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NHS Foundation Trust

The Big Book of Best Practice 2018/19

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To find out more about each submission, search the team's name at www.cwp.nhs.uk

Foreword from Dr Anushta Sivananthan, Consultant Psychiatrist and Medical Director

I am delighted to welcome you to our sixth edition of CWP's Big Book of Best Practice.

With each edition I have seen the publication go from strength to strength: its profile has risen across the Trust and beyond. The number of submissions has grown, and it has changed the way that we share ideas around innovation, improvement, and working in partnership with our colleagues and the wider community.

This year has seen the success of a number of person-centred initiatives, many of which I am proud to say are featured in this edition of the Big Book of Best Practice. For example, the work that Wirral CAMHS has done in launching an advice line open to anyone who would like support regarding a child or young person's mental health is a true example of person-centred care. The steps Liaison Psychiatry (East and Central) staff have taken, alongside local partners, to reduce frequent attenders at A&E is a fantastic example of what a positive impact early intervention can achieve.

Our Broxton Community Care Team has strengthened its relationships with the local community, which has helped them offer patients the right care in the right place at the right time. Another hugely successful initiative of this year has been the Red2Green pilot on Brackendale Ward, which has seen a 33% reduction in length of stay within the first 2 months.

Of course these are just a handful of contributions to the Big Book of Best Practice 2018/19 and I'd like to thank everyone who submitted. Each of the case studies within this year's book indicate the level of dedication our staff display to ensure we deliver the highest quality care possible to the people who access our services.

I am hugely proud of the success of the book – not least because it emphatically highlights the extent to which our #CWPZeroHarm campaign, launched in 2014, has been embraced into the organisation's values and culture.

An important aspect to how we develop our services and support a learning culture is through research. Our staff are recognised internationally for their pioneering work through their involvement in research to discover best practice and innovative ways of working. For more information about our commitment to research read our latest Quality Account at www.cwp.nhs.uk.

We have taken our next steps on this journey with the recent launch of our Quality Improvement (QI) Strategy. This strategy builds on these values and empowers every member of staff to be a leader and take responsibility for their part in the quality of care. You can follow the QI team on Twitter @CWPQITeam.

I am already eager to see how colleagues further develop their services over the next 12 months and I am always interested to hear ideas from staff. If you find yourself inspired by this year's Big Book of Best Practice please feel free to get in touch via email at: Anushta.Sivananthan@nhs.net

Care group: Clinical Support Services
Team name: Patient and Carer Experience Team

The Creating and Running of the Lived Experience Connector Role with the new Trainee Nursing Associates (TNAs)

What did we want to achieve?

To create reflective practice and ensure the professional is constantly grounded in the true spirit of being person centred and ensuring everything we do is to help that person be the best they can be!

What we did:

- We created the Lived Experience Connector (LEC) role to help our Trainee Nursing Associates (TNA) remain person centred. A Lived Experience Connector is someone who has experience accessing services. They inform the whole learning experience and provide trainees with continuous support and feedback in their journey to develop person centred practice. As part of the process we:
  - Used volunteers already with the Trust to develop the role and began recruiting more lived experience volunteers for future cohorts
  - Tried to match Lived Experience Connectors from mental health services with Trainee Nursing Associates from physical health and vice versa to share learning
  - Sent all LECs on a one day training course where we discussed the role of the TNA and LEC, what is involved, how it works, boundaries, confidentiality and what to share

Results:

The impact is being recorded as both the TNAs and LECs have to complete feedback forms after every meeting. Here are some examples of the impact:

- When we first started the programme, a couple of TNAs from acute hospitals phoned to say that they felt uncomfortable meeting a service user with a MH diagnosis alone and that they felt vulnerable. After assurances, they met and one of the TNAs wants to continue his career in mental health after spending several years in an acute hospital
- Another example was a TNA worked for many years in an A&E department and referred to patients as bed No. 1 or bed No.2. After meeting with their LEC, they now refer to patients as 'Mr Jones' or 'Mrs Smith'. Patients are no longer numbers
- TNAs now have the opportunity to realise that they often only see patients when they are sick but now understand that although patients may always have their long term condition, there is life beyond the diagnosis and many people lead and manage their lives with theses illnesses
- One LEC fed back that the language her TNA used at their initial meetings is very different from the language they use now. Her TNA has said this is because he listened to his LEC and has a greater understanding now
- We also have carers who are LECs and this brings another dimension to the TNA training in that the TNA can look at issues through the eyes of a carer. How they feel and how sometimes, they don't always get told what is happening to their loved one. This learning can be taken into practice

Next steps:

We are on our second cohort of Trainee Nursing Associates so we have roughly put 75 Lived Experience Connectors through the process and this will be a running system for the next few years.

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Care group: Neighbourhood Based Services
Team name: Broxton Community Care Team

Neighbourhood Care

What did we want to achieve?

To empower the team to work autonomously and in a self-managed way to provide person centred care for Broxton community. Working with the neighbourhood of Broxton to build stronger relationships with the community and the 3rd sector.

What we did:

Our project involved the team exploring new ways of working differently, with the assistance of a team coach. The project involved working with the CCG, NHS England, Mental Health services and third sector. We were able to look at ways of freeing up time to care. Being part of the process to look at the framework for the team.

Working with the West Cheshire CCG, we had some vanguard monies to explore the process of self-management. The monies from vanguard were non recurrent and this was used to employ a team coach, mental health worker and community independent living advisor. The project linked the launch of neighbourhood care within the Broxton community with the local community and the 3rd sector, looking at ways of responding to the needs of the local community.

Results:

- Staff report that following the implementation of the project they feel valued and happy to come to work
- Being able to offer patients the right care, in the right place
- The team have worked closely with the coach in exploring new initiatives and how to sustain the proactive working culture
- The team have found by streamlining processes and working in a self-managed way has empowered the team to make joint decisions, share responsibilities, no decision is made without a team consultation
- All team members feel part of the processes and committed to providing person centred care for the local community

Next steps:

The team is continuing the work in a self-managed way and building on new initiatives that have been commenced and look at further ways of improving person centred care. The plan is for this process with the framework to be rolled out to other teams in the near future.

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Care group: Specialist Mental Health Services
Team name: Liaison Psychiatry East and Central

National CQUIN – Reducing Frequent Attenders at A&E

What did we want to achieve?

To work in collaboration with A&E, community services, GPs, police, ambulance service and third sector organisations to reduce frequent attenders at A&E by 20%.

What we did:

- Identified the 50 most frequent attenders at A&E in the previous year (with over 10 attendances)
- Agreed on 13 of those people to focus on and contacted them to engage them in the process. Care plans were created for each individual
- Some of the patients involved were directed to the Liaison Psychiatry Clinic, the Personality Disorder Hub, other community services while others needed interventions from social services or the police
- Worked closely with A&E to improve the coding of mental health presentations to improve future data collection

Results:

- We managed to achieve a 40% reduction in attendance in the cohort. Having comprehensive care plans for management of frequent attenders has reduced the risk of iatrogenic harm from unnecessary investigations and treatments
- One service user said: "I can't believe that I was attending A&E all the time thinking I had a brain tumour. Now I realise it was anxiety related, and have had the right help, I can get on with my life"
- This CQUIN presented a large increase to our existing workload. It has involved extra meetings and closer work with the acute trust A&E service manager. However, it has been a very satisfying piece of work that has provided clear benefit to patients and resulted in a more productive working relationship with A&E and other agencies

Next steps:

The CQUIN continues in to 2019 with the goal to maintain our current work and tackle a further cohort of A&E frequent attenders. We have also identified the most frequent attenders at GP out of hours and developed care plans, involved care co-ordinators and other agencies to address their attendance. We will continue the good practice of partnership working to achieve improved services and health outcomes for our service users.

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Care group: Specialist Mental Health Services
Team name: Psychosexual Medicine and Therapy Service

Sexuality and Breast Cancer

What did we want to achieve?

An evaluation of the sexual consequences of breast cancer and discussions between patient and healthcare professionals in their therapeutic encounters. 'Design Activism', using art as a metaphor for patient voice, develop a tool to empower patients to open conversations, and to challenge the health professionals notion of patient needs.

What we did:

The research takes a qualitative approach with women with breast cancer to explore the effects of the cancer on their sexuality. Focus groups of patients were developed to undertake discussions on their sexual difficulties, needs, emotions, relationship effects, body image issues, communication difficulties and losses, resulting from their diagnosis and treatments. The focus groups were asked to discuss/consider several questions. The groups were facilitated by an experienced consultant psychosexual therapist and a consultant psycho-oncologist. Feedback from the group discussions were recorded and then tabulated into common themes. Volunteers from the focus groups were invited to work with a group of artists to produce artworks from the themes identified, which acted as a metaphor for the patient voices.

Results:

The artwork resulting from the work is in the process of being evaluated as a tool to enable empowerment of the patient voice in opening up conversations with health professionals. Each of the 6Cs is reflected within the work undertaken, but Communication, Courage and Compassion are uniquely reflected.

- Courage working with what is often seen as a "taboo" subject in empowering women to discuss a range of issues and the psychological effects on the sense of sexual self and the impact on both the relationship and social context in which people live their lives. Evidence shows that both patients and health care staff have communication difficulties in this area
- Compassion in giving voice to issues that often go unspoken, in a manner that is empowering
- Communication in listening and checking out what has been said and understand what has been meant by the participants

By working with artists the focus groups have been supported to represent difficult and intimate symptoms in a manner that not only representative of their experience but also results in something that is truly attractive using the medium of fabrics, ceramics etc.

