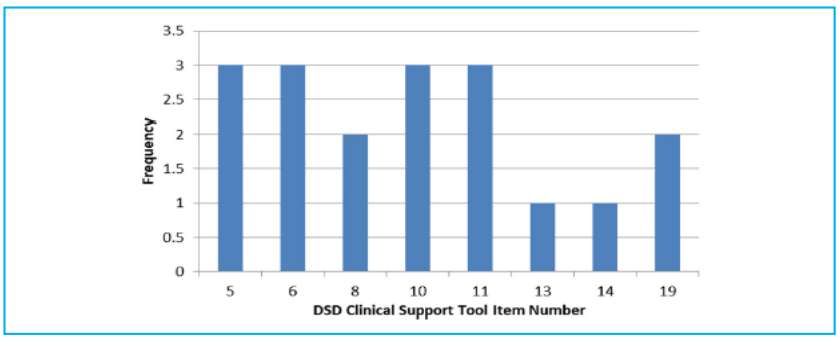


Graph 1. *On a scale from 1 (being very difficult) to 5 (being very easy), please rate the ease of completion of the DSD support tool?*



Graph 2. *On a scale from 1 (not at all) to 5 (extremely useful), please rate the utility of the DSD in helping the person you work with?*

As the tool is becoming more widely used and with the risk stratification ("red", "amber" and "green" ratings) leading to pathway recommendations for clinical processes, it is important that the ratings are consistent across areas, i.e. one person rated as "red" holds the same degree of risk of admission as someone else rated as "red" no matter who has completed the tool. It therefore follows that reassurance is needed that the tool is completed in the same way by different people. The 'inter-rater reliability' needs to be strong. We have investigated the inter-rater reliability between health care professionals in the rating of people's risk of admission, within adult community intellectual disability teams, across the CWP using the DSD clinical support tool. The analysis showed that 95% of the time, the two raters filled out the items on the tool the same for each person when looking at the items individually. Graph 3 shows the frequency of times clinicians scored differently on individual items on the DSD clinical support tool. In total, 8 out of 12 items were rated differently in the 30 data sets between the raters; this ranged between 1 and 3 occasions.



Graph 3. *Frequency of clinicians scoring particular items differently.*

Next steps:

- Further analysis on the CWP admissions (and the journey those people took within our services prior to their admissions).
- Developing a plan for the roll-out of the Autism Spectrum Disorder (non-LD) support tool within Specialist Mental Health care group.

For more information, please contact Dr Ceri Woodrow, Consultant Clinical Psychologist at ceri.woodrow1@nhs.net

Pilot of Pharmacy Technician adds value and improves patient experience on Croft ward

Background:

Traditionally, nursing staff carry out medication rounds on mental health wards; this can take up to three hours in a morning and limits capacity to engage in other elements of their role during this time, including supporting people with their self-care needs and undertaking activities with the wider multi-disciplinary team. The Carter Report into productivity in hospitals (2018) identified activities that hospital pharmacy services could undertake; this included 'medicines administration'. Kate Chapman, Matron, wanted to explore the expansion of the role of the Pharmacy Technician by introducing a Medicines Administration Pharmacy Technician role on the organic older adults ward in the Cheshire East locality.

What did we want to achieve?

To conduct a pilot to evaluate the impact of having a Medicines Administration Pharmacy Technician on an organic older adults ward. Kate found that other trusts had varied how they used similar roles; the needs of the ward were considered and it was decided that it would be more efficient for the Medicines Administration Pharmacy Technician to be embedded into the ward team, undertaking all duties associated with medicines administration including maintenance of medicine areas, medicine safety, and education and training. The primary objective of the pilot was to release nursing time to carry out other elements of their role, with additional performance measures identified for the role as follows:

- **Reduction in administration errors and near miss medicines incidents**
- **Reduction in omitted or delayed doses**
- **Cost saving in supply of medication and drug waste**
- **Improved patient safety from introducing a ward based pharmacy technician**

What we did:

The role was mainly developed to support the morning and lunchtime medication rounds to free up nursing staff to undertake other patient focused tasks; the morning medication round was identified as a large draw on nursing time and the round often took longer to complete due to the complexity of medication regimes. It was identified that as well as administering medication, the role would include venepuncture, recording ECGs and the monitoring physical observations this was a add on to the role.

