NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

THE **BIG BOOK OF BEST PRACTICE** 2019 - 20

Highly Commended at the HSJ Value Awards

HSJ VALUE AWARDS 2019

Shortlisted for a Chartered Institute of Public Relations PRide Award 2019

CIPR PRIDE AWARDS 2019 SHORTLIST

The Big Book of Best Practice 2018/19 in numbers:

The Book

A Royal endorsement from the Duke and Duchess of Cambridge

4,478 Big Book downloads

Submissions more than doubled since first publication

80,000 media engagements (retweets, likes, shares)

1000 printed Big Books shared

Testimonials

Dr Geraldine Strathdee OBE, former National Clinical Director for Mental Health, NHS England:

"I remember the first Big Book of Best Practice and the pride Board members and non-executive directors took in that journey. It has influenced policy and the drive to improvement and sharing learning."

Justin Madders MP (Ellesmere Port and Neston) Shadow Health Minister:

"I think this is something that we should be sending out to every member of Parliament, so that they can see some of the great work that goes on here, and be asking their own Trusts and Partnerships whether they are doing something similar."

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

Our Event

1000 printed CWP Life magazine and 410 downloads

300+ targeted stakeholder mailings

Highly Commended in the HSJ Value awards 2019

Shortlisted for a Chartered Institute of Public Relations PRide Award 2019

75% took away learning or good practice they could use

A good networking opportunity 89%

220 delegates at launch event

93% interesting

Dale Maskell – CEO - Age UK Cheshire:

"They've come up with some brilliant ideas that I will be taking back to the team particularly around Makaton and introducing Makaton to the team, so we're probably going to use a similar approach that they've used. Hopefully it will help the team with their understanding of Makaton and to communicate better with the people that we help".

David Rutley MP (Macclesfield):

"It was an honour to learn more about the wide range of important services the organisation offers. There were impressive case studies that showed how CWP staff are working hard to provide high quality mental health care".

Contents

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 seventh edition of CWP's Big Book of Best Practice.

The quality of entries for the Big Book improves each year, with last year's edition being the most recognised regionally and nationally to date. The publication was Highly Commended at the HSJ Value Awards 2019 and has been shortlisted for the Chartered Institute of Public Relations PRide Awards 2019. Read more about this on pages 2-3.

I was excited to see the number of submissions had risen again this year as it shows how CWP's leaders at all levels are innovative, passionate, and want to improve services. The entries to the Big Book help us to share our ideas about quality improvement and partnership with our colleagues and the wider health 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, our Macmillan Specialist Community Palliative Care Team has developed greater collaboration with hospice colleagues to ensure better care for the people they serve page 10. You can also read about our exciting new Centre for Autism, Neuro-Developmental Disorders and Intellectual Disability (CANDDID), which has worked with families and carers to develop a suite of online training for people who care for people with learning disabilities or autism on page 11.

The new evidence-based sensory pathway being used in our Bowmere adult inpatient setting is using person-centred techniques and interventions to help people better understand and manage their distressing experiences on page 20.

Thank you to everyone who has submitted this year, competition for a spot was fierce and we really do wish we could include all of the submissions we get. All of the case studies submitted showed how Quality Improvement (QI) is bedding into the fabric of CWP and truly indicates how committed our staff are to deliver high quality care.

We've made great strides in QI this year, the number of staff actively engaging in innovation and improvement is reflected in CWP being shortlisted for Mental Health Provider of the Year Award at the HSJ Awards 2019. This reflects all the services CWP provides, not just mental health, and is a fantastic endorsement of our staff on page 13. The hub can be accessed by more than 3500 staff and provides an online zone where staff can go and begin their QI journey.

I am already keen to see the developments from the Trust 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.

Contact:
alison.treloar@nhs.net

Care group: Children, Young People and Families
Team name: Speech and Language Therapy Team (SALT)

Speech and Language Therapy Team (SALT) and Child Adolescent Mental Health Services (CAMHS) joint care pathway for children with selective mutism

What did we want to achieve?

Children who present with selective mutism have often been referred into a number of different services. We wanted to achieve a joint pathway to work in the most efficient and collaborative way to gain the best outcome for the child and family.

What we did:

SALT and CAMHS met and looked at best practice. Close collaboration between services was the best outcome, so we created a clear pathway for families to access the expertise of SALT and CAMHS.

Training was carried out with SALT and CAMHS staff and we explored what was uniquely offered by both services.

For example we streamlined getting advice so that CAMHS would lead on this and we devised a joint session that meant that joint goals could be set by both services with the family.

The pathway was launched January 2019 and is now being used by both services.

Results:

Staff have defined roles and this has enabled SALT to access the child's language and then liaise with CAMHS.

The SALT team are not required to advise the family about the child's anxiety as CAMHS are best placed to do this.

CAMHS can follow the SALT recommendations and if necessary adapt their communication. This means that both services are working to their own strengths.

Time has been saved for both services e.g. CAMHS liaise with settings and joint targets are then created for the family which is an efficient way to work.

Staff reports that they have felt more confident in dealing with children with selective mutism.

Referrers have a clear pathway which will mean that the families are not referred to a number of services at one time; families do not need to tell their story lots of different times.

Next Steps:

- Monitor the pathway with regular meetings between SALT and CAMHS
- Adapt the pathway using the feedback from the families, the child and settings
- Train up new staff from both services
- Joint training for referrers and settings to increase the awareness of selective mutism

Care group: Specialist Mental Health
Team name: Child and Adolescent Mental Health Youth Justice Service

Specialised trauma informed training to the Youth Justice Service

What did we want to achieve?

We wanted to deliver training on 'trauma and adolescents' to increase the knowledge and influence of the working practices of the Youth Justice Service (YJS) volunteers to become trauma informed. CWP Child and Adolescent Mental Health Service (CAMHS) practitioners in the YJS provide frontline intervention, consultation and training and are collaboratively working with management from the YSJ towards becoming a trauma informed service.

What we did:

The YJS volunteers work with young people from the ages of 10 to 18, who have come to the attention of the police as a result of anti-social/offending behaviour. The volunteers facilitate the local justice panels and meet with every young person and their families to plan and review the order. The training covered the impact of 'Adverse Childhood Experiences (ACES)': the effects of trauma on the brain/ cognitive changes; attachment and changing the language we use with young people; vicarious trauma and resilience professionally and personally; strategies to use when reading complex reports and meeting traumatised young people.

Results:

The training generated extensive discussion and personal disclosure about the impact of trauma on physical health, mental health and overall wellbeing. The group utilised the time to ask about specific case examples, best practice and how the 'panel meetings' could become more trauma friendly.

- *"Just to say I thought the training was very good, such an eye opener – pity we didn't have more time (or perhaps we should talk less!)."*
- *"I thought that the meeting yesterday was very good and useful. If I have a criticism, it is that we could have done with longer to explore the issues, as it was clear they had much more they wanted to share with us."*
- *"Thank you very much for such an inspiring informative session, we are so lucky having you two working directly with us as a service."*

Further training will be delivered at the whole service away day with the YJS.

Next Steps:

Trauma training will be delivered at the whole service away day with the YJS and the theme is 'becoming trauma informed'. This is in addition to ongoing trauma consultation with YJS management and service leads. CAMHS practitioners will continue to work directly with young people who have experienced trauma and provide consultation to other YJS staff. Funding has just been obtained by CAMHs practitioners to purchase further specialist trauma training and resources.

Contact:
jim.williamson@nhs.net
jane.white20@nhs.net

Care group: Neighbourhood-Based Care
Team name: Neston and Willaston Care Community team

Neston and Willaston Care Community team collaborate with the third sector to improve quality of life

What did we want to achieve?

Our aim was to try to improve quality of life and educate, whilst being inclusive with other demographics such as male residents over the age of 65, with the hope of decreasing the chance of possible hospital admission in the future. In order to do this, it was identified that collaborative working with other services to enhance patient care and improve understanding of support available would be of real benefit.

What we did:

The team engaged with Healthbox, who are just starting up initiatives in the Neston area such as introducing foodbanks and combatting social isolation. The team also engaged with Live at Home an initiative which arranges events for local people who may be socially isolated and aims to offer lunches, outings and guest speakers. The team met with representatives from both initiatives and arranged for their therapy assistant to attend a session and deliver a talk on falls prevention. In addition, one of the community nurses is to soon deliver a talk on the importance of looking after your skin, especially in areas of the body which may be at risk of pressure sores.

Results:

The results so far are demonstrating cohesive and collaborative working with the third sector to improve the patient experience within the local areas, with lots of positive feedback from many different stakeholders.

- *"Lovely meeting your team and felt the session was excellent."*
- *"Really looking forward to helping reduce inequalities in the Neston area and offering health education to our residents."*
- *"Excellent opportunity for working together to improve quality of life for Neston residents."*
- *"Enjoyed the talk today and found the information very useful."*
- *"It was nice to listen to the nurses and I found the session comforting to know that the nurses are there."*
- *"Such a nice afternoon and very interesting."*

Next Steps:

The team are planning to deliver sessions on care provision by the integrated community team and engagement in compassionate communities. The end result will hopefully identify people who are potentially at risk of hospital admission and, as a result, the team can intervene earlier and offer support to prevent admission and further complications.