Next steps:

The resultant artwork is continuing to be evaluated by patients, healthcare professionals and the wider audience. It is hoped that a tool to aid communication between patients and healthcare professionals can be developed for use in communication around Sexuality and Breast Cancer. It is hoped also to publish the results from the research work.

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Care group: Specialist Mental Health Services
Team name: Acute Inpatient Wards

Improving Quality, Effectiveness and Patient Flow – Red2Green Quality Improvement Project

What did we want to achieve?

The impetus behind the application of Red2Green from physical acute care into mental health is the national issue due to increasing pressures on inpatient beds and the importance of patients receiving active and timely care in the most appropriate setting. This builds on the CWP purposeful admission model so that patients do not lose one more day of community living than is necessary. For inpatient settings, this is vital in improving quality of care and freeing up capacity within the system.

What we did:

- Following the successful Red2Green pilot on Beech ward, the initiative was rolled out to Brackendale in January 2018, achieving a 33% reduction in length of stay within the first 2 months, and then to Bollin, Adelphi, Juniper and Lakefield in June/July 2018
- All wards implementing Red2Green hold daily MDT board rounds and use an electronic database to record patient status, identify internal or external barriers and target unnecessary barriers or delays by allocating same day actions to inpatient and community staff to progress the patient's journey to receiving active care, intervention and ultimately timely discharge. This facilitates improved flow and patient experience by ensuring that patients are discharged as efficiently as possible back to the community once they no longer require acute care

Results:

Red2Green has impacted positively on improving quality and effectiveness of the inpatient part of the patients' care pathway, with improved flow and a reduction in length of stay experienced on each of the participating wards, and complex, long-standing external delays resolved quickly as a result of the daily MDT board round and escalation process.

- 10.3% reduction has now been sustained on Beech ward for almost a year
- 31.6% reduction has now been sustained on Brackendale ward for 6 months
- 13.6% reduction has been achieved on Bollin ward

The success of Red2Green has been attributable to the buy-in, ownership and commitment of the full MDT present at daily ward rounds. This has improved team cohesiveness, empowerment and communication within and across inpatient and community teams, due to increased focus and MDT staff proactively identifying, addressing or escalating barriers and delays in order to expedite discharge. Always Events were integrated into Red2Green and feedback from Lived Experience Volunteers and inpatients on pilot wards used to inform improvements to practice to ensure that specific processes identified as being important to patients always occur.

Next steps:

Red2Green will continue to be implemented in acute wards across the Trust and data will be gathered and analysed to validate and monitor the impact and outcomes of the initiative, over time, to gather a full year effect for each ward. This will also endeavour to mitigate the risk of regression to mean and reduce the possibility of the Hawthorne effect. Red2Green is soon to be piloted in Wirral Crisis Resolution Home Treatment Team and adaptability being explored for use within the District Nursing Team and Rehab wards.

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Care group: Specialist Mental Health Services
Team name: Specialist Perinatal Mental Health Team

Creative Collaboration: Specialist Perinatal Mental Health Team Working in Partnership with the SMILE Group

What did we want to achieve?

To collaborate with the SMILE Group, a third sector charitable organisation, to provide specialist information, education and support to mothers and families experiencing perinatal mental illness. Working together to enhance service user experiences, upskill workforce through the sharing of skills and expertise and forging strong and authentic links between NHS and third sector services.

What we did:

The team's occupational therapist attended SMILE's Peer Support Groups and delivered a series of "wellbeing sessions." The sessions offered information, education, signposting and some skill based practices relating to wellbeing and self-help strategies such as mindfulness, progressive muscular relaxation, thinking traps and managing expectations.

Results:

The wellbeing sessions were very well received by all of the peer support groups and we received lots of positive feedback from parents who attended. The Top and Pants sessions have evolved further and we have since facilitated a number of additional sessions asking parents to support the co-production of a leaflet capturing some of the experiences shared so the resource can be used to offer support, signposting and normalise issues within the perinatal period.

Next steps:

We are continuing to work on the design of a co-produced leaflet that we hope to share with health professionals, services and third sector organisations to promote conversations about perinatal mental health. We have also made further plans to work with the SMILE Group and aim to continue to share our expertise, skills and information with their staff to enable them to facilitate their own wellbeing sessions.

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Care group: Children, Young People and Families Service
Team name: Emotionally Healthy Schools Links Team (EHS)

Self-Harm Pathway for Schools

What did we want to achieve?

To support schools in their response to children and young people who harm themselves intentionally and to identify a clear pathway for children who self-harm.

What we did:

- We met with school leads in Cheshire East to identify what information they would find useful to support their responses to self-harm
- The information was collated and a review of good practice was conducted to identify existing toolkits and pathways that could be adapted for the EHS Links pathway
- A small pilot in a group of schools was undertaken to obtain feedback from school staff. Young people were consulted on the language and content and the pathway was produced and disseminated to all schools and colleges

Results:

- The Self-Harm Pathway has been rolled out to all schools and colleges via the EHS Links Mental Health Awareness Training, is posted on the MyMind website (mymind.org.uk), EHS Programme landing page at Middlewich High's Website and with Cheshire East Local Authority
- School staff have reported feeling more confident and equipped to respond appropriately to children and young people who have harmed themselves deliberately
- School staff attending training have found the pathway informative and easy to use and have valued the scripted questions that can be found in the document to drive questions around risk to self
- Staff report that the self-harm pathway component of the training is the one they value the most
- We have been working closely with CAMHS, local hospitals and the local authority to use the pathway to reduce admissions to A&E by improving the response from school staff

Next steps:

Since the pathway's successful roll out across all schools and colleges, the next stages will be continuing to improve the response for children and young people. Further simulation training based on the pathway is being developed with East Cheshire Trust and continued monitoring of A&E self-harm admissions.

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Care group: Children, Young People and Families Service
Team name: CAMHS Wirral Primary Mental Health Team

Wirral CAMHS Advice Line

What did we want to achieve?

In 2016, as part of the Future in Mind transformation plans, we transformed the offer for primary prevention and early identification of child mental health problems on Wirral. We developed a new approach which focused on a training and consultation model in a bid to support 123 schools, social care, health and third sector agencies within the Wirral. A key part of that approach has been the development of an advice line.

What we did:

- Provided access to immediate advice by launching an advice line (open 9-5 Monday to Friday) and a Trustwide Out of Hours advice line (open 5-10pm Monday to Friday and 12pm-6pm Saturday and Sunday). This advice line is open to anyone who would like support regarding a child or young person's mental health
- From April 2017 to April 2018 the advice line provided support and resources to 1566 individuals
- Following a consultation over the phone we send out our resource pack (formatted according to THRIVE model) which contains signposting information to young people, schools, parents and the CYP workforce. The resource pack contains a list of websites, self-help resources, organisations as well as crisis support

Results:

We always request feedback from our callers and of those who completed the feedback, 100% have said that their discussion was useful. Quotes have included the following:

- "Yes at least I know I can ring you for advice rather than go to A&E as that would be really upsetting for my autistic son"
- "This was really helpful thank you. It is reassuring to know you're not on your own out there, thank you very much for the advice given and for your help"
- "I've noticed a dramatic change in waiting times and appropriate referrals"

Next steps:

We plan to improve telephone systems and are exploring options for other means of providing consultation such as online consultations.

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Care group: Children, Young People and Families Service
Team name: Paediatric Community Continence Service

Paediatric Community Continence Service

What did we want to achieve?

This year the Paediatric Community Continence Service celebrates its 5th anniversary. It has grown year on year with referrals to the service increasing and over 400 children being seen in 2018. We are a small team based at Hope Farm Clinic comprising: Fiona Gerrard (Paediatric Specialist Nurse & Lead Nurse), Kate Dimelow (Nurse Specialist) and Barbara James (Nursery Nurse). We specialise in working with children/young people from 0-19 years with urology and bowel problems, i.e. daytime and nocturnal enuresis, constipation and soiling problems; toilet training for children/young people with special needs /physical disabilities, and children/young people with neurogenic bladder/bowel problems. We have clinics Monday to Friday in various locations: Hope Farm Clinic in Great Sutton, Prince Way in Frodsham, Blacon Children's Centre and Lache Clinic.

What we did:

During our assessments we carry out diagnostic procedures such as bladder scanning and uroflowmetry when required, and we are trained in clinical examination skills. If required we can refer children/young people to secondary care at the Countess of Chester Hospital and Alder Hey Children's Hospital, with whom we have close links in an advisory capacity, which can at times avoid unnecessary referrals.

Our Nursery Nurse has strong links with the special needs schools in our area, providing specialist support to the child/young person and their family with a view to them reaching their full potential. This has proven successful over the years by treating children at an earlier age thereby reducing the number of older children requiring referral.

We pride ourselves in providing informative training sessions several times throughout the year on Children's Continence Promotion and Toilet Training, and these can be booked through ESR.

Results:

Recently we have deployed new and innovative working initiatives to reduce our waiting times by offering telephone reviews where appropriate and facilitating extra clinics. We have introduced new programmes of care for children and young people to empower them and their families to be involved in their treatment programme which in many cases has resulted in quicker successful outcomes. The average waiting time in January 2018 for a new patient was 12 weeks. This has been dramatically reduced to 5 - 6 weeks. Likewise follow up reviews have followed suit with a 12 week wait reduced to 10 weeks. Feedback from service users has revealed that they appreciate our safe professional friendly approach:

- "You've made a massive difference to our lives"
- "Nurses are always kind and friendly"
- "Good advice and support"

Next steps:

We aim to continue building upon our success resulting in quicker successful outcomes. In the future we are looking to develop our Nursery Nurse role and facilitate extra clinics by utilising her skills, and provide training sessions within the Children's Centres.