The role was full time and was available Monday – Friday. During their shifts on the ward, the technician was present at the morning handover and would then carry out the daily medication round; as well as giving people their medication, he would be responsible for the continuity of supply of all medication, ensuring all medication needed was available for the weekends when the technician was not available. The technician also monitors side effects, speaks with patients, carers and educates them about their medications and completes relevant physical observations.

Results:

There have been many benefits of the Medicines Administration Pharmacy Technician Role. A second survey conducted in July 2020 showed 100% positive feedback on the role, some of the comments from various ward staff members are below:

A great asset to have on the ward freeing up the Nurses' time, enabling them to spend time with the patients.

The Technician has the time to spend with patients, to ensure that medications are administered. They can revisit the person 2 or even 3 times as this is his job role. Nursing staff are called away and interrupted numerous times which can lead to mistakes being made or the card not being signed.

The patients have **a good relationship with the pharmacist** and because of the consistency of their role Monday to Friday they know who is giving their medications and **can be on hand to give their expertise and knowledge** of the differing medications to the patients to **put them at ease** and to talk through their medications if needed.

The role has allowed nursing staff to work in a more patient focused and person centred way. It has given time to **allow better MDT working and family involvement** during working hours.

Feedback from Dominic, Pharmacy Technician, further showed the benefits of his role on the ward; this included ensuring regular supplies of certain medicines are always kept in stock by adding additional items to the regular ward stock list. This meant there has been less need for out of hours orders and saves costs on processing and collecting additional orders. As many controlled drugs have short expiry dates, it can be easy to over-order for those people on end of life care pathways, however Dominic was able to monitor the use of the controlled drugs and ensure excess stock was kept to a minimum.

As mentioned in feedback from other staff on the ward, Dominic believes his role provides consistency for patients and means he has an increased rapport and recognition with patients which has improved compliance with medication, meaning less medication is wasted. Dominic's sole focus is on the medication round, whereas the nursing staff can often get interrupted to carry out other duties which can increase the risk of drug errors.

Next Steps:

All feedback showed that staff on the ward found the role beneficial and would be supportive of the role continuing following conclusion of the pilot. A wider scoping exercise is currently being undertaken to consider how this role or an alternative role could be developed across inpatient services that supports safe and efficient medication administration and enables nursing staff to maintain and improve competencies in this area of practice.

Clinical Effectiveness Improvements

Delivering *affordable* care

The following projects show how CWP teams are delivering care which maximises use of resources and minimises waste.

Podiatry clinical rotations improve skills, confidence and effective care

Background:

The Podiatry service provides a high risk community foot health service in a variety of treatment settings including hospitals, local community clinics, GP practices and people's homes within the City of Chester, Ellesmere Port and the surrounding areas.

What did we want to achieve?

The aim of this project was to upskill current band 5 podiatrists by exposing them to new skills in assessment, wound management, debridement and offloading of the actively ulcerated diabetic foot.

What we did:

We have worked in conjunction with the Lead Podiatrist at the Countess of Chester Hospital Diabetic Foot Clinic to develop a programme of assessment which is completed in six weekly blocks. Our three band five podiatrists have taken their turn to attend for six weeks at a time and the first rotation focuses on assessment skills. They completed an initial assessment to help identify areas of improvement and set their own learning objectives at the start. This will be ongoing for six

weekly sessions in individual rotations, so this is not impacting on our community clinical caseload. This also gives the individual clinician's time to focus on their own learning objectives with one to one support from the clinical lead at the Countess of Chester Hospital.

Results:

Our band 5s have really enjoyed this. They are more confident in their ability to assess a wound and are currently bringing back their ideas and new knowledge and skills to help inform a new wound care pathway within our community services. We want this work to also impact upon a new vascular pathway we are looking to develop. They are up-skilled to be the first in community services to be able to assess toe pressures which can aid in the very early detection of peripheral arterial disease, assisting in the purchase of new equipment to enable us to do this. This has also hugely improved links with the Countess of Chester Hospital and our joint working relationship is continuously improving.