Contact:
frances.johnston@nhs.net

Care group: Learning Disabilities, Neurodevelopmental & Acquired Brain Injury (ABI)

Team name: Greenways Assessment and Treatment

The development and implementation of the Dynamic Support Database Clinical Support Tool

What did we want to achieve?

The Care and Treatment Review (CTR) policy recommended that commissioners keep a local database of those individuals with learning disabilities and/or autism at risk of admission to hospital. CWP Learning Disability (LD) services developed a tool to support this and implemented it across LD services and then across the North West.

What we did:

Commissioning for Quality and Innovation (CQUIN) requested the Community Learning Disability teams develop a tool that would support the commissioners to understand which individuals with learning disabilities and/or autism were at risk of admission.

The Dynamic Support Database Clinical Support Tool was developed, piloted and implemented across the community LD adult teams. We then rolled it out across children and young people's services and now the three Transforming Care Partnerships across the North West have requested its implementation for all people with learning disabilities known to services. The tool helps teams understand people's needs and directs service input.

Results:

The Dynamic Support Database Clinical Support Tool has been transformational within LD services (a collaborative effort between all LD services). The tool rates people as red (high risk), amber (moderate risk) and green (low risk) in relation to needing a hospital admission in relation to their mental health/challenging behaviour.

The tool is completed with all people using the service. The Intensive Support services are aware of all people rated amber or red and this identifies their caseload. People rated as red have an admission avoidance meeting with the Multidisciplinary team and commissioners to be supported to remain in the community where possible.

The tool allows us access to data in relation to additional support needs, percentage of community caseloads at risk of admission, number of people at risk of admission who were kept out of hospital, which wards/units were accessed and where people were discharged to. Commissioners across the North West have requested this tool be embedded in practice.

Next Steps:

Sussex and East London trusts are interested in using the tool. We are developing on-line training. We have submitted a paper on validity of the tool and are completing research on inter-rater reliability. We access quarterly data in relation to people at risk of admission and admissions avoided and will use this information to direct service provision.

Contact:
ceri.woodrow1@nhs.net

Care group: Neighbourhood-Based Care
Team name: Macmillan Specialist Community Palliative Care team

Greater collaboration between CWP's Macmillan Specialist Palliative Care team and their hospice colleagues

What did we want to achieve?

Our aim of the relocation was to ensure that the link or 'joined up' care was maximised for the people we serve, many of whom are also Hospice of the Good Shepherd patients.

What we did:

With the help of CWP Estates and ICT, the team systematically moved base to the hospice. The team consider themselves very fortunate that the hospice were able to offer a large office space which was vacant following the building of a new day hospice, now known as the Living Well Centre. The team are now fully settled and are on site and able to attend multi-disciplinary team meetings more frequently and liaise more closely with their hospice colleagues.

Results:

The team have greatly improved their working relationships with their hospice colleagues who both strive to provide a seamless service for patients. As a result of the move, closer working has been easily facilitated and the ability to work more collaboratively due to their co-location with hospice staff has meant that more timely admissions and discharges are achieved. The team are also able to seek face to face expert advice and, reciprocally, hospice staff are able to discuss patient issues with them. Although the team have always provided occupational therapy and physiotherapy to the hospice, being based on site has furthermore improved access to more timely interventions.

Next Steps:

The team are working with their colleagues within the hospice and the Countess of Chester Hospital to look at the possibility of pooling referrals via a single point of access. This will avoid duplication and further enable the patient to be seen by the most relevant team and clinician in as timely a manner as possible.

Contact:
a.bunnell@nhs.net

Care group: Learning Disabilities, Neuro-developmental & Acquired Brain Injury (ABI)

Team name: Transforming Care/Care Group Management

Online training for family, unpaid carers, support workers and personal assistants who care for people with learning disabilities or autism

What did we want to achieve?

To develop sustainable training across a variety of themes for family and paid carers

What we did:

Under the remit of Centre for Autism, Neurodevelopmental Disorders and Intellectual Disability (CANDDID), CWP was successfully awarded funding of £112,000 from the Local Workforce Action Board (LWAB) via the Transforming Care Partnership (TCP) to develop 7 of a total 11 available training topics for family/unpaid carers, support workers and personal assistants of children, young people and adults with learning disabilities or autism to help improve the quality of care and quality of life.

With Education CWP we developed online modules for the Virtual Academy; content was coproduced with experts by experience including members of the Cheshire East parent-carer forum as our key partner. Content includes audio and video to improve the learning experience.

Results:

The training has just been launched but has already received positive feedback from users –

"I will share this with members of our wider family to help them communicate with my son."

The training is consistent, accessible and flexible. It focuses on practical advice, tips and solutions as well as sign-posting further reading and support.

No diagnosis is required and it is free to access for family/unpaid carers. These aspects have all been regarded positively by users.

Each training module includes an evaluation questionnaire which will be used to improve future content or new training. Questions cover the system and the content, as well as seeking to identify practical changes in care and support. As an online platform it is available around the globe.

Next Steps:

A small charge is levied for paid carers which will be used to improve existing and develop new modules, based on feedback and priorities from the core user groups. We would again look to coproduce the content and develop reciprocal links to other LWAB/TCP online training of benefit to learners e.g. Wirral Mencap.

Contact:
cwp.canddid@nhs.net

Care group: Children, Young People and Families
Team name: Wirral Primary Mental Health team (PMHT)

Mental health 'Accelerator Schools' project

What did we want to achieve?

Wirral PMHT link with schools and develop a whole school approach to mental health. Our current flagship project in this area is the 'Wirral Accelerator Schools' project. The purpose is to work with identified schools known as 'Accelerator Sites' to develop and foster best practice around mental health and wellbeing in educational settings and to share this across the borough.

What we did:

20 schools were identified as 'Mental Health Accelerator Sites' and the PMHT champion best practice and facilitate additional learning.

The network meets regularly to:

- Share examples of good practice in mental health support
- Recent training in mental health
- A passion and enthusiasm for championing children's mental health and reducing stigma
- Commitment to cascading knowledge and practice across the Wirral. The sites pilot new courses added to our rolling training programme such as 'Rainbow Circles' and 'Understanding Emotions'
- Annually host the 'Teach Meet' networking event for school staff and senior leaders. We discuss strategies for implementing change as well as run workshops delivered by mental health professionals and school staff

Results:

Feedback from schools is consistently positive, highlighting the value they get from our events. Our 2019 'teach meet' event held at Wirral Grammar School for Boys hosted over 50 senior staff members and 96% of attendees were satisfied or very satisfied.

Examples of what attendees said they found particularly useful:

- "The session Orrett's Meadow ran."
- "The whole school approach."
- "(How to) Audit what they already do to promote positive mental health."
- "The children included in Raeburn's presentation."
- "Practical ideas of how to implement strategies to embed a whole school approach to Mental Wellbeing."

Examples of what they will take away:

- "Looking at the targeted intervention gap & reading the book by Paul Dix."
- "Really useful – thank you – will definitely be back next year with the SENCO as well!"
- "More of the same please! More time."
- "Excellent speakers and a great opportunity to network."

Next Steps:

We seek expressions of interest to expand the programme to more of the 131 schools we link with on an annual basis and also seek to rotate the schools included, providing respite should schools need it and focusing our efforts on innovative practice within local schools. In this manner the project is robust, forward thinking and will remain valuable in future years.

Contact:
v.dunham@nhs.net

Contact:
ben.lee@nhs.net

Care group: Clinical Support Services
Team name: Safe Services

CWP's Quality Improvement (QI) hub - #cwpqi

What did we want to achieve?

Quality Improvement Faculty identified it was clear that there was no predominant location for staff to find information about QI. There were multiple stand-alone intranet pages located across a wide range of teams, with snippets of information about QI, but this caused confusion when trying to find resources or look for signposting. QI is everybody's business and our aim was to make the information and resources about QI to be as engaging and easily accessible from a central intranet based hub. We wanted the QI hub to be a jargon free environment that enticed staff to read the content rather than frighten them away.

What we did:

The quality support manager from the Safe Services team knew that the team's administrator had experience with web design, was skilled on the computer and would love a challenge. She took her idea of a centralised QI intranet hub to him and explained the vision. Engagement with other colleagues helped to develop a creative image that would become the identity of any CWP QI work and become the QI theme for the Trust.

Everybody involved enjoyed being creative with coloured pens and post-it notes, and with some great contributions #cwpQI was born. A Twitter account was also created and this image became the 'handle' that any staff member can use when tweeting about their QI projects and achievements.

They worked collaboratively with other teams across the support services network to engage participation and encourage contribution of resources with which to populate the intranet pages. Using mobile phones, clinical staff were filmed talking about how they had started their QI projects and what steps they had put in place to sustain the project; this part of the intranet site will continue to expand.

Results:

The project gained momentum and buy-in from senior Trust management when the leads delivered a series of presentations to the Safe Services team, the Quality Committee and the Non-Executive Directors' business meeting. On each occasion, the enthusiasm and praise was inspiring and motivating for the team to keep progressing with the project.

Feedback included congratulations for being a QI champion and for taking on a project using initiative, rather than waiting to be asked. By tweeting regularly about QI related work that is happening in the Trust, the number of twitter followers has rapidly increased from two on launch day to now more than 150.

Next Steps:

The current QI hub can be accessed by more than 3500+ CWP staff and whilst the Twitter account is available for public access, the hub is not. CWP is keen to share with other NHS trusts and members of the public the excellent work they are doing around QI, a project plan is being developed to assist with the launch of a public accessible internet QI hub.