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Care group: Children, Young People and Families Services
Team name: 0-19 Starting Well Service

Supporting Disadvantaged Two Year Olds into Free Funded Childcare/Education to improve their Learning and Development and Ensure the Best Start in Life

What did we want to achieve?

Our Children's Centres want every child to have the opportunity to learn and develop in line with their peers. For some children access to a childcare setting will help them to try new things, practice their skills and develop new ideas. We support families to find the best childcare setting for their needs and ensure all other areas of the family needs are considered.

What we did:

Support disadvantaged two year olds into free childcare/ education to improve their learning and development to ensure the best start in life by having an assertive outreach and engagement approach.

Results:

The Children's Centres Early Years Workers aim to meet every child who is eligible for two year old childcare funding. This has resulted in the team hitting the streets and door knocking those parents who may need additional information or a friendly face to take that first step. The EYWs are trained to encourage and enable adults who may find themselves without their child for 15 hours a week once they enter childcare to access training or adult/family learning courses in their area and ignite conversations around aspirations, employment, education and training.

Next steps:

Our service is looking at how we can link the child's 2 year Ages and Stages Questionnaire (ASQ) assessment into this process to avoid two contacts at 2 years from one service, a more fluid process for families and a more integrated development review with their childcare setting.

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Care group: Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services

Team name: Community Learning Disability Team Cheshire West and Chester

Developing a Workbook-based Challenging Behaviour Training Package for Care Provider Staff Working with Adults with Learning Disabilities

What did we want to achieve?

To champion the Transforming Care agenda, we are increasing the skill/knowledge base of care providers supporting adults with learning disabilities. The aim was to: increase quality of life; improve person-centred care; reduce inpatient admissions; reduce the risk of restrictive practices for vulnerable adults.

What we did:

- Developed an innovative new workbook covering: challenging behaviour, active support and communication
- Moved away from previous teaching methods towards a collaborative approach involving active participation from all participants
- We addressed participants' core values and challenged non-person-centred views. Facilitators support participants to work through real-life case studies into how their everyday support decisions affect the wellbeing, behaviour and mental health needs of some of the most complex service users we support
- Through running training, the team is developing wider reach into community agencies, and building local care providers' capability to support complex services users

Results:

- By moving to this interactive, workbook-based approach, we have seen: an increase in engagement from participants; greater understanding and retention of information; increased debate between participants, including participants challenging their peers' views when they feel there is possible poor practice or non-person-centred values; participants discussing how they can become leaders within their organisations to increase person-centred, positive practice; higher expectations from the facilitators about participants' engagement and knowledge
- We have received positive feedback from participants regarding: the booklet as a resource to take away and refer back to; use of video to help relate learning to real life examples; learning about formulation and taking a psychological approach towards challenging behaviour; learning about the importance of proactive and reactive strategies in relation to challenging behaviour, and learning the difference between these two; the knowledge of facilitators around challenging behaviour and how best to manage this in a person-centred way

Next steps:

We plan to use pre- and post-measures to assess participants' knowledge. This will help us measure learning and ensure we continue to build capacity in local provider agencies. We will increase service user involvement in developing the package further using video interviews about their experiences.

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Care group: Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services

Team name: Adult Autism Assessment and Diagnostic Service

Hitting the Triple Aim through Care Pathway Redesign to Improve Access to Adult Autism Assessments

What did we want to achieve?

Wirral and Cheshire CCGs commission us to provide an Autism diagnostic service for adults without Learning Disability. By 2016 the demand for assessments exceeded funded capacity and this was leading to increasing waiting lists. We agreed with CCGs to redesign the pathway to reduce cost and enable more people to be seen for the same money.

What we did:

The pathway was redesigned by reducing face to face assessment time and introducing a pre-assessment questionnaire, to enable the assessment to focus on gaining relevant information that was not already available. This was co-produced with the clinicians in the team and people who had been through the service, who got a diagnosis or another opinion, carer/informants and GPs to ensure that we maintained the elements that, in feedback, were the key benefits and essentials. The assessment process remained NICE (CG142) compliant, multi-disciplinary and offered locally.

Results:

It achieves the triple aims:

- Patient experience - waiting lists for assessments have reduced and people can access a diagnosis more quickly. The questionnaire allows people to carefully consider the information they want to provide and they have reported that it helps them anticipate what to expect in the assessment which reduces anxiety and promotes clinic attendance and engagement
- Population health - it is known that autistic adults without a learning disability die 16 years earlier than the general population (autistica). Through having a thorough diagnostic person centred assessment, the person can access an autism opinion and a psychiatric review informing them and their supporters what reasonable adjustments are needed to access and engage in healthcare services, how to best meet their needs, play to their strengths, and support them to achieve their aspirations, optimum functioning and wellbeing
- Reduce per capita costs - the redesign of the care pathway has resulted in a 75% increase in numbers seen for same funding i.e. we have moved from a traditional assessment service to a co-produced one

Next steps:

- We are developing a 'go to' hub for all CWP services needing advice on working with Autistic people without LD
- We are working with a range of partners to make best use of the resources in local communities and are continuing to campaign at local, regional and national level for more funding of post diagnostic support

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Care group: Specialist Mental Health Services
Team name: Rosewood Occupational Therapy Team

Implementation of the VdT Model of Creative Ability within the Intensive Rehabilitation Environment

What did we want to achieve?

The purpose of the project is to implement the VdT Model of Creative Ability within the Intensive Rehabilitation Environment as part of a 12 month service improvement project, which commenced in January 2018. The VdT model is an Occupational Therapy practice model which looks at someone's level of functioning in relation to being able to change their behaviour and 'create something that didn't exist before' in response to environmental, social or occupational demands in life.

What we did:

Training has been provided to the Occupational Therapy Department staff through the Clinical Lead Occupational Therapist on the treatment principles of the Vona Du Toit Model of Creative Ability (VdT MoCA) model, theory and application, which allows the OT to clearly identify which level of occupational functioning (or 'creative ability') a patient is currently at by observing certain actions and attributing these to corresponding levels of motivation. By observing these, the OT can establish the patient's level of 'creative ability' as well as chart any improvement or regression. Once this level is established, the OT can then ascertain how much independence the patient has at this level.

Results:

To date, the department has received positive feedback with regards to the changes in service provision, outcomes and revised documentation from service recipients, the multidisciplinary team, ward staff and commissioners. The team are able to evidence the effectiveness of 1:1 and group interventions through the use of the specific outcome measure and revised documentation.

Next steps:

In terms of service development, the Rosewood Occupational Therapy Department is planning to provide basic training to the rest of the ward staff on the treatment principles of the VdTMoCA approach to practice so that the principles can be implemented throughout the service and as a development opportunity for support staff. In addition to this, the Rosewood Occupational Therapy Department will write up the implementation process for publication as part of a service development project.

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Care group: Specialist Mental Health Services
Team name: Adult Mental Health Services, Chester

Team Away Day Using Person Centred Thinking Tools

What did we want to achieve?

Due to there being a number of new staff within the team it was agreed that an away day would support the team in getting to know each other and looking at new ways of working.

What we did:

Having worked with a colleague from the Community LD Team in Chester it was identified that the use of person centred thinking tools during an away day had worked well. Therefore, it was agreed for this colleague to support the team by facilitating the away day and using person centred thinking tools throughout. These included, looking at what was working and not working within the roles in the team, a "doughnut" around responsibilities within the roles and a team one page profile, all of which has helped develop action plans for the team.

Results:

The feedback from the team was positive and they engaged well in the use of all the different tools. This enabled them to use and understand the tools in a practical way. It was also helpful in identifying the qualities within the team and it was a very engaging process throughout. Also with the use of the 4 + 1 tool to evaluate the day this has helped to identify future actions for the team and ways of supporting clinicians to carry out their roles.

Next steps:

The action plan following this away day includes:

- A rolling education/training programme being developed for clinicians
- A group of clinicians to look at the caseload waiting tool
- Use of evidence based approaches to future service improvement within the team

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Care group: Specialist Mental Health Services
Team name: Bowmere ECT Team

A Study of Student Nurses Attitudes towards Electro Convulsive Therapy (ECT), Before and After Training and Observation of Treatment

What did we want to achieve?

Although a safe and effective treatment for severe depression, prolonged or severe mania and catatonia, ECT remains controversial. TV and media portray ECT as a barbaric and un-researched treatment. The purpose of this study was to identify future staff's perception of ECT before and following a training session and then again following observation of ECT. This would also allow the team to evaluate the quality and relevance of the ECT training. It was hoped that by completing the training students will be able to have an informed perception of ECT which they can use to support people when they are considering and receiving ECT.