This project has helped to develop clinical skills and improved the quality of the referrals into the Diabetic Foot Clinic, but also knowledge which will assist in staff taking the next step in their careers. The Lead Podiatrist at the Countess of Chester Hospital has completed a piece of work that shows the progress of our team members by looking at the referrals they had made prior to their rotation and after they had completed their rotations, which showed a fantastic improvement. They also all completed a basic knowledge quiz prior to their placement and afterwards and each of them showed a huge improvement in their knowledge and skills after they had completed their placements. Each of these candidates are now band 6 Podiatrists within our department and will continue to attend the Countess of Chester Hospital on an ad hoc basis to support the team and also maintain their higher skill levels.

Next steps:

We have now purchased one toe pressure kit for use within our wound care clinics in the community and also for use within our home visits. This will prove invaluable in telling us whether a wound on the toe is likely to heal or not and therefore indicate whether vascular intervention at the earliest stage possible is required. We will be monitoring the progress as we go along with this one piece of kit and we hope we will be able to demonstrate how effective this could be in the prevention of much more serious complications in the foot/ leg. We hope that further down the line this will prove to be the piece of kit that, as Podiatrists, we all have as standard in our day to day practice.

For more information, please contact Emma Gallagher, team manager, at emma.gallagher2@nhs.net

Tissue Viability Service's innovative training aids improve staff competencies to support delivery of high quality care

Background:

The Tissue Viability service offers in-house education and training on pressure ulcers to all CWP teams as well as link nurse training. During the training, photographs are used to educate people on the importance of pressure ulcer damage; this was helpful, however it is difficult to gauge certain wound characteristics such as depth, tunneling and undermining.

What did we want to achieve?

Mo Dyke, Tissue Viability Nurse (TVN) Specialist, approached Community Nurse, Toni Griffiths, after watching a podcast on TVN News (a news website for health professionals) and asked her to create a more tangible educational learning tool to be used during tissue viability training sessions. The materials currently used in training were laminated photographs and an accompanying PowerPoint presentation; there are mannequins to demonstrate 'real-life' pressure ulcers, however, they are very expensive and there are only so many wounds to display on a single foot mannequin.

What we did:

Toni used polystyrene, colouring pens, pencils and tippex to create apples demonstrating each stage of a pressure ulcer; each apple was cut out to show the right depth for each pressure category and made to look as realistic as possible. Toni also wrote flashcards which describe each pressure ulcer category; these are to be used in the training for the learner to match the card with the correct apple. This allows staff to test their individual knowledge and can be used in group training

Results:

Toni received a lot of **positive feedback from staff** on the training tools, and it was **shared widely on social media**; on Twitter, the training tool had 139 'retweets', 461 'likes' and lots of comments from healthcare professionals across the country. The apples are very effective at accurately showing the various stages of pressure ulcers, especially underlining which can be difficult to visualise by looking at photographs; when the apples are picked up, the learner can feel and see the undermining of the pressure ulcer. As well as **the benefits for training**, the apples are very **cost-effective and a much cheaper alternative** to the mannequins that can be used to demonstrate pressure ulcers; these mannequins can only have so many injuries applied to them, whereas there is an apple for each category of pressure ulcer.

Next steps:

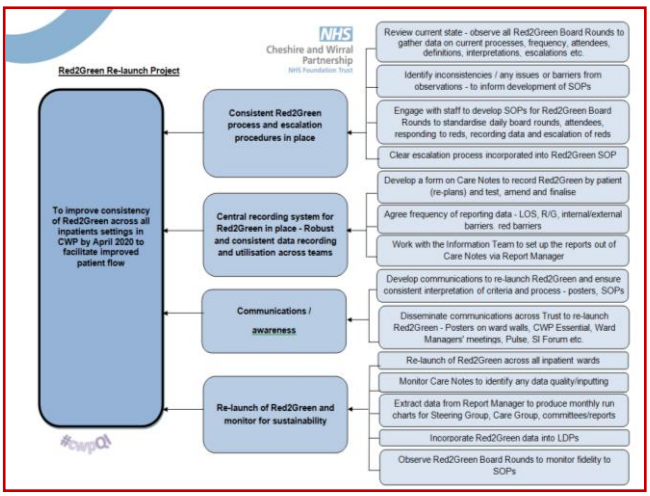
To gather more feedback from training sessions and potentially replicate the training aids.