Contact:
beverley.tudor@nhs.net
michael.croman@nhs.net

Care group: Clinical Support Services
Team name: Quality Surveillance team and Performance and Information

Journeygram – a visual picture of a patient's journey through CWP teams and wards

What did we want to achieve?

Our aim was to create a new charting tool to illustrate a patient journey through CWP teams and wards, showing spells, episodes and community contacts. It is designed to support complex patient review with visualisation techniques and accompanying spot analysis.

What we did:

The medical director shared a news article from the Nuffield Trust about an approach to visualising patient journeys. Whilst there were data access restrictions to NHS activity other than within CWP, Bev Tudor recognised that an adaptation of this approach to show all CWP engagement and treatment within services in one view was a new concept.

There was a consultation with the Performance and Information team to discuss creation of this report that stalled due to current server design. Bev and Michael used some lateral thinking and were able to devise an alternative method to deliver an Excel version.

Results:

The first use of a journeygram supported a 'collective crisis response' meeting. This combined inpatient, liaison psychiatry, consultant, psychologist, Community Mental Health team (CMHT), Home Treatment team (HTT) and social services representatives to pool knowledge and identify how different CWP teams could integrate to meet the patient's complex needs.

Feedback was very complimentary and that the visualisation technique gave details previously unseen. That journeygram revealed a gap from CAMHS to adult services that resulted in an urgent GP referral. An approach was outlined including flexibility built into the crisis management plan for short admissions of up to 72 hours to circumvent some of the known behaviour escalation and subsequent admission/ assessment procedures.

Other journeygrams have shown multiple community activity whilst a patient was admitted, a patient's increasing involvement with crisis teams after discharge from a rehabilitation ward and a patient with a consistent spell under CAMHS and then shorter and frequent spells under adult services.

Next Steps:

The 'collective crisis response' meeting commissions new monthly journeygrams to support complex patient planning. Contact with the Performance and Information team continues to streamline our alternative method until an automated report can be implemented.

Care group: Neighbourhood-Based Care

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

Implementation of an evidence-based magnetic resonance imaging (MRI) pathway

What did we want to achieve?

To reduce non-pathway changing MRI referrals for musculoskeletal (MSK) conditions, and to ensure capacity was released for urgent clinically indicated MRI.

What we did:

We designed a new pathway to ensure all routine MSK MRI requests were assessed by the Advanced Physiotherapy Practitioners at AMAMS. ensuring clinical relevance and evidence base for the referral for advanced diagnostics.

This involved extensive communication with our GP colleagues, as they would no longer be able to refer for MRI scans for routine conditions. We worked with the Clinical Commissioning Groups (CCGs), GP networks and the Diagnostics team to ensure all were able to input to the pathway. We publicised the pathway widely and rolled it out from June 2018 onwards.

Results:

The principle outcome was a marked reduction in unnecessary MRI referrals to diagnostics. In the first 6 months of the pathway, 972 MRI referrals were saved, releasing significant capacity for urgent pathway scans, and releasing the equivalent of £122,000.

Wait times for MRI scans are now reduced to within 4 weeks for routines, meaning that investigations needed to determine onward care are now more efficient and within a clinically acceptable timescale with no impact on patient care.

Next Steps:

The next step will be to review provision of ultrasound scan referrals for routine conditions. As with the MRI pathway, all clinically urgent referrals will remain within the scope of the GP to request.

Contact:
tanya.booth@nhs.net

Care group: Neighbourhood-Based Care
Team name: Community Erectile Dysfunction service

New innovative nurse-led CWP Community Erectile Dysfunction service

What did we want to achieve?

Erectile dysfunction affects more than 50% of men at some stage in their lives which can affect relationships and general health and wellbeing. Historically the provision of the Erectile Dysfunction service is delivered as part of the secondary care urology services at the Countess of Chester Hospital and is consultant-led. The purpose of this project was to highlight the safe and cost effective implementation of a new Community Nurse-led Erectile Dysfunction (ED) service.

What we did:

Over an 18 month period by working with Clinical Commissioning Groups (CCGs), consultant urologists and CWP GPs, a community-based highly specialist nurse-led ED service was planned by developing integrated care pathways. The service was implemented in January 2019. This was achieved through expansion of the current community-based continence/urology service. The service will accept referrals from GPs, consultants and other health professionals.

Results:

This initiative has resulted in the transfer of activity from the Countess of Chester hospital Urology service to Community Continence & Urology service for male patients who require treatment for ED.

Achievements to date are:

- A fully operational established Community Nurse-led ED service
- The service has stopped patients needing to attend hospital appointments and utilising consultant's time which will ease pressures on secondary care resources' greater scope to meet their 18 week targets
- Patients have choice of community clinics
- Improve access to care (care closer to home)
- The new innovation is recognisable as an open, progressive service that is about care, wellbeing and partnership

Next Steps:

The introduction of a community urology nurse specialist has developed new services over the last 5 years. There is greater scope in the future to continue to work collaboratively with secondary care to transfer more traditional hospital-based services to the community.

Contact:
kenneth.henderson@nhs.net

Contact:
jo.jury@nhs.net

Care group: Learning Disabilities, Neurodevelopmental and Acquired Brain Injury (ABI)

Team name: Community Learning Disability Team

Setting up and running staff wellbeing initiative - 'mindful lunch'

What did we want to achieve?

To improve staff mindfulness, wellbeing and give them a space to pause and reflect.

What we did:

To give staff the best opportunity to pause and reflect we set up a lunchtime space every Thursday and engaged in mindfulness exercises designed to help staff bring their awareness to their physical and psychological wellbeing.

We included activities such as:

- body scans
- breathing exercises
- guided imagery

We have also set up a 'mindful lunch' WhatsApp group for those who wish to be sent relevant articles, reminders or memes related to mindfulness.

Results:

The 'mindful lunch' continues to run and we have been able to share best practice and help implement it, and improve the wellbeing of staff, in other areas of CWP. We have a consistent group of staff who attend each week and this has successfully been taken up by social care staff now that we are co-located.

Feedback from staff: "It's brilliant; it is what it says it is. It brings you back to the now and gives you a chance to break up your day."

Next Steps:

We continue to offer a space each Thursday, and have started to develop a small group of co-facilitators to ensure continuity of provision each week.

Our aim is to analyse the outcomes from attending 'mindful lunches' to see if this has made a difference to wellbeing measures.

Contact:
katherine.bramwell@nhs.net

Care group: Neighbourhood-Based Care

Team name: Great Sutton caseload Ellesmere Port Care Community Team

Using social media and making adjustments to safety brief meetings to improve efficiency of working and increase capacity

What did we want to achieve?

Our aim was to:

- Work more efficiently
- Increase capacity
- Improve communication
- Lift morale by reducing pressure on staff
- Ease parking congestion

What we did:

The team asked for safety brief meeting time which allowed more time to complete the workload for the day without having to travel a number of miles back to base. This was especially helpful when trying to make sure lists were always completed.

To complement this we set up a team WhatsApp and all community nurses used this as a method of keeping in touch with their care co-coordinator who would be able to send alerts instantly when extra visit requests came on.

Results:

One of the major benefits this system had was that it allowed staff to pick up visits whilst in the geographical area, saving driving time.

This also meant the patient got seen faster and that there was no backlog of patients for afternoon visits.

This has resulted in:

- Increased capacity
- Almost no patients are being deferred
- Investigations have been more timely
- Staff have been freed up to shadow each other to gain new skills
- The reduction in patients being deferred has been evidenced in the daily situation report

Staff now have improved access to PCs due to the later safety brief time and more time in the afternoon for admin due to extra visits being completed throughout the morning.

Next Steps:

We will continue to build on this good practice and think about the time around safety briefs. We are now considering how the change in our safety brief time could be shared with other teams in Ellesmere Port.

Care group: Children, Young People and Families
Team name: Macclesfield and Crewe CAMHS

Macclesfield and Crewe Child and Adolescent Mental Health Service (CAMHS) teams evidence-based therapeutic groups for children, young people and parents

What did we want to achieve?

The purpose of the groups was to offer children and young people an alternative to individual therapy allowing them to have a choice.

What we did:

The 'Timid to Tiger' programme is an evidence-based programme which uses a cognitive behavioural therapy (CBT) approach to provide parents with simple CBT techniques for helping their children to manage their worries and fears.

It is for parents of children aged 3 to 11 who present with anxiety and aims to provide early support and intervention for parents and families. The programme is based on evidence that anxious children benefit substantially from parents using attachment-based play, lots of praise and reward for good and confident behaviours, and gentle disciplinary techniques and planned ignoring for unwanted behaviours.

Parents are taught a number of simple cognitive-behavioural techniques for managing their children's fear and worry. The CBT therapist in Crewe delivered a CBT Obsessive Compulsive Disorder (OCD) group and a CBT low mood group.

The art therapist has delivered an art therapy group for children and young people. The CBT therapist and 3 case managers in Macclesfield CAMHS developed an anxiety group for young people with anxiety and autism. The group comprised 8 x 90 minute sessions with 8 young people using adapted-CBT as per NICE Guidelines (No. 170) and 2 x 90 minutes sessions to support parents. Additional research literature informed the decision to proceed as a group. A pilot group was facilitated with the Wildlife Trust for young people with low mood.

The young people were involved in outdoor activities followed by group CBT.