What we did:

- Before treatment student nurses were given a questionnaire which contained thirteen attitudinal statements relating to ECT
- Students were then given an hour's talk and a fifteen minute practical demonstration of ECT which included the history of ECT, why it's used, the legalities, the physical health requirements pre and post ECT, the treatment process, the process of recovery, post recovery, effects, side effects and contra indications. The demonstration also included nursing care of the service user on return to the ward
- The practical demonstration included a look at the ECT machine, how it works and the results expected relating to stimulus dose etc

Results:

The findings suggest that there is a positive change in student's attitudes regarding ECT as a direct result of the training. Furthermore, following observation of an ECT treatment there was a further positive change in student's attitudes. Several questions identified a shift in attitude. These were most strongly evident from students who believed that ECT was barbaric, the belief that ECT is outmoded and should never be used and whether or not ECT should only be given under the mental health act. The ECT training and particularly the observation of ECT is effective in changing the negative attitudes of students towards ECT to a more positive attitude. The results included a shift of students who would agree to have ECT if they were depressed and that students would be able to recommend ECT to patients if required.

Next steps:

To repeat the survey with other groups who attend ECT training. This will include nurses, medical, occupational therapy, psychology and pharmacy students.

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Care group: Specialist Mental Health Services
Team name: ECT Team

Nurse Administered ECT (NAECT)

What did we want to achieve?

In 2016 the Royal College of Nursing, the Royal College of Psychiatrists and the Nursing Midwifery Council agreed that experienced ECT nurses with 3 years senior nurse experience could, following a period of training and ongoing supervision administer Electro Convulsive Therapy (ECT). This until now had been only a role for doctors. It is anticipated that this development will improve continuity of care for service users receiving ECT and is in line with Chief Nursing Officer's proposal for more advanced nurse and autonomous practitioners.

What we did:

Springview and Bowmere ECT suites amalgamated in September 2017. Discussions had taken place within CWP at an earlier date to implement Nurse Administered ECT following this amalgamation. The requirements to fulfil the role were published by the Electro Convulsive Therapy Accreditation Service (ECTAS) in their 13th Edition of ECTAS Standards. These included:

- Completion and updates of the ECT training course organised by ECTAS
- Attendance of an ECT Training day in the last 3 years
- Attendance and contribution to a regional special interest group
- Completion of the RCP competencies for junior doctors and ECT nurse competencies
- An up to date appraisal
- Monthly medical supervision by the Lead ECT consultant
- Administer at least 20 treatments a year to maintain competency

Over a six month period the above standards were achieved by two nurses, with competencies assessed by the Lead ECT Consultant. ECT is now delivered by nursing staff.

Results:

Nurses administering ECT provides more back up within the department and allows for better continuity of care for service users. It allows for ECT to be given regularly by the same staff offering a familiar face to service users. Nurse administered clinics in mental health have been slower to develop than in general medicine. This practice has further extended the role of the nurse in mental health. Including those treatments given under supervision since March 2018, 20 service users have been treated and a total number of 100 treatments have been administered by nurses.

Next steps:

To include a question in the service user questionnaire about any differences service users have noticed. Maintain competencies required to fulfil the ECTAS Standards. Consider publishing results in the nursing press or ECT journal.

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Care group: Specialist Mental Health Services
Team name: Psychology Team, Rosewood Intensive Rehabilitation Unit

Using Qualitative Feedback to Improve Service User Satisfaction and Quality of Life

What did we want to achieve?

To develop an understanding of the factors influencing service user satisfaction and quality of life using qualitative responses obtained from administering the DIALOG (Priebe et al., 2007) outcome measure. Using this method to identify areas for service improvement and increase service user satisfaction.

What we did:

- All service users on Rosewood Rehabilitation Unit were invited to take part
- Service users were asked to rate quality of life in eight areas (e.g. mental health, physical health, job situation, accommodation, leisure activities, relationship with partner/family, friendships, personal safety) and treatment satisfaction in three areas (e.g. medication, practical help received, meetings with mental health professionals) using the DIALOG
- Service users were asked about the rationale for their ratings (e.g. factors contributing to dissatisfaction, suggestions for improvement) and the qualitative feedback was gathered and analysed by the assistant psychologist, using thematic analyses

Results:

- Service user satisfaction provides a reliable indication of the quality of care in mental health settings (Shipley, Hilborn, Hansell, Tyrer & Tyrer, 2000)
- The DIALOG can be used as a patient-reported outcome measure in inpatient settings to gain an indication of treatment satisfaction and quality of life among service users (Priebe et al., 2007). However, the qualitative feedback gained in addition to the DIALOG went beyond a quantitative value, enabling the identification of factors contributing to satisfaction and dissatisfaction
- Eleven out of eighteen service users participated (five declined; two were unable to participate)
- Results suggest that service users value emotional support and therapies
- Service users report that they would like to feel more empowered through the promotion of freedom, independence and choice. Exploring qualitative responses enabled identification of specific interventions which could be used to increase patient satisfaction e.g. looking at processes around leave and staffing issues, community meetings, service user groups, access to the internet, a service user printer, and dietary choices

Next steps:

The results of the project will be fed back to service users verbally and in the form of a 'You said, we did' document. After a period of nine months, the project will be repeated. At this time, service users will also be asked to rate their satisfaction with the outcomes of the current project.

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Care group: Specialist Mental Health Services
Team name: Older People's Mental Health Services Chester West

Service Evaluation of Artist Involvement in a Post-Diagnostic Group for People with a Diagnosis of Dementia and their Carers

What did we want to achieve?

The Post Diagnostic Support Group (PDSG) offers information and support to people recently diagnosed with dementia and their relatives. A recent government drive has highlighted the benefits of bringing arts-based activities into healthcare provision to improve wellbeing. The purpose of the project was to improve the engagement and experience of people with dementia attending the groups, using arts-based activities.

What we did:

- In a collaboration with University of Chester, an artist led four additional sessions of the PDSG group in June and used creative methods to engage group members in talking about their lives and their experiences of living with dementia
- Participants created personal scrapbooks and did a sensory walk where they took photos of the surroundings and wrote poetry
- The group then worked collaboratively on a collage that expressed their life journey
- Staff from the Memory Service and Alzheimer's Society were invited to contribute to the collage
- Focus groups were held to evaluate how the artist-led sessions and standard group were received

Results:

People with dementia and their relatives reported that the group led by the artist had been very enjoyable and that they felt strongly part of the group. They commented:

- "It's relaxing isn't it? Once you get into this atmosphere in here you're not frightened of saying anything or doing anything….it's so friendly. I must admit (that) when they first put me on this course, she (his wife) brought me with my arm up my back. I didn't know what I was coming to, cos I had just been diagnosed, I didn't know what I was thinking to myself…" (Person with dementia)
- "I found it really, really, fascinating and enjoyable and I took a lot from it, listening to everybody, y'know. I loved listening to your poem… I thought that was brilliant." (Relative)

In the focus group following the standard sessions, participants were in consensus that talking with one another was hugely beneficial and that the opportunity for interaction and to share experiences needed to be prioritised above information giving.

Next steps:

We are going to discuss the feedback from the post-diagnostic support groups at a meeting to review and update the content and delivery of the sessions. We will also feedback the outcome to the Memory Service Accreditation Team visiting on 8th September.

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Care group: Clinical Support Services
Team name: Person Centred Thinking and Planning

Care Planning in Action – Pilot Programme

What did we want to achieve?

The aim of the pilot was to develop a more person centred approach to care planning, focusing initially on the crisis contingency plan, and developing a person centred safety plan prompt for all community patients. The drive for this pilot came from many avenues of feedback but the key driver for change was the concern from service users, carers and staff that the crisis plan was purely a list of people to contact in a crisis and this wasn't providing best care and support for people.

What we did:

- The pilot comprised of 4 workshops with 4 staff at Cherry Bank in Ellesmere Port. We looked at why we needed to change our approach to care planning and what the barriers were. We introduced the 'My Safety (Crisis) Plan' prompts and discussed a range of person centred thinking tools that could be used with service users to ensure their plan captured what and who mattered to them, and what best support would look like in a crisis
- Staff then invited a service user to be involved and worked together to develop a new crisis plan. We captured feedback on the approach, a report was produced, and the results were then shared at the wider team meeting

Results:

- The pilot identified that the current care plan format is actually a barrier to person centred care. Following the pilot we spoke to 2 of the service users involved to get their feedback. "I think the new crisis plan is great. It's especially important for me in a crisis because people will know more about me. But filling out the tools and talking through them really helped me to know more about myself"
- "The headers on the plan need to be used for everyone. Its insight, it's personal for that person. It's the important things that really matter in the worst time in your life"
- We also spoke to the staff involved for their feedback. "Highlighting and simplifying our service users' needs and strengths for their recovery was a refreshing model to champion"
- "The feedback from service users highlights that if we want to deliver person centred care our approach to care planning needs to change"

Next steps:

The feedback from the pilot will be taken to the Quality Committee and integrated into the CWP Person Centred Thinking Training, which we hope will soon become mandatory for all staff. It is clear from the feedback that the current crisis plans and support available aren't working for people and therefore we aren't delivering the best support possible. The pilot has shown that by having different conversations with people, and using the 'My Safety Plan prompts, we can then capture invaluable information and develop a co-produced and person centred plan to support people better in crisis.

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Care group: Clinical Support Services
Team name: Workforce Wellbeing Service

Staff Health and Wellbeing Checks (MOTs)

What did we want to achieve?

To offer staff a workplace health and wellbeing check that would provide an opportunity to assess their current health and identify any concerns and signpost accordingly, whilst receiving helpful advice and guidance to support optimum wellbeing.