For more information, please contact Toni Griffiths, Community Nurse, at toni.griffiths2@nhs.net

Red2Green is re-launched to optimise patient flow and outcomes

Background:

The Red2Green pilot project began on Beech ward in September 2017 and was subsequently rolled out to all other acute and organic wards across the Trust to achieve similar improved outcomes of the inpatient pathway, with reduced length of stay being one key measure demonstrating this. Red2Green **aims to optimise patient flow through the identification of wasted time** in a person's journey and the reduction of internal and external delays through the allocation of same day actions.



Quality improvement (QI) methods were used throughout the pilot, with PDSA cycles, Statistical Process Control (SPC) charts and Pareto charts used to measure the impact and improve the identification and reduction of internal and external delays and barriers to expedite the patient journey to discharge. This empowered staff to implement and embed improvements, including improved team cohesiveness and communication within inpatient and community teams being reported, due to increased focus and staff proactively identifying, addressing or escalating barriers and delays.

CWP was in a minority of mental health settings that had **successfully adapted and implemented Red2Green with improved outcomes for patients in reducing non-value added days** and importantly, **reducing length of stay**. This subsequently generated a lot of interest in the project from mental health trusts across the country and CWP working collaboratively with NHS Improvement to incorporate resources and information of the approach and findings into its national presentation as **an exemplar of good practice** in improvements made to bed flow within mental health acute care.

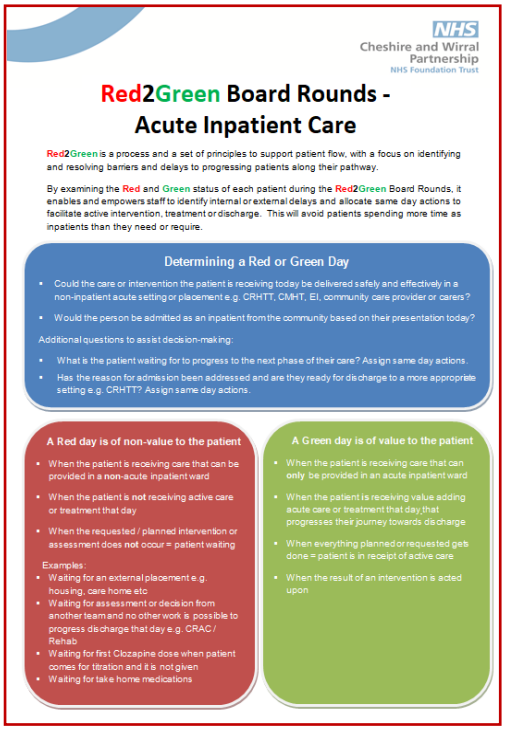
What did we want to achieve?

Despite the initial successes of the pilot in improving flow through reducing wasted time in a patient's journey and ultimately reducing length of stay, there was variation identified across the Trust, not only in the daily implementation of Red2Green and the escalation of barriers, but also in the recording and interpretation of Reds and Greens and the escalation of barriers to expediting discharge. This was due to a number of factors, including staffing changes within clinical and clinical support

services involved in the pilot, the need for a robust and regular core group of representative staff to oversee the spread and sustain phase of the project and the software issues affecting the recording of the Red2Green board rounds.