Results:

Routine 'Outcome Monitoring Questionnaires' were used to monitor progress of the parents, children and young people that attended the groups.

The anxiety group showed in 95% of cases the goal to reduce anxiety was met. RCADs similarly showed more than 80% reductions in symptoms.

"We were listened to and given time to talk."

Next Steps:

Both Crewe and Macclesfield CAMHS will continue to offer the group.

Contact:
jane.edwards21@nhs.net

Care group: Specialist Mental Health
Team name: Acute Care Inpatient Occupational Therapy service, Bowmere Hospital

Using evidence-based sensory approaches in adult inpatient mental health settings

What did we want to achieve?

The aim of the project was to identify sensory techniques and interventions to help individual service users manage their distress within an inpatient setting, and to evaluate the effectiveness of this approach.

What we did:

A literature review was requested via Glyndwr University students on sensory based approaches with people with mental health issues. This was reviewed and recommendations were identified.

Results:

From the service users who have completed all or some of the sensory pathway, the feedback has been positive. Service users have identified that completing a screening tool and discussing this with the occupational therapist has allowed them to understand some of their needs in more depth.

Some of these service users have been empowered to go on and create personal sensory boxes, either with support or independently. These boxes and the contents were chosen by them to address their sensory needs, and have provided these individuals with a means to help them to manage their own distress.

Some feedback from service users included:

- 'The assessment tool helped me identify I was a sensory seeker'
- 'I use the things in the sensory box to keep me distracted such as colouring and squeezy toys'

Next Steps:

Now that the initial pathway has been established, the aim is to develop global and targeted interventions, such as:

- Producing information leaflets on sensory based interventions and approaches
- To increase understanding of the approach for staff and service users
- To introduce a sensory drop-in session to the current occupational therapy programme alongside the individual work already started

Contact:
lucy.mahon1@nhs.net
victoria.jones50@nhs.net

Care group: Specialist Mental Health
Team name: Diabetes Essentials

Tailored diabetes education for patients with a mental illness

What did we want to achieve?

'Diabetes Essentials' collaborated with the Blacon Recovery College to facilitate a tailored group, which met the needs of service users with a mental health condition. The informal sessions were attended by a mix of staff members and patients.

What we did:

We adapted the regular 'one off diabetes education session' and spread it over 6 weeks to meet the needs of service users that may have reduced concentration as a result of antipsychotic medications. The sessions were friendly, informal and set in a positive, non-clinical environment.

Results:

The session was well attended by staff and patients. The evaluations included the following comments:

"I will use the information I have learnt within our clinics along with clients I support. For my personal use, I will be more aware of my food intake and portion control, checking for sugars etc."

"I think it will encourage me to make some positive healthier choices. I thought Ellen had a sound knowledge of the subject of diabetes and the way she presented the course was comprehensive and easy to listen to."

"Very good course."

"I found the course very interesting and informative. I didn't know much that much about diabetes, other than the usual 'less sugar'."

Next Steps:

We would like to continue to work with the recovery college to facilitate future sessions and hope the positive feedback from staff members will encourage patient and future staff attendance.

Contact:
ellenmitchell@nhs.net

Contact:
robert.lupton@nhs.net

Care group: Children, Young People and Families
Team name: Emotionally Healthy Schools team

Responding to self-harm simulation training

What did we want to achieve?

Our simulation training is a collaborative partnership approach to improve the confidence of school staff when responding to self-harm in school settings. A simulation training package has been developed to address this need in schools and aims to reduce unnecessary attendance at Accident and Emergency (A&E) departments by children and young people by improving the initial response by school staff.

What we did:

The report 'Case for Change - self-harm in children and young people 2017', found that the numbers of A&E attendances and admissions per 10,000 is worse than the North West and UK average in Cheshire East. The Emotionally Healthy Schools team approached East Cheshire NHS Trust to develop a short simulation education programme focusing on scenarios and facilitated group reflection and discussion. Two preliminary pilots were developed and the young people's input was crucial in the fine tuning of the course content. Further pilots brought in teachers for the first time and the parts of the children were played by students from a media and drama course at the local college.

Results:

This has been a successful pilot which has not only improved confidence and awareness but improved the participation and engagement of young people. We were supported by Macclesfield College drama students who played the part of the patients in the three scenarios and this added a much needed young person's perspective to the training.

The students were also involved in the feedback after each scenario. Collaboratively we believe that this is an innovative method of teaching that undoubtedly adds value to service users, education and health. So far a total of 25 school staff have attended the training in small cohorts from a variety of both primary and secondary schools. Staff from the school settings have provided positive feedback, the majority of whom expressed that they found the 'role play and simulation and post discussion' very useful.

Next Steps:

The initial pilot feedback was extremely positive and strategically over the next two years we will be targeting the schools in the Cheshire East geographical footprint that have the greater numbers of A&E referrals and hospital admissions. The information about A&E attendance is currently provided by South Cheshire CCG and has been requested from East Cheshire CCG with commissioners eager to respond to the need in both A&E departments. We have agreed a two year programme with Macclesfield District General Hospital and have arranged dates for the next academic year for training cohorts.

Care group: Children, Young People and Families
Team name: Child, Adolescence and Mental Health services (CAMHS)

Care Education and Treatment Reviews (CETRs): Raising awareness of the CETR process from a young person's perspective

What did we want to achieve?

The purpose of creating this Care Education and Treatment Review (CETRs) educational video was to raise awareness and increase knowledge about CETRs.

Across the North of England, children/young people with a learning disability and/or autism have been admitted to a CAMHS Tier 4 setting without having a community CETR.

'Root Cause Analysis' highlighted that in some cases professionals working with children/young people did not know what CETRs were or how to request them.

Equally, young people and families had never heard of CETRs and were anxious about what the process would entail. The purpose of producing the CETR video was to provide a resource that young people and families, as well as professionals, could relate to, in order to raise awareness and prepare them for what to expect in a CETR.

What we did:

Following identification of the gap in knowledge and awareness of CETRs, NHS England bid for funding and procured an organisation to prepare a video. This involved key professionals who had previously been involved in a CETR working with a young man to help tell his story and experience of his CETR. In collaboration with our colleagues at NHS England we created an environment that was similar to the young person's CETR, which would offer a visual aid as the young man told his story. A script was prepared and edited with input from the young person and allied professionals, to ensure it was realistic and easy to understand, whilst getting the relevant and key points across about what happens in a CETR.

Results:

The impact of the work was the production of an educational video to be shared (i) as part of training sessions for professionals about CETRs, and (ii) young people and families to inform them about their community or hospital CETR. The purpose of producing a CETR educational video is to increase the uptake of community CETRs, which offer an opportunity to consider alternatives to CAMHS T4 admission or residential school placements for young people through this new person centred approach to care planning.

Next Steps:

The video can be seen to complement a suite of information for professionals, young people and families to help them feel prepared to participate in a CETR.

Contact:
lisa.thompson24@nhs.net

Care group: Learning Disabilities, Neurodevelopmental & Acquired Brain Injury

Team name: East Cheshire Community Learning Disabilities team

Multi-disciplinary complex case discussions

What did we want to achieve?

The purpose of this piece of work was to develop multi-disciplinary team working within the Learning Disability team to enable team members to feel supported when working with a complex case, and for team members to bring new ideas and suggestions which may be beneficial to the service user.

What we did:

Complex case discussions have been set up to take place twice weekly with one discussion being held at Rosemount Lodge on Mondays and another held at Stalbridge Road Clinic on Thursdays.

Holding the case discussions in both areas enables all clinicians to get involved and the format offers clinicians peer supervision. We aim to ensure that there is representation from each discipline at the case discussions to ensure a full Multidisciplinary team (MDT) approach. There is a rota and each clinician prepares their case beforehand; there is also the opportunity for clinicians to bring a case to discuss more urgently. The discussions have expanded and we invite professionals from other agencies or teams to attend where this is deemed helpful, for example Social Services or the Forensic Support service. The discussion is recorded on the service user's CareNotes.

Results:

Evaluation of the case discussions has highlighted that the clinician feedback has been very positive.

Clinicians reported they initially had doubts about the process, feeling that preparing a case for discussion would be an addition to their already busy workload; however following bringing their case for discussion they found that the process was extremely helpful, allowing them to feel supported by the team and helping them to develop a plan of action to move the case forward.

Feedback from those who have not presented a case have also found the process useful, as it enables clinicians to learn from the experience of others. When social workers have been invited to attend, they have found the process useful as again, new ideas or suggestions have been offered and they have left the meeting with a MDT action plan. As a team, we feel that the case discussions enable us to become more focused with our interventions which can only benefit the service user's journey.

Next Steps:

We plan to continue to use the case discussions to review our complex cases, however moving forward we will also be using the discussions to discuss lower risk service users as we feel that it is useful for the team to think about what is going well and how we can transfer this learning to other aspects of our work.

Contact:
sarah.latham17@nhs.net

Care group: Learning Disabilities, Neurodevelopmental & Acquired Brain Injury (ABI)

Team name: Acquired Brain Injury service

Contact:
rebeccabuxton@nhs.net

Acquired Brain Injury (ABI) service rehabilitation and placement panel

What did we want to achieve?

Our aim is to use quality improvement for both ABI rehabilitation patients and commissioners to:

- Improve patient and carer involvement
- Establish a new ABI patient pathway for out of area placements

This specific cohort of patients are known to be low in volume but high in cost, are not exceptional and should not therefore be directed to the individual exception funding request (IEFR) process.