What we did:

- Health screening for staff began in July 2015 and has since gone on to screen over 380 staff
- Each health check appointment is with an Occupational Health Clinic Nurse, and during this hour long appointment a set of health screening tests are carried out which include: Diabetes, Cholesterol levels, BMI, Blood Pressure readings and General Health questions, to gain an insight into each member of staff's overall health. The health checks are increasingly popular, with very good feedback

Results:

The initiative has been successful, with staff highlighting an improvement in their current health since their initial health check including energy and activity levels, weight loss and lowering of cholesterol. One member of staff reported that: "If it hadn't been for the staff health check she may have ignored an alarmingly high cholesterol reading. Her doctor advised that her appointment 'significantly helped save her health'." The health checks have the potential to reach staff whose health may be at risk before they become an issue. This initiative has identified undetected health needs in several people who have received Health Checks.

Next steps:

Next steps for the initiative is to fund equipment for all 3 of our departments so that the Health Checks can run concurrently and target larger numbers of staff. We are also evaluating the current checks and following up with staff to ascertain whether or not they have been able to continue to support a healthy lifestyle.

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Care group: Specialist Mental Health Services
Team name: Central & East Recovery College

C&E Recovery College and Crewe and Macclesfield Older People's Team Work Collaboratively to Ensure People Living with Dementia have a Stronger Collective Voice

What did we want to achieve?

After hearing about the encouraging work the Dementia Engagement & Empowerment Project (DEEP) is facilitating UK wide, the Recovery College and the Older People's Teams in Crewe and Macclesfield collaboratively worked together to form two groups in these areas. The aim is to work together to try and change services and policies that affect the lives of people living with dementia.

What we did:

Meeting monthly, each group works on a specific project. Time is also utilised to share community links and to learn coping strategies from a peer and professional perspective.

Results:

Some suggestions made by the DEEP Thinkers regarding DRC at Crewe involved structural changes, which are being considered. There were, however, other changes carried out immediately that have had a major impact on improving accessibility for people living with dementia e.g. providing clear toilet and exit signage, organising the clutter of posters in reception, removing out of date advertising and arranging information into orderly themes. These issues have been carried out with little or no cost and have made a difference to our service users, whose voices have been heard.

Next steps:

The DEEP groups will continue to be facilitated by CWP staff until September 2018. Thereafter, the plan is to hand over the responsibility of these groups to an elected chairperson i.e. someone who lives with dementia, or who cares for someone who lives with dementia. This chairperson will work under the guidelines of the national DEEP network project, supporting them to carry on the good work of making a difference to a person's quality of life and wellbeing via the DEEP groups.

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Care group: Specialist Mental Health Services
Team name: Occupational Therapy, Bowmere

Expressive Writing in an Acute Care Inpatient Setting - Does it Support Service Users Wellbeing?

What did we want to achieve?

To increase the variety of evidenced based group activities for service users in the acute care service in Bowmere.To evaluate its impact on service users' wellbeing and recovery.

What we did:

- Completed a literature search on use of expressive or creative writing (including identification of NICE Guidelines supporting its use with the inpatient service user group), and identified it as an evidenced based intervention
- Recruited a skilled and experienced volunteer, (a recently retired English teacher), to help facilitate the group, alongside occupational therapy staff
- Scheduled in a weekly Expressive Writing session to the occupational therapy group timetable, and promoted it on the wards with posters
- Developed a simple anonymous feedback questionnaire to evaluate the group by asking service users to complete this at the end of each session, and kept a record of the numbers who attended each group over a 6 week period

Results:

Over the 6 week period there were 48 attendees (averaging 8 per session some of whom repeatedly attended during their stay). The feedback provided by these service users was overwhelmingly positive, both verbally and on the anonymous feedback forms. The results from the feedback questionnaires provided evidence that service users found the sessions to be interesting, fun, constructive, helpful and stimulating.
In addition they added freehand comments which included that they found the volunteer to be:

- "Friendly, interesting and knowledgeable on the subject"
- "He (the volunteer) is a very good teacher and has an amazing knowledge and passion for writing"

This demonstrates the clear benefits of recruiting volunteers to enhance patient care through their unique knowledge and skills sets.

Other comments included:

- "I really enjoyed that"
- "It was lots of fun"
- "Nice to see everyone getting into their own story, and using their imagination"

Repeated attendance by some people also suggests that the session is valued and useful

Next steps:

Now that the success of the group has been established it will become a permanent feature of the occupational therapy group timetable, though subject to regular reviews. The occupational therapy technical instructors are also learning from the volunteer to deliver the group themselves to ensure it is sustainable in the future.

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Care group: Specialist Mental Health Services
Team name: Alderley Unit

Group Therapy for Individuals with Histories of Substance Misuse

What did we want to achieve?

We aim to deliver a safe and structured group therapy setting for individuals with complex mental health difficulties to discuss their histories of drug and alcohol misuse.

What we did:

- The therapeutic approach draws from a narrative framework that facilitates open discussion between attendees and, in turn, the development of a shared understanding and knowledge of the predisposing and precipitating factors integral to individuals' substance misuse and addictive behaviours
- Co-facilitators, based on these shared narratives, aim to draw themes and psychological constructs together so as to enhance insight and protective factors for the future
- We draw from a group philosophy that encourages the ethos that: 'the power of the group rests within the group'
- We aim to assess individual risk factors and modify distorted attitudes about drugs and alcohol through a process of group challenge
- We aim to validate and normalise the significant difficulties in desisting urges to misuse and in modifying addictive behaviour

Results:

We described our successes in qualitative, descriptive and theoretical terms. Specifically, we believe that the impact of the group can be most meaningfully described in idiographic and qualitative terms. Co-facilitators note, in the first instance, a positive impact of the group based the consistent weekly attendance of a small number of members; we consider this to represent a marker of the relevance of the group 'space' and content for those who attend. Co-facilitators have reflected on the positive comments received by group members and coping for: "just one day at a time"; this attitude has become a theme for enhancing desistance with members.

A final impact observed has been the hope provided by members and the role-modelling between members and facilitators. Co-facilitators offer each other hope for the future, a way through addictive behaviour, and in facing what seem like unmanageable urges to misuse.

Next steps:

We aim to continue delivering the group and have scope to increase the number of members who attend. The group is currently open to all patients at Soss Moss Hospital; however, we would like to review different approaches to the group for individuals with intellectual disability and those with mental health disorders. We aim to follow-up current members and complete outcome measures on attitudes to substance misuse and to construct idiographic psychological formulations, including relapse prevention plans for each group member. Relapse plans would be constructed within the group and modified by co-facilitators.

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Care group: Specialist Mental Health Services

Team name: CWP Podiatry, Occupational Therapy Team and Bowmere Hospital Staff

The Development of Podiatry Services at Bowmere Hospital

What did we want to achieve?

The service aimed to offer timely access to basic foot care for people on the inpatient wards at Bowmere Hospital. It was hoped that this may have a positive impact on mood and wellbeing by reducing pain and discomfort, and for a timely referral for specialist intervention as appropriate.

What we did:

- Working jointly with the podiatry team, training was rolled out for ward and occupational therapy staff
- This included the provision of basic foot care, including nail cutting and filing, along with training to identify when a specialist referral is required
- A pathway was developed, specifically tailored to Bowmere Hospital wards to support this
- The podiatry team provide nail care kits for use on the wards and an electronic referral form has been developed to reduce timescales when referring for specialist treatment from podiatry
- The CWP podiatry team continues to offer the specialist interventions on the ward or within a clinic at the hospital

Results:

Occupational Therapy staff offer regular foot care on the acute wards following the identification of need and a registered nurse undertakes weekly sessions on the dementia care ward. It has been identified that having staff trained has dramatically reduced the time to receive appropriate care. Feedback has been received from CWP podiatry team who have confirmed that this initiative has reduced the number of referrals they receive. This has resulted in the reduced need for clinic dates and increase in the capacity the team have for one to one specialist referrals. Feedback has been received from a carer of a service user who has reported her thanks as she could see an improvement in her mother's mood. Another service user has discussed the reduction in pain and discomfort, along with an improvement in mobility.

Next steps:

This is now an established service that will be reviewed regularly to ensure it continues to meet the needs of those on the inpatient wards. Links remain with the CWP podiatry service who are willing to train further staff in the future if this is identified.

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Care group: Clinical Support Services
Team name: Procurement

Materials Management in Clinical Areas at CWP (Trial at Springview)

What did we want to achieve?

To introduce good stock control and sound ordering processes to reduce waste, duplication and maximise standardisation in line with national guidelines and the Small Changes big differences project run by the RCN.

What we did:

- We analysed purchasing activity over the last financial year and counted all the existing stock on the ward taking out any waste and out of date stock
- Using the historical data and working closely with the wards we were able to establish a reduced core list of products and agree appropriate re order levels
- These re-order levels are to be maintained and reviewed to ensure that it continues to be suitable
- The information relating to the stock levels was then put onto a bar code scanner to allow it to be scanned in order to speed up the process
- We also identified better storage areas to allow it easier to find and put away items again improving efficiency and saving time

Results:

The project at Springview has shown that by introducing stock levels and controlling spend through standardisation we have reduced the amount of waste and reduced spend by 10%. If this was to be replicated throughout the Trust we would save a minimum of £50,000 as well as reducing a crucial amount of nursing time to allow more time with patients.

Next steps:

We are about to re-engage with key stake holders to roll this out across the Trust with a view to being completed by December 2018.

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Care group: Specialist Mental Health Services
Team name: Occupational Therapy Team, Cherry Ward

Memory Café with the Alzheimer's Society

What did we want to achieve?