It was therefore agreed to re-launch Red2Green in March 2020 with a refreshed project plan, driver diagram, standard operating procedures and the development of an electronic Red2Green form on CAREnotes to produce robust daily real-time data. This would be overseen by the Red2Green Steering Group in order to embed, standardise, sustain and monitor Red2Green across the Trust. The Steering Group is clinically led and is representative of the key stakeholders involved in Red2Green within CWP. This clinical leadership is vital for the successful dissemination of information, implementation, sustaining of R2G and reduction in variation of R2G across the Trust.

What we did:



A review of the current state was undertaken in November 2019 through a series of observations at each Red2Green board round across the Trust in order to identify variation, interpretations and issues with Red2Green. This insight was used to inform the development of refreshed Red2Green Standard Operating Procedure (with key questions and principles to ensure standardisation) and escalation process to ensure standardisation and avoid variation in practice and interpretation.

A Red2Green form was developed on CAREnotes to allow administrative staff to input Red2Green data directly on a daily basis. A thematic analysis of the delays and barriers recorded in the previous Red2Green electronic database was used to inform the development of a drop down list on the new CAREnotes form, along with free text for allocated actions and the action lead in order to improve data recording, reporting, analysis and escalation of delays. This was piloted in March 2020 by the centralised Bed Management Hub and staff in each area were trained on the new form, to allow them to record the Red2Green board round information. It is anticipated that Red2Green reports will be accessed via Report Manager and a *real time* Red2Green report created on CAREnotes to be accessed by the centralised Bed Management Hub in order to **improve flow** through the reporting and escalation of barriers and delays.

The Red2Green Steering Group began to **focus on patient involvement** in order **to empower patients** to ask questions and understand information regarding their admission, care plan and discharge planning during their inpatient stay. The Patient and Carer Experience team offered to support the development of the questions through engaging patients to identify what type of information they would like to know during their time within acute care and what is important to them at each stage. It is anticipated that these questions could be used throughout a person's journey to empower them to ask staff during their stay as appropriate.

Results:

Although the Red2Green had started to be recorded on CAREnotes in March 2020, the embedding of the daily Red2Green board rounds and the accompanying recording on CAREnotes was impacted by the COVID-19 pandemic in the same month. A refreshed plan is now in place to recommence the Red2Green project within acute inpatient care across the Trust, with a specific focus on improving the recording and reporting of data.

Quality improvement methodologies will continue to underpin this phase 2 of the project and SPC charts and Pareto charts will again be used to monitor outcomes and the principal internal and external delays, and identify variation or statistical shifts signifying improvements. It is anticipated that data from the Red2Green forms on CAREnotes will be accessed via Report Manager reports and analysed and shared with the Steering Group on a monthly basis to monitor the project outcomes, as well as incorporated into the Trust's Locality Data Packs.

Next steps:

A further series of observations at each Red2Green board round will be planned for December 2020 in order to identify any variation, good practice or issues with Red2Green across the Trust. Data will continue to be analysed to gather a full year effect for each ward and therefore mitigate the risk of regression to the mean and the Hawthorne effect.

It is anticipated that the refreshed Red2Green process will also be subsequently rolled out to Wirral Home Treatment Team, Psychiatric Intensive Care Units and Rehab wards, with adaption of the criteria and principles to make it applicable to each team and the identification of outcomes to be measured.

For further information, please contact Lauren Connah, Transformation Manager (Effective Services), on 01244 397396. Further information regarding Red2Green can be found on the Best Practice portal or the CWP Red2Green site on the intranet.

Patient Experience Improvements and Patient Feedback

Delivering *Acceptable* and *Accessible* care

The following projects show how CWP teams are delivering care which takes into account the preferences and aspirations of people. They also show how CWP teams are delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs.

New Rural Alliance collaborative working practices improve patient experience

Background:

The Rural Alliance is a group of two community care teams in rural West Cheshire who have come together to work collaboratively. Broxton and Tarporley Community Care Teams (CCTs) have been jointly managed over the last 18 months, by one manager, however the teams have worked separately. Broxton team was based in Malpas surgery and Tarporley team based across two sites, Bunbury practice and Tarporley Health Centre.

What did we want to achieve?

The idea was to work collaboratively to tackle common issues and make better use of staff and resources, helping to deliver a better and more consistent patient experience.