What we did:

The ABI panel developed a new pathway and a clear identifiable system of internal and external governance for ABI rehabilitation patients requiring complex or slow stream rehabilitation in a step down private provider units e.g. rehab complexity tier 2b & 3.

Initial remit:

- Review and scope number of ABI patients in existing placements
- Create new pathway
- Effect cost savings
- Appeals process

We also:

- Developed new patient and carer feedback
- New referral and information leaflets developed

Following this our rehabilitation placements were commissioned on a 12 week basis, reviewed within 6 weeks and followed up at week 11-12, then every 3 months.

Discharge planning and conversation starts on admission and we follow up on discharge.

Results:

- The ABI panel has replaced an inappropriate IEFR pathway and associated costs
- It has reduced the number of patient referrals being placed inappropriately
- It has enhanced transfer of patients from acute provision
- It has reduced length of stay from 1½ – 7 yrs to between 20-23 weeks.

Discharge Locations:

- Wirral = Home: 25%
- Provider Unit: 13%
- Open cases: 25%
- Acute NHS: 37%
- Cheshire West Home: 25%
- Provider Unit: 13%
- Supported Living: 6%
- Nursing Home: 19%
- With referrer: 6%
- Open: 25%

The ABI panel specialist oversight allows for positive challenges, e.g. reducing additional placement cost for 1:1 care. The ABI demonstrates cost efficiencies in the period Oct 18-June 19 Wirral total savings totalling £241,156.70 and Cheshire West £69,001.62.

Feedback:

"Rebecca Buxton kept me informed of all our options and I felt it was like having a warm arm around my shoulder helping us through this harrowing time (Carer 2019)."

"I felt your help and support was integral in supporting this lady to a suitable rehab setting (Kath Conway, Neurology Occupational Therapist, Countess of Chester Hospital (2019)."

Next Steps:

- To extend the scope of the successful ABI panel model to South, Vale Royal and East Cheshire Clinical Commissioning Groups (CCGs)
- To continue to build on our relationship with commissioners and other key stakeholders and advocate on behalf of our patients
- Continue our work with NHS England to develop a Cheshire and Merseyside Standard Operating Procedure for ABI placements

Contact:
nikitarudd@nhs.net

Care group: Neighbourhood-Based Care
Team name: Chester South Care Community team

Standardised off duty and annual leave processes

What did we want to achieve?

The purpose of this work was to standardise the processes in which we complete off duty, also the way we request and authorise annual leave. This ensures everyone has fair and easy access to enable them to request shifts and annual leave.

What we did:

Firstly as a team we highlighted the issues that have been encountered previously. From this we developed solutions that could be practically incorporated into everyday practice. These were agreed as a team and a trial was commenced in April 2019.

Annual leave requests are to be sent via email, and we are currently in the process of setting up a separate generic email address. Annual leave capacity has its own weekly tables so availability can be easily seen. Once authorised it will be added onto individual annual leave spreadsheets and sent via email, as a receipt/confirmation of request. The off duty has month by month request systems with deadlines in place for requests.

Results:

These processes have had a positive impact on the team, and it has increased staff satisfaction in relation to off duty and annual leave requests. Off duty is completed in a timely manner and staff are aware of when off duty will be completed and can plan their personal lives. Also annual leave can be requested at any time as sent via email.

Having the majority of documentation paperless is not only saving money but also gives the individual a record of their annual leave. The annual leave forms also have a running total so individuals can see exactly how they have used their leave and how much leave they have remaining. Overall the response from all staff in the team is positive and is now part of everyday practice within our team.

Next Steps:

The next steps in the future would be for the admin team to take on more of the administration. Once we have the generic email address set up for annual leave only, we plan to have a few different colleagues able to access it to ensure annual leave requests are dealt with in a timely manner.

Care group: Children, Young People and Families
Team name: Wirral Primary Mental Health team (PMHT)

Helping your child thrive – resilience workshops for parents

What did we want to achieve?

As part of the Future in Mind transformation plans 2016, the Wirral Child and Adolescent Mental Health service (CAMHS) and PMHT support 123 local schools and all professionals in the children's workforce, providing training, advice and support around mental health. We have listened to families and worked with them to bring support into the home, coproducing psychoeducational resilience-based workshops for parents in the borough.

What we did:

After successfully implementing our annual rolling training programme and building strong links with local schools, we consulted with parents to identify their needs for mental health support. They requested resilience based workshops with a non-stigmatising setting. 'Helping your child thrive' was born and we worked with them to develop the content. Workshops are facilitated by 2 experienced team members to up to 100 attendees in twilight sessions to fit parents' schedules and are held in local schools and community hubs.

Results:

To date we have delivered 'Helping your child thrive' to over 1000 parents across the borough from the 123 schools we link with. At the beginning and end of each training session attendees are asked to rate their confidence in understanding mental health on a scale of 1 – 10, they also rate their satisfaction from very to not satisfied (1-4). We received 289 evaluations last year, 97% of parents were satisfied including 70% of these being 'very satisfied' and confidence increased on average by 31% (3.1). Qualitative feedback from parents was similarly broadly positive and constructive:

- "Excellent evening, thank you so much! Please can we have more – so informative."
- "I would love more support for children – education in schools is essential."
- "(I will take away that) I am not alone. My children are not the only ones with these problems/issues."

Next Steps:

We have requested volunteers who would be willing to self or co-facilitate workshops in the future and have collected over 100 names. We have now planned to develop the model to be self-facilitated by local parents to maximise their scope, impact and engagement. The first phase involves three full training session followed by co-delivery with parents and members of the team.

Contact:
v.dunham@nhs.net

Care group: Children, Young People and Families

Team name: Wirral Child and Adolescent Mental Health Service (CAMHS) centralised neurodevelopmental clinic

Development of a centralised attention deficit hyperactivity disorder (ADHD) monitoring clinic

What did we want to achieve?

- To standardise the process of ADHD monitoring within Wirral CAMHS and develop good practice
- To free up capacity in the CAMHS partnership teams to enable them to work with young people with moderate to severe mental health issues
- To develop nurse-led clinics
- Long-term aim is to develop a specialist neurodevelopmental team within CAMHS

What we did:

Initially young people receiving ADHD treatment and monitored by the main CAMHS team were transferred to the centralised monitoring clinic for medication reviews with a consultant psychiatrist. Due to increased staffing, nurse-led clinics have been developed providing greater flexibility in terms of clinic location and also scope to provide increased psychoeducation and brief psychological intervention in addition to medication monitoring. As the nurse-led clinics have become more established, psychiatry time has been freed up to complete ADHD assessments within the centralised clinic. Assessments are now completed by the team followed by a transfer to nurse-led clinics for medication initiation and titration if indicated. More recently the team has broadened its remit to include Autism Spectrum Condition (ASC) assessments.

Results:

Young people being treated for ADHD are now routinely transferred to the centralised ADHD monitoring clinic. The team is completing ADHD assessments with young people at the request of the main CAMHS teams. Since 2018 the team are also completing ASC assessments.

All of this has led to an increase in capacity in the CAMHS partnership teams. This has mainly increased psychiatry capacity as the psychiatrists working in the CAMHS partnership teams no longer need to run ADHD monitoring clinics. The amount of ADHD and ASC assessments completed by the psychiatrists working in the partnership teams has also reduced as these are now completed in the centralised clinic.

Next Steps:

- Improve transitions into adult services
- Contributing to the joint Wirral Neurodevelopmental Pathway Group to develop an efficient Wirral-wide neurodevelopmental assessment pathway with contributions from CAMHS, community paediatric staff and early help providers

Contact:
helen.hardcastle@nhs.net

Care group: Specialist Mental Health
Team name: Juniper Ward

The introduction of safety huddles on acute inpatient wards

What did we want to achieve?

The aim of using safety huddles on acute mental health wards was to review any patients who were on increased levels of therapeutic observations and use a team based approach to care plan for a safe reduction of observations. They increase safety awareness among staff, allow for teams to develop action plans to address identified safety issues, and foster a culture of safety.

What we did:

The wards in Bowmere were looked at and the wards with the greater number of increased therapeutic observations were involved in a pilot. Juniper Ward being one of them and the other Cherry. We decided to pilot safety huddles on both of these wards as they were identified as having the highest therapeutic observations for the longest durations. Initial discussions took place with the team consultants and ward managers and then with ward staff. A template was devised and a start date for the pilot agreed. The safety huddles are attended daily by the ward manager, nursing staff, occupational therapists and ward consultants. The discussion and plan are captured in a clinical entry on CareNotes.

Results:

Since the introduction of the safety huddle there has been a significant reduction in level 3 observations and the duration of these observations. We have also started including discussions regarding level 2 observations and there has also been a noticeable reduction in the number of patients requiring 5 or 10 minute observations. All staff have engaged well with the safety huddle and have noticed the benefit of this being a Multidisciplinary team (MDT) approach and staff report that they feel supported in making decisions in relation to therapeutic observations. By utilising the safety huddles we are nursing our service users in the least restrictive way.

Next Steps:

- To continue to gain feedback from MDT members
- To monitor patient feedback in relation to care planning and level of observations
- The modern matron would like to embed this practice on all the wards in Bowmere

Contact:
gemma.levy@nhs.net

Contact:
gemmacoombes@nhs.net

Care group: Neighbourhood-Based Care
Team name: Macmillan Community Palliative Care team

Hospice strength and balance class success

What did we want to achieve?