The Memory Café was set up to offer a safe, therapeutic and supported environment for carers to engage with the person they care for and to offer and receive informal support from others in a caring role. The opportunity to gain access to formal carer support is available through the links with the Alzheimer's Society.

What we did:

- Links were built with an Alzheimer's Society representative who supported in the development of the Memory Café within the Oasis Café at Bowmere Hospital
- The sessions include informal carer support and a supportive environment with social activities including quizzes and reminiscence items available for carers to engage in with the person they care for or with other carers/facilitators
- Carer supports can be identified and addressed immediately due to Alzheimer's Society representation
- The session is open to all and location was chosen to encourage and support attendance of those who have current or who have had previous involvement within the inpatient or community older adult services in Chester. This can allow for graded involvement with the aim of links being built, followed by continued support and attendance

Results:

Two sessions have taken place and both carers and those they care for have attended. Attendees have had connections to inpatient or community services or have heard through word of mouth. Attendance has been moderate to start, with interest received regularly. Carer support needs have been identified as part of the session by the Alzheimer's Society representative and referrals have been discussed and completed. A carer for a gentleman on Cherry Ward had previously declined support and following a direct talk to the Alzheimer's Society consented to a formal referral. It is possible that this would have not been taken up had the session not taken place. Another carer has highlighted that it was the first time she felt that she could talk to others "in a similar situation" and felt relaxed and supported. Another carer discussed how she found it difficult to find community activities where she felt supported with her husband and that attending the café gave her the confidence to be out of the house.

Next steps:

The café will continue to run on a monthly basis. Options for additional carer support are to be identified including the carer's trust and the citizen's advice bureau. A formal review will take place at approximately 6 months to ascertain development strategies, feedback from attendees and what they would like for the future. Further promotion of the café will take place to widen connections to offer informal support to a wider audience.

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Care group: Clinical Support Services
Team name: Wirral Administration Service

Redesign of Administration Services on Wirral

What did we want to achieve?

To ensure that administration services could support the changing NHS – an administration service that is 'fit for the future'. A key component was that the people doing the work led the redesign as long as it was safe, legal and within budget. This included standardisation and optimisation of key working processes.

What we did:

- Asked for volunteers to be a part of the project group, which met weekly for 18 months
- Surveyed the administration staff to see what they thought worked well and what they didn't
- Process mapped different administration tasks and team processes
- Looked at enabling technology
- Visited other NHS administration services
- Consulted with administration staff, clinicians, managers on an ongoing basis and held various events to capture feedback
- Set aside an hour every week for admin staff to call in to support the project
- We rolled out digital dictation to those areas that weren't using it

Results:

- The redesign created 5 administration hubs and a new front of house service with a switchboard facility
- In March 2017 the average wait on Wirral for clinical letters to be typed was 3 months.
- We are now able to move the work around and so the average wait is now 1 week. This was achieved without additional staffing resource
- We also achieved a CIP value of £250,000. This was achieved by altering working practices and introducing cross cover across all hubs. Subsequently bank and agency usage has drastically reduced
- As a service we now have our own budget which enables us, as administrators, to decide on the best skill mix and where additional resources are needed to support services, thus ensuring a robust service
- It established a recognised and meaningful career pathway for the administration profession

Next steps:

We are continually re-evaluating our service and looking at other quality improvements. This enables us to make timely changes at pace where required. This responsiveness helps support the clinical delivery of high quality care.

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Care group: Neighbourhood Based Services
Team name: Community Matrons

Advanced Practitioners Undertaking Acute Home Visits

What did we want to achieve?

To ensure that patients that request home visits by the GP are seen earlier in the day by the ANP enabling timely investigations and treatment to avoid unnecessary hospital admission.

What we did:

- Identifying patients with complex needs that present with acute symptoms that may make them vulnerable to unnecessary hospital admissions
- Undertaking early morning assessments of these patients enabling timely investigations
- Giving these patients access to specialist GP assessment units and treatment enabling them to return home the same day
- Enabling swift mobilisation of other team members e.g. social workers, AHPs and charitable agencies to support patients in their own home
- Discussion and future care planning with patient and family ensuring a person centred approach
- Follow up visits by the community ANP ensure continuity of care and evaluation

Results:

- We have received positive feedback from patients and GP colleagues
- Unnecessary hospital admissions have been avoided
- Patients have been assessed, investigated and treated where required within the same day and enabled to stay at home
- Becoming house bound is a trigger to alert services that a patient is deteriorating in their ability to function independently. By identifying these patients early it allows mobilisation of services to maintain safety and independence
- Patients have reported added value of this service as ANP able to spend the time to coordinate and deliver care.
- It allows the GPs to see patients with more complex medical needs that require a doctor and enables effective use of resources by avoiding duplication of visits from other professionals

Next steps:

The pilot is continuing and we hope that we can continue it collaboratively. We are waiting to clarify future funding for the Community ANP role to role it out to include other surgeries.

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Care group: Neighbourhood Based Services
Team name: Crisis & Reablement Team

Enhanced Competencies and Skills to Support Community Care Teams in Providing Patient Centred Care

What did we want to achieve?

The Crisis & Reablement Team visit patients in their own homes who have an acute physical health crisis and are at risk of hospital admission without the appropriate care. We also support the community care teams by providing care for patients in their final days of life whose preferred place of care is home and provide valuable emotional support to patients and their carers.

What we did:

- Our project involved delivering a range of nursing and therapy competencies to support workers from a standard operating procedure formulated by previous CART staff
- These competencies involve both nursing and therapy skills such as monitoring blood sugars, taking blood pressure, carrying out simple dressings, recommending therapy equipment and fitting appropriate equipment following prescription by a therapist
- Support workers are able to identify different gait patterns and highlight any acute changes in patient medical conditions by reporting to trained staff with clearly identifiable facts and results
- We devised a handy booklet for support workers to keep in their work diaries which lists the interventions support workers can carry out in order to reassure patients and their families and act as a prompt for support workers to ensure they have completed the competencies and had them "signed off" by trained staff following demonstration of safe practice
- We have purchased equipment such as Sphygmomanometers, Stethoscopes, Thermometers, specimen jars, and equipment holdalls

Results:

The outcome of the project is already showing positive results as feedback from service users and our colleagues demonstrates. If all staff have the competencies required the team is able to offer additional support to the community care teams on referral.

Next steps:

Next steps would be to include venepuncture in the competencies.

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Care group: Children, Young People and Families Services
Team name: Wirral CAMHS Primary Mental Health Team

Wirral CAMHS Primary Mental Health Team (PMHT) Training Programme

What did we want to achieve?

In 2016, as part of the Future in Mind transformation plans, Wirral CAMHS Primary Mental Health Team (PMHT) transformed the offer for primary prevention and early identification of child mental health problems on Wirral. The team developed a new approach which focused on a training and consultation model in a bid to support 123 schools, social care, health and third sector agencies within the Wirral. A key part of that approach has been the development of a rolling training programme.

What we did:

We deliver a minimum of two training sessions on mental health, which are open to the entire children and young people's workforce. Attendees include: teaching staff, pastoral workers, social care and third sector agencies. Topics include: anxiety, attachment, challenging behaviour, parental mental health, self-harm and suicide, mental health in under 5's, trauma and mental health awareness in CYP with a learning disability.

Results:

We always request feedback from our training attendees and of those who completed the feedback. From 2016 to 2017, an average of 77% of attendees for our CAMHS training, and 66% of attendees for bespoke training said that they were very satisfied. Qualitative feedback for 2018 has included the following:

- "Very well delivered, excellent resources. A good day – thank you"
- "Really important reminder of how to help children and adults with behavioural issues. Great opportunity to talk to other people from other schools about their strategies. Thank you"

Feedback from our workshops has included the following:

- "The whole session was enjoyable and when carried on would definitely benefit the children"
- "The information booklet given after the session was great, because it gives lots of ideas for games/ activities to do"

Next steps:

We will continue to deliver a high quality training programme, using a quality improvement approach to ensure content is regularly reviewed in response to attendee feedback. Our next steps include increasing access to peer education programmes for young people, developing our strategy for supporting parents using co-design and enabling schools across Wirral to implement whole school approaches to mental health.

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Care group: Neighbourhood Based Services

Team name: Adult Musculoskeletal Assessment and Management Service (AMAMS) and Musculoskeletal (MSK) Physiotherapy

Introduction of a Clear Pathway for Patients with Low Back Pain Referred for Facet Joint Injections

What did we want to achieve?

To ensure that patients referred for facet injections have a clear pathway for a diagnostic procedure, with active rehabilitation post injection, and structured follow up.