Although plans were already in place to move the staff based at Bunbury into Tarporley, the lockdown and the number of admin staff shielding across both teams accelerated the move.

What we did:

A decision was made to base admin and care coordinators together at Tarporley Health Centre. The office staff have worked tirelessly in finding ways of working with limited staff and different processes of each other's teams. The team came across the issue around GP referrals as some surgeries used emails and others preferred the use of the task system on EMIS. This meant a desktop for each GP practice was required to prevent the system coming under too much pressure and crashing, which was hard to facilitate during the COVID -19 pandemic. The team decided to streamline the referral process and discussed with each surgery that in order to receive safe and effective referrals, all surgeries have to send an email to the generic inbox account that all staff have access to. Furthermore, the team's Palliative Care Complex Case Nurse now takes referrals for the Rural Alliance as a whole, not only Broxton CCT, providing **seamless care for people**, and also supporting and educating the clinicians in the Rural Alliance. This will be reviewed post the pandemic to ensure safe management of palliative care across the Rural Alliance.

Results:

The Rural Alliance has made further progress in working together and is **ideally placed for its patients to benefit from consistent patient experience**. The team found that having a central hub for admin, care coordinators, team manager and clinical leads has been an effective way of working. Using the email referral system for all referrals is successful and **reduces the chance of confidentiality and data protection breaches**. Moreover, having clinical leads in one base allows for better communication, and delegation of staff to where there is a need. The team has noticed that the communication across all disciplines has improved and all staff have had face-to-face contact with each other across the teams, which will support experience of different learning experiences.

Next steps:

- To embed the hub and spoke model for Rural Alliance (Tarporley Hub, Malpas Spoke).
- For the office based staff (now all returned from shielding) to make plans for the future model within the team to continue the high level of work they undertake.
- To discuss the future of how we manage palliative care across the Rural Alliance post the COVID-19 pandemic.

For more information, please contact Emma Lea, Rural Alliance Team Manager, at elea@nhs.net

Introduction of smaller caseloads within Ellesmere Port Community Care Team promotes person-centredness

Background:

In 2019, a decision was made to amalgamate Ellesmere Port North Community care Team (CCT) and Ellesmere Port South CCT together with the leadership of one manager. On a review of the whole caseload and following feedback from patients and colleagues it was clear that the continuity of care was not consistent for the people accessing the services in the area.

What did we want to achieve?

We wanted to provide continuity of care for patients and enable colleagues to have closer working relationships with GP practices.

What we did:

The team came to together to identify the areas they wanted to collectively work on, to deliver more consistent care and a standardised service. It was recognised that a variation existed across the area with regards to the continuity of care. The team manager set by working with the team and trialling the introduction of three smaller caseloads per clinician.

The three smaller caseloads have now been embedded into practice following a successful outcome. Each caseload has its own safety brief which has **saved on time efficiencies** and the team have recently introduced a senior clinician per caseload to support management and leadership within the team.

Results:

The team have embraced the change as the adjustment has led to clinical staff getting to know well a smaller caseload of people and therefore **built better working relationships with the MDT**. The GPs seem to prefer the caseload approach as they report knowing the clinicians better.

- Patients are happy and report that they see the same health care professional frequently. This supports the person to only need to tell their story once and promotes person-centeredness.
- GP colleagues have better working relationships and links to caseload.
- The team are positive about this change in practice and have greater job satisfaction.
- Feedback from patients has been positive.

Next steps:

The team is now progressing with the introduction of an urgent responder in nursing (therapy already have this embedded) on a weekday basis so that there is minimal interruption to already planned care. The urgent responder will have a free diary and will rapidly respond to an urgent call, e.g. blocked urinary catheter, deteriorating of fast track hospital discharge, palliative care.

For more information, please contact Yvonne Ball, Ellesmere Port Community Care Team Manager at yvonne.ball@nhs.net

Veterans benefit from employability support

Background:

The Poppy Factory is the country's leading employability charity for veterans with mental and physical health conditions. We bring together our long-established expertise into an NHS healthcare setting to provide a package to secure meaningful long-term employment for veterans. The project draws on the principles of Individual Placement Support (IPS) and applies them to a mental and physical health service.