To target a patient group at risk of falls, who have limited access to third sector services due to their complex health needs. To maintain and/or improve their strength, balance, mobility and general wellbeing.

What we did:

We arranged with the hospice an appropriate time and day for the class. We planned the class structure around appropriate exercise programmes depending on patient need and invited a cohort of patients. As time went on, we recognised the vast variation of patient morbidities, which prompted further re-modelling of the class structure.

Results:

- Cost saving - the class enables us to see 6 patients in an hour, hence reducing the travel and clinical time of seeing patients in the community
- Prevention of falls, early identification of physical, social, psychological and environmental needs of the complex patients
- Collaborative working with the hospice for signposting to their services and vice versa. Nurturing our relationship with the hospice
- Natural evolvement of the patient's carers engaging on a social level, whilst the patients were attending the class

Quotes from patients:

- "Class keeps me motivated and maintains my fitness."
- "I do not worry about falling now, due to improved balance."
- "Class has increased my confidence and general well-being."
- "My co-ordination has improved and I feel very comfortable attending the class."

Quotes from carers of patients:

- "We get great support from each other - it's really good to talk, but also to be able to listen to other carers."
- "I feel very happy coming and seeing other carers when my partner is in the class - I have made new friends."

Next Steps:

To continue to re-evaluate the class due to its popularity and consider more specialised classes for different age ranges/ conditions. To keep promoting the service and to engage patients who are at a level where third sector services are no longer appropriate.

Care group: Specialist Mental Health
Team name: Fitness and Wellbeing team

Love to Move: A dementia-friendly chair-based exercise program on Cherry Ward, Bowmere Hospital

What did we want to achieve?

We wanted to help service users with dementia benefit from exercise. Love to Move is a successful programme for people with dementia originally developed by the Korean / Japanese Gymnastics Federation and adapted by the British Gymnastics Foundation. We wanted to facilitate our own Love to Move groups on Cherry Ward.

What we did:

A fitness instructor from the Fitness and Wellbeing service contacted a Love to Move coach for advice. Following this a Love to Move seated exercise group has been facilitated on the ward every week from March 2019. It incorporates bilaterally asymmetrical exercises where individuals make different movement patterns with the left and right hand side of the body simultaneously. All service users on Cherry Ward are invited and it is supported by occupational therapy staff and ward staff. Exercises are graded to suit varying levels of fitness. A copy of the exercises is available for carers and ward staff to repeat the program.

Results:

The Love to Move sessions have been a positive addition to the established therapeutic activity schedule on the ward. There has been an average of 5 participants per session. Improved engagement is a positive outcome. Service users have been observed to support others in the group and some have improved their ability to do the exercises with practice. Carers have also participated in sessions. Feedback July 2019:

- "It engages those who ordinarily would not have the opportunity to attend the gym. There are always smiles from those participating, proving the class works on both body and mind." - Clinical lead, Cherry Ward
- "It was good, a bit of fun, using your arms and muscles." - Cherry Ward service user

Han and Araki et al suggested that this exercise design may improve cognition and strength when practised over a longer period of more than 12 weeks (2016). Reference: Han, Y-S, Araki, T, Lee, P-Y, Choi J-H, Kwon I-S, Kwon K-N, Kim J-Y. (2016) Development and effect of a cognitive enhancement gymnastics program for elderly people with dementia. Journal of Exercise Rehabilitation 12(4) 340-345.

Next Steps:

- Continue to facilitate regular groups on Chery Ward and consider quantitative evaluation over a longer period of time to gauge benefits
- Link with local Love to Move classes
- Share good practice with other service areas including other dementia care wards.

Contact:
gemma.ross6@nhs.net

Care group: Neighbourhood-Based Care
Team name: West Cheshire Dialectical Behaviour Therapy (DBT) team

Managing self-harm and suicidality effectively in the community

What did we want to achieve?

One of the most common identifying features of personality disorder is risk taking behaviour such as intentional self-harm and suicidality, which in some instances, will result in suicide. The purpose of the DBT team in West Cheshire is to provide primary and secondary care clients with access to specialist psychological therapy as recommended in NICE guidelines. Through individual therapy, skills training and telephone coaching, the overall goal is to help individuals change behavioural, emotional, thinking and interpersonal patterns associated with problems in living and reduce life threatening behaviours.

What we did:

In the last year a number of staff from different teams have offered time aside from their usual clinical work to ensure the continued delivery of this programme. Consisting of a combination of weekly individual psychotherapy, skills training groups, therapist consultation and telephone coaching, staff meet weekly. The small team of staff have worked hard to deliver skills training sessions for clients across West Cheshire who wish to engage with treatment in the community, and to deliver weekly groups for 12 months. An honorary assistant has been recruited by the team so that adaptations can be made for service users who meet criteria for autism spectrum disorders as well as personality disorders, and a service user representative has helped to support skills only groups, providing service users with a perspective from someone who has benefitted from the strategies taught.

Results:

People who access the service are asked to feedback 6 months into treatment and at discharge. Some quotes are as follows:

- "I didn't think I'd verbally do justice to the amount you have helped me and the difference in my life between now and two years ago. I hope this letter portrays at least some of the changes as for the first time in my life I feel as though I'm living rather than surviving."
- "Firstly, thank you for listening… really listening. For so many years before I met you my existence, for the most part, was just painful."

Regarding outcome data, we track self-harm and suicide attempts weekly, whilst also comparing progress whilst in DBT with the year prior to it commencing (I.e. when accessing treatment as usual such as adult mental health teams). Current data tracking for three clients indicates costs savings for CWP of at least £54,801 – this data is accessible.

Next Steps:

Follow-up work planned is to share the outcome data with other interested professionals through the personality disorder clinical network day. The team are also in the process of collecting data to present at the next annual DBT conference.

Contact:
katie.thomas14@nhs.net

Care group: Specialist Mental Health
Team name: Beech Ward, Bowmere Hospital

Reduction in absent without leave (AWOL) incidents requiring police involvement

What did we want to achieve?

The initial purpose of the project was to reduce incidents of service user AWOL and in doing this also reduce the involvement of emergency services in returning service users to the ward. Using 'CP25 Therapeutic Observations Policy' signing out sheet as a guide we sought to make the interaction more meaningful for the service users and staff.

What we did:

To begin with we discussed the aim of the project with service users. We were clear that it was not designed to be restrictive, at the time the system in use was the signing out sheet attached to CP25. This was not utilised properly and provided only the very basic of information. Firstly, we redesigned the sheet, making it individual to each service user. Crucially it's the first part which is completed by qualified staff who carry out an assessment of the service user's mental state, where they are going, for how long and the expected time of return including what they are wearing. Staff and service user then sign out and sign in on return. The second part of the sheet is a continuation, updating mental state and what the service user is wearing as changed or unchanged. The expectation is that service users do not leave the ward before they have spoken to staff and signed out.

Results:

Regardless of how busy the ward is service users will wait until a member of staff is free to sign them out. There have been a small number of service users who have left the ward without signing out but have been able to see the benefit of speaking to staff before leaving the ward. The first contact with qualified staff prior to leaving the ward ensures that service users are having a risk assessment carried out earlier, staff are assured that service users are able to keep themselves safe and this feeds the daily risk assessment which is documented. If a service user does not return in time there is a clear marker for when they were last seen and a shorter time delay in carrying out a search of the hospital grounds and surrounding areas often negating the need to inform emergency services.

Overall there has been a 32% reduction in the number of AWOL incidents reported to the police in the 6 months since we implemented the project compared to the previous 6 months. The cost saving has been reduced time for staff spent in reporting to the police. Service users have stated that it gives them an extra connection with staff which is an opportunity to raise questions they may have.

Next Steps:

Next steps are to further modify the signing out sheet to include a prompt for staff to ask service users if they have brought restricted items back to the ward such as illicit substances, alcohol or ignition sources for themselves or others. This could support service users who are vulnerable to exploitation.

Contact:
a.coyne1@nhs.net

Care group: Specialist Mental Health

Team name: Central and East Involvement, Recovery and Wellness Centre

Facilitation of inter-professional and interagency collaborative working to support the communities of Crewe, Macclesfield and Winsford

What did we want to achieve?

We wanted to support and transform local preventative service provision for the general public, as well as the people accessing services to promote and support educational, holistic self-care by providing a place where different local partners in a neighbourhood come together to address, signpost and support the health and social care issues that matter most to the individuals of that community. For example, subjects such as:

- Blood pressure checks
- Weight management
- Diabetes
- Smoking cessation

What we did:

Our team and other dedicated CWP staff, along with local organisations, such as; Healthwatch, Action On Cancer, One You, Citizens and Employment Advice Bureaus to name a few, come together to staff stalls once a quarter, either at resource centres or at other community venues, to promote and raises awareness of the services available within the community. These stalls provide information, signposting and empathetic understanding to support the users of CWP services and the wider community with their social, employment, physical and mental health issues. During the events, as well as visiting the stalls of their choice, people are invited to attend Mindfulness and 'The Reader' taster sessions, or to just sit and have a chat and cup of tea/coffee with their fellow citizens.