What we did:

- Established strong working with the Countess of Chester Hospital's Pain Management team, identified patients receiving multiple injections, as there was no pathway in place
- Agreed a clear pathway, in line with NICE guidelines, establishing Facet Joint Injection as a purely diagnostic procedure
- Designed and delivered a Facet School, a patient education session to explain the procedure, the benefits and risks, and allow patients to fully understand the diagnostic nature of the injections
- Patients are given an explanation of the expected outcomes, and how the outcome will lead to appropriate follow up care. Patients are also encouraged to access post procedure active rehabilitation to strengthen weak muscles, increase confidence and return to function
- Patients are consented for the procedure at the Facet school by the Advanced Spinal Practitioner. As part of the pathway, 6 weeks post injection patients are followed up in a telephone review clinic managed by the Advanced Spinal Practitioner, and appropriate care is actioned according to the pathway

Results:

The biggest gain is that patients are really pleased to have a chance to ask questions, understand the procedure they have been referred for, and have the chance to access follow up physiotherapy to gain the maximum benefit from the procedure. Prior to introducing the pathway, there was no route into active therapy after injection, and this did not fit with NICE guidance. Typical patient feedback includes:

- 'So pleased to have been able to go to the facet school and understand why I'm having the injections'
- 'Nobody ever followed me up after the injections before, so now I feel like I know what to expect'
- 'This is great because I've been able to learn exercises and now I get why I should think about my posture'
- 'Graham explained it all really well, so I know what to expect and what will happen'

The numbers of internal repeated procedures are significantly reduced, and the numbers of patients discharged following procedure are still increasing. This has also resulted in improved value for patients and the health economy.

Next steps:

This is still a relatively new pathway; having started just under a year ago, so full data analysis is still being conducted to guide next steps.

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Care group: Children, Young People and Families Services
Team name: Learning Disability CAMHS West Cheshire

0-5 Early Years Preventative Intervention Initiative

What did we want to achieve?

Research has shown that early intervention in the care of children with learning disabilities can prevent challenging behaviour from developing. We wanted to help parents of children with a moderate to severe developmental delay (identified through their involvement with the Early Years Specialist Support Service) to develop a set of universal strategies that prevent and manage behavioural difficulties.

What we did:

- We promoted the service to parents through the Early Years Specialist Support Service (EYSS) and encouraged parental self-referral
- We offered a telephone triage which ensured rapid access to the service and we were able to sign post
- We developed a stepped model of care approach: initially offering general advice sessions, followed by individualised behaviour support if needed. The content of the advice sessions was created by combining well-researched universal strategies
- Parents completed a worksheet to help them individualise the different strategies to their own child. Wherever necessary, we provided parents with additional materials that they thought would be helpful. For example, creating a visual schedule for children who struggled with particular routines
- We created work booklets with all the information given with the aim of empowering parents to use these strategies again in future if necessary. In addition, we used the Friends & Family Test to ensure parents could provide honest feedback and improvements could be made whenever necessary. We collected additional feedback from parents through the Experience of Service Questionnaire

Results:

As a result of the increased access to the service and telephone triage we were able to offer an initial choice appointment within 5 weeks from referral. Urgent referrals were seen within 2 weeks. By offering initial advice sessions, we have reduced the number of appointments per child whilst still achieving increases in goal based outcomes. On an initial audit over a 6 month period, we found an average goal improvement of 3.5 on a 10 point scale. Research has indicated that a change of 2.46 or above is indicative of improved outcomes.

More importantly, feedback collected from the Experience of Service Questionnaire found parents thought we were: "Just really helpful – I have already recommended the service to a friend!"

Another parent added: "Just thank you – because the strategies are really helping." One parent commented on the questionnaire: "I think more parents need to be made aware of the service and the fact you can refer your own child."

Next steps:

We are still continuing to make improvements to the scheme using the feedback we receive to monitor and improve our work. Our next steps are to continue to offer the service and get more feedback from parents about what they would like from the service.

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Care group: Neighbourhood Based Services

Team name: Professional Development Lead Community Nursing with Community Nurses

Implementation of an Adult Community Nursing Induction Programme for New Starters

What did we want to achieve?

Community nurses are integral to support care at or closer to people's homes. Community nursing is a diverse challenging environment coupled with increasing patient complexity, public expectations and technology advancements. The vision was to enhance transition to community nursing for new starters, develop an understanding of the community setting and the importance of collaborative inter-professional working with differing healthcare professionals that provide care to people in their homes. This included having the knowledge of what services are available, making best use of resources to support clinical decision and making timely referrals to other health care professionals. In addition, it is imperative that community nurses feel supported in new roles, competent and confident to provide safe, effective and high quality person centred care to patients, carers and families.

What we did:

- Arranged an initial meeting with a cohort of community nurses to ascertain our vision and plan how best we could achieve our goal
- Held discussions with nurses who had been employed within the last 12 months to capture an understanding of their experience, thoughts and ideas. This was essential as it highlighted what was important to them

Results:

Feedback was positive from both community nurses and speakers, generating professional discussions and challenges. It is a reminder to 'stop the clock' and be mindful of the complexity of community nursing for those new to the community from differing sectors such as acute hospitals or first nursing role for nurse graduates. The cohort of nurses ranged from transition from the acute sector, experienced community nurses, return to practice student trainee Nurse Associates and trainee Advanced Nurse Practitioners.

- "The programme is essential for new starters to CWP community nursing"
- "Motivational, been at CWP for 4 years and was not aware of all the varied resources. This will improve my patient care, better knowledge of resources and what different services do"
- "Use the knowledge to enhance my practice"
- "Identified individual learning and professional development needs"

Next steps:

To continually review programme feedback and build upon the foundations of the programme. To discuss taking this forward with a multi professional approach.

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Care group: Children, Young People and Families Services
Team name: Wirral CAMHS 0-13 team

CAMHS 0-13 Team ASD Assessment Clinic

What did we want to achieve?

To streamline and standardise the ASD assessment pathway for service users and families. To reduce waiting times and increase efficiency by creating a centralised assessment process, with parallel young-person and parent assessments taking place on the same day. Aim to feedback results to families within a week. Create a flexible skills pool within the team to reduce waiting list.

What we did:

- Provided training for staff to allow greater flexibility in undertaking assessments
- Centralised database of referrals for ASD assessments to allow better overview of young person's progress along the assessment pathway
- Single pathway for all ASD assessments within the team allowing standardisation of assessment process for service users and families
- Standardisation of diagnostic reports
- Identification of physical environment for clinic space
- Provision of photographs of assessors with overview of process on accompanying paperwork sent out to young person and families. Young people given the option of attending clinic space before assessment to familiarise themselves with the environment, to help minimise anxieties

Results:

- In the first year, the waiting list reduced from over 12 months to approximately 8 months from initial screening to completed assessment
- Standardisation of service user access to ASD assessment and time scales clearly identified
- Increased efficiency of staff time and the development of pool of skills to allow greater flexibility in assessments
- Centralised waiting list and outcome data will allow the improved scrutiny of process to identify further improvements, for example, improved screening process
- Clearly defined pathway for case managers to access when considering ASD diagnosis

Next steps:

Further reduction to the waiting list through: improved screening process; increase of number of assessments using current model. Continued improvements to service user experience through: planned further use of visual materials to introduce young people to assessment process, for example, to include photographs of clinic space; develop young person & parent focus groups to review assessment process; obtain service user feedback re: quality of diagnostic reports.

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Care group: Transforming Care for People with LD, Neuro-developmental Disorders and ABI Services

Team name: Community Learning Disability Team Cheshire West and Chester

Total Communication Pathway

What did we want to achieve?

To provide person centred training around Total Communication in a timely manner in order to reduce waiting times for staff/families supporting people with a learning disability to access Speech and Language Therapy.

What we did:

We created a Total Communication workshop which involved training in how to use a Total Communication approach and creating a person centred plan with staff team/families as partners to ensure the person receives good quality support without having a long wait. The aims of the pathway were:

- To reduce waiting times
- To encourage staff/family to invest in Speech and Language interventions
- To create a time/space for total communication training that then allows other staff to access as needed. e.g. advocates
- To ensure people leave us with a person centred plan

Results:

The project has significantly reducing waiting times for Speech and Language Therapy support using a Total Communication approach and is a more effective use of therapist time. Staff and family have given us positive feedback. They have described the course as helpful and particularly like seeing all the resources.

We achieve in one day what would otherwise take 3-4 visits.

Next steps:

We will continue to run the Total Communication Workshop and hope to complete an audit on this approach. This will shape the future of the workshop. We also hope to expand the workshops, offering more sessions during the next 12 months. We also would like to offer brief visits to meet the person with a learning disability prior to their staff/family attending.

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Care group: Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services

Team name: East Cheshire Community Learning Disability Team

A Service Evaluation of Suicidality in a Community Learning Disability Team

What did we want to achieve?

Suicide prevention is a key health priority. Risk factors for suicide suggest that people with a learning disability could be vulnerable to suicidal thoughts and behaviours. The link between a learning disability and suicidality has been largely un-investigated. Existing research suggests suicide figures may be under-reported in this population.

What we did:

- Dataset 1 was taken from incident reporting records from November 2016-November 2017
- Dataset 2 (n=88) was comprised of the CLDT's consultant psychiatrist's caseload. Basic demographics for the service (n=409) were also included
- For dataset 3 information from 200 learning disability deaths reviewed by the national mortality dataset (LeDeR) were also included

Results:

- The number of deaths by suicide reported in the trust in a 12 month period involving an individual identified as having LD was zero
- Four service users presented with suicidality in the team in the last 12 months
- Risk factors for suicide, including diagnosis of mild LD and a concurrent mental health diagnosis, were present in over 80% of the sample

Next steps:

The LeDeR team at University of Bristol acknowledge that suicide data in the learning disability population has been noticeably absent from all of the mortality reviews conducted over the past 10 years. We aim to work together to 'reformulate' how suicidality is assessed and identified in the learning disability population.

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Care group: Neighbourhood Based Services
Team name: Fountains Community Care Team

Personalised Care through Competency Training

What did we want to achieve?

To enable people with complex needs to participate fully in day care activities without needing to wait for medication to be administered.