The service is veteran-centred and helps people of all ages, including many over 50. Four out of five of the people it works with report a mental health condition. Whatever their situation, and whatever they are going through, the Poppy Factory's employability team is **on hand to offer one-to-one support**. Funding has been provided by The Forces In Mind Trust (FiMT), a £35 million funding scheme run by the FiMT using an endowment awarded by The National Lottery Community Fund.

What did we want to achieve?

As well as **creating positive outcomes for veterans with health conditions**, we hope the project will contribute to the improvement of existing services. We also aim to **forge closer links between health providers** and the service charity sector. The team will continue to promote the service, encouraging veterans to self-refer directly to our Employability Consultant, Lynne Evans, at the Stein Centre, and medical practitioners to refer people who might benefit from employability support.

What we did:

We work closely with health and social care partners in the area. We have embedded and co-located an experienced local Employability Consultant from The Poppy Factory in the NHS multidisciplinary team to **deliver high-quality comprehensive employment support to ex-Forces people** who are wounded, sick or injured. Lynne grew up on the Wirral and has a wide network of local contacts, as well as extensive experience in employability support.

Health practitioners can help veterans with health conditions on the Wirral on their journey into employment by referring them for employability support from The Poppy Factory. The charity, which has been working closely with local NHS teams since July 2019, continues to receive new referrals of veterans who are being treated for mental and physical health conditions – including those who have been affected by the COVID-19 pandemic.

Results:

Since the launch of its Wirral-based support programme, The Poppy Factory has **helped more than 10 local veterans start new jobs** in a range of sectors, including construction, logistics, retail, catering, property services and manufacturing. It also continues to provide in-work support to veterans, helping them and their employer settle into the role and overcome any challenges they may face.

Next steps:

The Poppy Factory wants to continue to support veterans in the Wirral area, and encourage referrals from GPs and other health professionals.

For more information, please contact Lynne Evans, Employability Consultant – The Poppy Factory, on 07387 415429, email lynne.evans9@nhs.net or visit poppyfactory.org/register to make a referral online

Between June 2020 and August 2020, CWP formally received **403** compliments from people accessing our services, and others, about their experience. Below is a selection of the comments and compliments received:

All Age Disability
"Praise from parents for the support from the team in respect of the shopping and pharmacy pick ups. It really is proving a lifeline for parents and it really is appreciated by them."

Children, Young People & Families
"I am so thankful for everything you have done for me, you have saved my life multiple times and for that I am going to miss you all so much. I cannot put into words how much I value your help and support."

Joint Therapies
"Outstanding level of care, always friendly and polite. Highlighted ways to cope with care needs, I could not have managed without them."

Neighbourhoods
"I wanted to express my sincere thanks and gratitude for all the care, compassion and support you gave to my husband and me during his recent illness. Your care was outstanding, the kindness never waivered and the shoulder to cry on always offered."

Specialist Mental Health – Bed Based
"I want everyone to know my gratefulness to those dispensing medication, those making food preparation, those that gifted me literature, those who chatted to me whilst being outside. To those that sat up and spoke to me, to those who stood supportively and those that cleaned and cared."

Specialist Mental Health – Place Based
"I have felt that the therapy sessions were very useful and have addressed the major issues in my life and things were pointed out to me that I had not considered. The telephone therapy has been really good and have found it most beneficial."

Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury
"I think it has been fantastic, we have been able to use face time, which has benefited both me and J, especially J as she always likes visual contact rather than just voice, and just been able to see each other and have contact through face time has been fantastic. I can always ring into the ward for an update and staff always take time out to update me."

Share your improvement work!

We welcome your best practice examples and Quality Improvement successes; please share your work via the Safe Services Department using the QI Hub page on the intranet or contact the Patient Safety Improvement Team at cwp.patientsafetyteam@nhs.net

Look out for more about Quality Improvement in Edition 3 2020/21 of the Quality Improvement Report