Results:

The events are well attended, received and have had a lot of success with many people signing up for different initiatives with our partnership organisations on the day. The feedback received from Cheshire East One You said: "Thanks for inviting One You to your 'Feel Good Friday' event. It was a very successful day for the One You Cheshire East Project. Along with speaking and giving out information to 20 people, I signed up three for Active Lives, two for Stop Smoking support, two for Reshape and two for the Taste for Life cookery course."

Members of the public said:

- "My husband and I visited your open day on Friday. It was a rewarding experience, the information was very helpful and the atmosphere was warm and welcoming."
- "I was happy to be there and a part of the event which I thought was a good success and well put together."
- "It was great to meet your team and some of your lovely service users. I certainly thought the afternoon flew by with plenty of really good conversations."
- "Really good that a trusted organisation like the NHS, particularly in mental health, is running these events."

Next Steps:

We have a number of additional events booked across Crewe, Macclesfield and Winsford until mid-June next year. The one in June is planned to take place at Everybody Healthy Lifestyle Centre, Crewe where we are hoping to meet and reach a wider and more varied part of the population of Crewe, including the Mayor of Crewe.

Contact:
tracey.williamson3@nhs.net

Care group: Clinical Support Services

Team name: Education CWP - Personal and Professional Development team

The CWP Virtual Academy – 21st Century Digital Training

What did we want to achieve?

Recent innovations have opened up possibilities to greatly enhance the training and education on offer to staff, including mobile learning, virtual reality and artificial intelligence (AI). We recognised the need to set up a more user friendly, modern learning system that takes advantage of these technologies and better supports our staff to access a more efficient system that improves user experience and learning with opportunities for a more technological blended approach now and for the future.

What we did:

Initially a free platform (Moodle) was sourced to administer our Care Certificate programme. The potential of this site was quickly recognised and soon we designed, developed and set up a number of other courses, for example, the psychopharmacology programme (created in partnership with University of Chester) and' STOMP' (created with our Pharmacy team). It soon became clear the benefits to our organisation of further developing this to have our own Virtual Academy and the possibilities this would open up for the Trust. Following a presentation at Operational Board in December 2018, we have been piloting e-learning mandatory training for new members of staff using our Virtual Academy and managing our leadership and management, preceptorship (Practice Education team), and CareNotes revalidation programmes (IT Training team) on our Virtual Academy. We have very recently added Quality Improvement training and 'Better Support, Better Lives' training.

Results:

We believe we have developed a system that provides a much improved quality learning experience for our staff as it is easier to access and navigate, is more user-friendly and is a free platform. We are reducing time taken to access e-learning, with a more visually appealing system thanks to the design skills of Matt Crouch, e-learning developer. We have been working with the Education CWP admin team to manage how we move all staff to this platform for mandatory e-learning whilst continuing to ensure quality of data transfer into Electronic Staff Record. This is being managed alongside our mandatory training review. We can also analyse completion data for the courses on offer. Since we launched the Virtual Academy:

- 47 staff have used it to complete the Care Certificate
- 17 people have completed the psychopharmacology programme allowing them to proceed to study non-medical prescribing
- 102 GPs across the North of England have had access to our STOMP course
- 48 staff have completed a programme of management training
- 311 staff have used the system for mandatory training

Next Steps:

After our successful pilot we will, over the coming months, be moving all CWP staff onto our Virtual Academy to complete their mandatory training (e-learning). We will continue to add new programmes to our Virtual Academy and we will be working as a team to develop a broader blended approach for example, discussion boards, web conferencing and live chat. We are currently researching the potential for creating virtual reality simulation exercises and making them available via the Virtual Academy to develop this into a collaborative learning environment and experience.

Contact:
sandra.johnson10@nhs.net
matthew.crouch2@nhs.net

Care group: Learning Disabilities, Neurodevelopmental & Acquired Brain Injury (ABI)

Team name: Community Learning Disability Team (West)

Ladies group - sexual health workbook

What did we want to achieve?

Strategic work to streamline amount of referrals for sexual health awareness for service users with learning disabilities.

What we did:

We liaised with NHS England and the public health sexual health lead as well as local sexual health clinics to gather appropriate information and resources to deliver person centred groups. Before attendance of the groups we would complete a screening tool to ensure that the group was appropriate to meet each service user's needs.

Results:

From running regular sexual health groups for service users with learning disabilities it has reduced the number of referrals to the team for work to be completed on a 1:1 basis and has provided each service user easy read information around sexual health and widening their knowledge and understanding around sexual health. Areas covered in the sessions are sex and relationships, consent, monthly cycles and pregnancy, how to stay safe online, what grooming is and female health screening.

After each session we provided an easy read feedback form to each service user. We received a lot of positive feedback from both service users and support staff, and we also made amendments to the sessions that service users requested such as more understanding around grooming and scenarios. We also added an additional quiz booklet. At the end of each session we provided each service user a certificate for attending the group.

Next Steps:

We will continue to run the groups with service users due to the positive feedback from the group sessions. We feel this work booklet could be facilitated in other areas such as mental health and we would be happy to joint work this with mental health. Resources from the booklet can be used on a 1:1 basis if required.

Contact:
stacey.pope@nhs.net
chantelle.burgess@nhs.net

Care group: Specialist Mental Health
Team name: New Leaf - employment advisors

New Leaf employment advisors integrated into Community Mental Health teams (CMHT)

What did we want to achieve?

Employment advisors, employed under the Cheshire and Merseyside New Leaf contract, have been integrated into Community Mental Health and Early Intervention teams in Cheshire since November 2018 on what is a one year project to support service users with severe mental health problems into work utilising the evidence-based Individual Placement Support Model.

What we did:

Individual Placement Support [IPS] is provided by Standguide in Central and East Cheshire and by Cheshire West and Chester Council in West and Vale Royal. IPS aims to get people with mental health problems into competitive employment. This can be via training and education or directly into work. The only criteria used to access the service is that the service user wants to work and the employment specialist takes 'referrals' from any member of the team. Our employment specialists have developed relationships with local employers and provide time unlimited individualised support for the person and their employer once successful in getting a job.

Results:

Cheshire West and Chester IPS have received approximately 200 referrals and are currently working with 84 'customers' who are accessing training courses or actively job searching and 14 who have entered paid employment so far with others in the pipeline. Central and East IPS have received approximately 130 referrals and have 78 active customers with eight having gained employment so far, but this figure is forecast to rise to around 30 before the end of the project. Examples of employment successfully being sustained by customers include data processing, office administration, self-employed dog walker and website designer. The feedback from staff has been excellent, with most commenting about the positive effect on their patient's mental health after accessing the New Leaf IPS service. One service user, who is now self-employed as a beautician and has weddings and party bookings until Christmas, said: "New Leaf IPS has changed my life for the better, I am so thankful that my community psychiatry nurse introduced me to the service."

Next Steps:

The current IPS project ends in September 2019 however the Wirral and Cheshire Clinical Commissioning Groups (CCGs) have recognised the importance of continuing to support people with severe mental health problems into work and are providing funding to ensure that IPS workers remain integral to the multidisciplinary team. Teams have begun to collect together patient stories from people who have benefitted from involvement from an employment advisor into a collection of 'good news' stories which can be shared with other customers embarking on their employment journey and with the staff.

Contact:
linda.friend1@nhs.net

Care group: Neighbourhood-Based Care
Team name: Broxton Care Community team

Broxton Care Community team - improving communication with care agencies to promote safer care

What did we want to achieve?

Our aim was to find out who the carers agencies were in the local area, looking after their patients and building up an open door approach for the carers to access the team and for the team to access them. We wanted to achieve seamless care by all parties in the person's care working to the same goals and standards.

What we did:

The Care Community team discussed how they could achieve open channels of communication and aimed to hold a carers event within the neighbourhood. We were able to utilise the waiting room within Malpas doctors surgery and set about inviting professional carers that worked in the area. We identified some speakers from outside of the team who could attend this event to offer advice and support, including a tissue viability nurse, urology specialist nurse and a representative from Brightlife.

Results:

The event was attend by approximately 18 professional carers from the community, and the local care home in addition to patients and carers. Over hot and cold drinks, cakes and biscuits, introductions were made. By putting faces to names, it enabled carers to know who, how and when to contact the office, and also where the office was for face-to-face conversations in order to ensure the best possible support is provided to the people they jointly care for. Brightlife, an organisation that works with partner agencies to reduce loneliness and social isolation, spoke about what they have to offer in the area and how to make referrals to the service. The tissue viability nurses spoke about pressure relief and how best to manage in a person's home and the equipment devices available to help. A practical demonstration of the 30 degree tilt for the carers was also given so they are better informed when communicating with the Care Community team about pressure sores.

The urology nurse specialist gave an education session on the use of convenes in the community and the benefits to patients. A carer of a patient also spoke about how the use of the convene instead of a catheter had given them control of their life and reduced the risk of catheter acquired infections. This event has improved communication with the carers in the neighbourhood, feedback from those that attended has been excellent and the team are looking to organise another event in the next six months.

Next Steps:

Due to the success of this event, the team plan to continue these events twice a year and discuss with carers topics that they would like covering.

Contact:
elea@nhs.net

Care group: Specialist Mental Health
Team name: Liaison and Diversion team

Liaison and Diversion team newsletter enhances team communication

What did we want to achieve?

Our team identified an opportunity to improve communication within the team, particularly with the staff who covered the more diverse geographic footprint.