What we did:

- Scoped the feasibility of day care staff administering medication via a peg tube instead of Community Nursing staff visiting
- Joint working with CWP LD, Community Nursing and Dietetic services, in conjunction with Vivo Care staff and Commissioners
- Service users and families had restricted access to activities due to the timing needs of his medication
- Governance reviewed for all staff involved
- A competency training package was created and then training through a competency programme was delivered to the care staff

Results:

Competency training has now been delivered to all necessary staff. All competencies have been achieved. PEG medication is now given daily by care staff, allowing people to fully participate in the activities and days out available within. This has also allowed families to benefit from the daily respite required. The result of this work has meant that care is personalised and delivered by the most appropriate person. In addition, this has also released the Community Nursing capacity.

Next steps:

Review of outcomes and training in 3 months' time, with a full competency review in 12 months. We are now looking at which other people across Western Cheshire may also benefit from a competency training approach to allow medication to be delivered without impacting on their daytime activities.

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Care group: Neighbourhood Based Services
Team name: Tissue Viability and Ellesmere Port North

Review of Wound Care Assessments

What did we want to achieve?

Pilot to reduce time spent completing paper work for small wounds.

What we did:

- Tissue Viability met with staff at Ellesmere Port North
- We came to a decision that a moisture lesion or stage 2 pressure ulcer measuring less than 20mm length and width would be involved in the pilot
- The wound had to heal within 5 visits or two weeks
- These wounds did not have to have a full wound assessment completed but the information was input in free text
- If the wound had healed within 2 weeks the patient was discharged as part of the pilot scheme if not a full assessment was completed

Results:

An initial 2 month pilot took place in Ellesmere Port North during which time data was collected on wounds included in the pilot. From 12 patients two required full assessments, the remaining 10 all healed within the two week period. This saved time completing paper work releasing time for the patients. We then included trauma wounds as part of the pilot and rolled this out to all Community Care Teams.

Next steps:

During reflective reviews for stage 2 pressure ulcers that have deteriorated we can monitor if the full assessments have been completed following the two week period i.e. monitoring variation against our pathways. A year later we haven't found any patients for whom a full assessment hasn't been completed when needed.

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Care group: Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services

Team name: Pharmacy

STOMP-Stopping over Medication of People with a Learning Disability, Autism or Both with Psychotropic Medicines

What did we want to achieve?

In July 2015, reports commissioned by NHS England were published highlighting widespread inappropriate use of antipsychotics and other psychotropic medication in patients with learning disabilities (LD). The purpose of this project was to review the use of antipsychotics in LD patients across the CWP footprint. We wanted to improve outcomes for learning disability patients prescribed antipsychotics.

What we did:

- We worked in collaboration with West Cheshire CCG, Vale Royal CCG, Wirral CCG, East Cheshire CCG and GP practices to identify those patients on the LD register who were prescribed an antipsychotic without a formal MH diagnosis or access to CWP services
- Specialist pharmacists then reviewed these patients
- In cases where the clinical judgment of the pharmacist was that a change could be made, a clear plan for switching, reducing or stopping the medication was documented. In addition, we built an electronic learning platform for STOMP resources

Results:

Advanced clinical pharmacists aided medication management in the community setting for a cohort of patients with complex needs. The following results were obtained from the pilot:

- In total 130 patients were reviewed at practice level, 60 were excluded based on on-going review by (or referral to) CWP or a formal MH diagnosis. In total, 41 recommendations were made to review or change medication based on the available information
- Although a small sample of 130 patients were reviewed 31.5% were recommended for a review or change in medication
- This was a short scale pilot of which NHSE local team have acknowledged that follow up would be required to confirm further outcomes and in this is currently being taken forward by NHSE
- We have been asked by NHSE to present the work regionally
- The report is currently being finalised following discussions with CCGs and NHS England, and will be available shortly
- There are other findings in the report such as the need for a behaviour ratings scale that is standard across the region or even nationally

Next steps:

Share project details on both a local and national level at NHSE Physical Health Good Practice Showcasing Event and Transforming Care Operational Board.

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Care group: Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services

Team name: Trafford Community Learning Disability Team (CLDT)

Learning Disability Coffee Morning Drop-In

What did we want to achieve?

For individuals with a learning disability (LD) to have access to social inclusion opportunities outside of the 'typically' commissioned service times. The coffee morning aims to combat loneliness for people who have limited opportunities for social engagement within their local community; as well as to re-establish longstanding friendships, thus improving their overall health and wellbeing.

What we did:

- CLDT identified that there were clients who had known each other since their youth and following a change in day service provision lost contact and did not have the means to re-establish this
- Research was completed and it was identified that there were limited services within the Trafford locality for people with LD at the weekends
- The idea of a drop-in was discussed with people within services that CLDT felt would benefit from weekend social engagement opportunities
- An accessible venue was sought and negotiations were had with the venue staff around cost and timings. Flyers were produced and distributed within the local community

Results:

The drop-in has been running since January 2018, and the number of attendees has increased each month. Friendships have been re-established. Since attending the drop-in, the confidence of some clients appears to have increased and some have also made their own social arrangements with one another, without CLDT involvement. Families and carers have volunteered their skills, for example one parent has volunteered to attend do some sewing / quilting with members. Positive feedback has included:

- "I like to go to coffee morning with my friend… I have a good morning." (drop-in attendee)
- "As a parent, it was a pleasure to meet other parents and form new friendships. We chatted about the ups and the downs of caring for our special loved ones"
- "Helping out at the coffee morning felt like I was giving something back and rewarding in itself and it gave me the opportunity to interact with our service users outside of the assessment and care planning processes" (Volunteer)

Next steps:

Future plans include: For additional drop-in groups to be, including an evening group; to have more volunteers to support at the drop-in; to get regular feedback from clients, parent/carers to ensure it continue to be person-centred; to have speakers attend the coffee morning to discuss topics such as cancer screening programs.

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Care group: Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services
Team name: Eastway Assessment and Treatment Ward

Makaton- Teaching a Sign a Week

What did we want to achieve?

To improve staff confidence in using signs and symbols. To ensure a Total communication environment to enable all patients to understand at their own level.

What we did:

- Posters were created of high frequently used that we needed to communicate on the Ward. These consisted of the symbol, word and a line drawing of the Makaton sign
- Staff were given key fobs with copy of the symbols to use in practice
- Staff could sign and speak and use symbols as needed
- The poster was changed every week. When removed they were displayed in another area for reference

Results:

There was a significant improvement in staff confidence to use Makaton and symbols. A total communication environment was evident on the ward. Patients with communication difficulties benefitted from this total communication environment and each one was able to understand and communicate at their own level.

Next steps:

The SALT Learning Disability Team suggested the development of a 2 year rotational programme. This will be implemented on Eastway, Greenways and Alderley. The CLDT's will be invited to be part of this if they choose.

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Honourable Mentions

With over 80 entries being submitted to the Big Book of Best Practice 2018/19, we have unfortunately been unable to include every entry.

However, many of the projects – despite not being selected for full publication – deserve to be celebrated for the fantastic outcomes achieved.

These are included below as honourable mentions. You can find more information about these projects, in addition to an online version of the entire publication, at www.cwp.nhs.uk

Care group: Clinical Support Services

Team name: Workforce Wellbeing Service
Title: Later Life Transition Workshops - Working Longer & Living Life to the Full

Team name: Workforce Wellbeing Service
Title: Achievement of the SEQOHS (Safe, Effective, Quality Occupational Health Service) Reaccreditation

Care group: Neighbourhood Based Services

Team name: Community Nutrition Service
Title: West Cheshire 'MUST' Care Pathway: Recognising and Managing Malnutrition in Care Homes

Team name: Westminster Surgery
Title: Delivering Patient Centred, 'On the Doorstep Care' Incorporating both Physical and Mental Health Needs

Care group: Specialist Mental Health

Team name: Integrated Dementia Liaison Team
Title: Integrated Working in an Acute General Setting

Team name: Dialectical Therapy Team – West Cheshire
Title: Delivering Specialist Treatment for Borderline Personality Disorder

Team name: Vale Royal Adult Mental Health Services
Title: Achieving Better Recovery and Service Outcomes in Community Mental Health Services with a Specialist Occupational Therapy Role

Team name: Ellesmere Port and Neston Adult Mental Health Services
Title: Person-Centred Discussion Group

Team name: Older Adults Community Mental Health Team (Cheshire West)
Title: Cognitive Stimulation Therapy Group

Team name: Bowmere Hospital
Title: Cervical Screening Service for Inpatients in Bowmere Hospital

Care group:
Children, Young People & Families

Team name: Wirral Primary Mental Health Team
Title: The Wirral Accelerator Schools Project: Cascading Best Practice around Emotional Well-being

Team name: Emotionally Healthy Schools Links Team
Title: Emotionally Healthy Schools Links Improving Confidence and Wellbeing across Cheshire East

Team name: Ancora House Psychology Team
Title: Developing Child Sexual Exploitation Support Sessions for Young People

Team name: Children and Young People's Out of Hours Advice Team
Title: Out of Hours Advice Line

Care group:
Transforming Care for People with LD and Neuro-developmental Disorders and ABI Services

Team name: Community Learning Disability Team – Cheshire West and Chester
Title: Pain and Distress Assessment Tool (DisDAT) Training

The Big Book of Best Practice 2018/19

To find out more about our new Care Groups read our CWP Five Year Forward View strategy on our website: www.cwp.nhs.uk

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