We wanted to ensure that all team members were kept fully up to date of events, news, and the latest information. Our aim was to make sure no one, especially those located further away or unable to attend team meetings, felt uninformed or at a disadvantage as a result of their location / posting.

We were aware team meetings are a great opportunity to catch up with colleagues, but also a chance to discuss work and utilise the skills of other team members for advice. With this in mind, we proposed the idea of a regular newsletter to be sent out to all team members.

What we did:

We enlisted another member of the Liaison and Diversion team to work on the newsletter initiative, collating information, ideas and content for the newsletter.

This included information such as upcoming birthdays within the team, any updates relating to recruitment, compliments and thanks to staff for a variety of things. An example of this is when a team member utilised the newsletter to send out links and information for World Autism Awareness Week. Another example of the usefulness of the newsletter is when a member of the team was leaving to commence maternity leave; the team used the newsletter to wish her well and planned to meet up outside of work for the team member's baby shower.

Results:

The newsletter is enhancing communication within the team. The Liaison and Diversion team underwent a patient safety improvement review in 2017 and scored highly for communication and teamwork, so the newsletter is an excellent resource to continue in sustaining this standard. The newsletter also has a Q&A feature for staff to ask any questions that they feel they can't ordinarily ask. So far, this hasn't been used by staff, but the option is there and ensures that members of the team always have an option for gaining help/advice.

Next Steps:

Feedback for the newsletter from staff has been positive. We will continue to coordinate the newsletter to ensure high levels of communication are maintained. It is hoped that the Q&A section will be utilised by those who need it.

Contact:
shelley.saunders@nhs.net

Care group: Specialist Mental Health
Team name: Access Sefton

Access Sefton provide a holistic, patient-centred approach to people with long-term conditions

What did we want to achieve?

Our aim was to increase the numbers of people with existing long-term conditions and/or medically unexplained symptoms who were able to access psychological therapies in Primary Care. We wanted to develop a pathway that would deliver therapy in an environment that people would feel comfortable, and remove stigma from mental health services.

What we did:

Initially we worked with one GP practice, meeting with staff and providing training to support the identification of people who would benefit from psychological interventions. The GP practice provided a room for a therapist, who was based in the surgery for one day a week offering assessments and therapy. The practice administration staff manage the appointments, directly booking in people at the request of GPs and nurses within the surgery. The nominated therapist was given access to the GP system and is able to add brief notes to support the holistic care of each individual. Therapists working on this project have had training in working with people with long-term conditions, and as we expect this to continue to expand, additional training places have been secured for the New Year.

Results:

The number of referrals into the service from the GP practice has increased significantly. This includes the number of people accessing the core service thought to be a by-product of the closer working relationships of the therapist and GP practice staff, as well as the general increased awareness and promotion of the service.

The development of the Improving Access to Psychological Therapies (IAPT) Long-term Conditions Clinic has increased the number of referrals of people who have a long-term physical health condition from the GP practice. People are now able to access therapy which will focus on the impact that a long-term condition may have on their psychological wellbeing, and also the effect that their psychological health has on their management of their condition. This approach has shown to be valuable in treating the person as a whole and recognising that these two aspects are inextricably linked.

Next Steps:

We will continue to evaluate the service in collaboration with GP practices and roll out the model to other GP practices within Sefton.

Contact:
ryan.forrest@nhs.net

Care group: Neighbourhood-Based Care
Team name: East Care Community team

Care community team transform referral system, improving access to care

What did we want to achieve?

The team identified that there was insufficient information being received at the point of referral which was impacting on time, resource and personcentredness, as a referral can be made for a huge variety of reasons reflected by the multi-disciplinary nature of the team.

The team recognised that the referral form was cumbersome and complex and required improvement. Furthermore, referrals were being made to the Care Community team in many different ways from the GP practices in the cluster, of which there are four. In order to address this, the team also wanted to standardise the overall referral system.

What we did:

The team developed a new referral form, ensuring that a triage system or priority assessment was included to ensure timely access to the service. The team were very keen to ensure that the form was piloted and undertook a Plan, Do, Study, Act (PDSA) cycle, collaborating with one of the GP cluster practices, gathering feedback on any areas on which to improve before spreading the initiative to the rest of the cluster.

Results:

The results have been very encouraging; everybody in the cluster feels the form is more efficient, streamlined and effective and has impacted positively on the delivery of patient care. There is a greater awareness and understanding of the person's needs on referral which precipitates an improved timeliness to a person's access to the appropriate service. Furthermore, through the PDSA cycle, the team have identified that the administration time within the GP practices and Care Community team has, on average, saved 45 minutes a day.

Next Steps:

The new referral form has been shared with the team's Care Community team colleagues within the Trust and their GP network colleagues with the intention of rolling it out to all teams.

Contact:
elizabeth.stewart2@nhs.net

Contact:
clair.jostingmoulder@nhs.net

Care group: Children and Young People

Team name: Ancora – Inpatient Child and Adolescent Mental Health Services (CAMHS)

Mini posters: Building relationships between patients and staff

What did we want to achieve?

Through gathering feedback from young people at Ancora House, we learned that, on admission, they would like to see pictures of who their mini team is in order to allay anxieties. Although Ancora already had a staff team board on the ward, young people wanted to know who their individual team members were, including their consultant, named nurse, associate nurse, clinical support worker, psychologist and occupational therapist. Our aim was to ensure that a simple way of providing this information was used that could be easily tailored to each young person and quickly completed on admission. What was very important was that it was young person friendly and easy to read.

What we did:

Co-production was identified as being crucial to the success of this initiative and as a result, young people collaborated with staff to design a poster to achieve the aim. They used rainbow coloured boxes and simple wording to explain who the team members are, designing the layout and creating the colour scheme.

Results:

The qualitative feedback from young people has highlighted how helpful they have found the posters:

- *"I love the colourful chart which brightens up my notice board."*
- *"I can't remember names so it's great to see the pictures of staff and know who I am seeing."*
- *"This is really useful and helps relieve anxieties of who I am seeing."*

Next Steps :

As this initiative has been really successful, the ward want to continue to work with young people to design and create helpful information and update and refresh existing literature, including the smoking cessation leaflet, Cheshire and Merseyside Adolescent Eating Disorder Service (CHEDS) welcome leaflet and information about keeping safe on the ward.

Care group: Specialist Mental Health

Team name: Cheshire and Merseyside Adolescent Eating Disorder Service (CHEDS)

Multi-family therapy workshop for anorexia nervosa wins national award

What did we want to achieve?

The team wanted to find out what the families participating in the workshop liked and disliked, valued and didn't value to better understand the experiences of the families invited to take part.

It was also important to find out if families had any preconceptions that were then changed by taking part, and whether there is anything that needed to be altered with regards to the workshop to make it more accessible to families, as attending the workshop for four consecutive days is a big commitment.

What we did:

The team liaised with the CWP research department who supported in the writing up of a proposal, and completion of an ethics application. Afterwards, the team created a questionnaire for the participating families that would cover four time points (pre-workshop, post-workshop, six-week follow up and 12-week follow up) in order to follow the views and opinions of the families over time and understand any changes, from preconceptions to ending-reflections.

Questions covered a range of topics and included rating scales and open-answer questions to allow for both qualitative and quantitative data collection. The families were happy to be involved in giving feedback, particularly to help us improve the workshop for the future. Once all the data was gathered, the results were analysed and grouped by their themes.

Results:

A range of themes were identified including "Feeling Less Alone", the "Importance of Other Families" and "Recovery Focused Drivers" (e.g. hope, less fear for the future, determination, optimism). It also highlighted themes of "Negative Emotions" (e.g. apprehension, emotionally draining, intense therapy) and made the team more aware of the impact the 4-day workshop has on family life (e.g. taking time out of work).

Despite the high commitment and emotional toll of such an intensive therapy, the qualitative results demonstrated that recovery focused language, e.g. hope and optimism, increased exponentially by the final follow up day 12 weeks after the workshop, in addition to "Familial Changes" such as more open communication, closeness and greater "Understanding of the Experiences of Young People and Anorexia". The project itself was greatly appreciated by the families who felt listened to and involved in their care by taking part in the project. It also allowed staff to understand more about their experiences and how their views of the workshop and of anorexia alter over time.

Not only did the workshop receive considerable positive feedback from families, a poster was submitted to the National Children and Young People Community Eating Disorder Conference in London earlier this year in in relation to the initiative and it won first place in the 'Interventions' category.

The team were very proud to be able to showcase the work of CHEDS' multi-family therapy workshop at a national level, but also to demonstrate how their commitment to getting feedback from people and families can help to maximise understanding of their experiences and ultimately improve services further.

Next Steps:

The intention is to repeat the service evaluation again in order to compare and contrast the feedback and experiences between different groups of families, and highlight what has been improved upon, but also to highlight any other areas that may need attention.

Contact:
elenya.harston@nhs.net

Care group: Neighbourhood-based care
Team name: Liaison Psychiatry (West)

Evaluation of the introduction of an information leaflet for carers and patients in accident and emergency and wards in a liaison psychiatry service.

What did we want to achieve?

Our aim was to develop leaflets to:

- Improve information for service users, carers
- Reduce service users anxiety
- Improve coch staff's understanding
- Aid communication and manage expectations
- Reduce assessment time
- Ensure more targeted assessments
- Improve quality of referral from Countess of Chester staff
- To evaluate the ability of the leaflet to deliver the above.

What we did:

Two leaflets were devised and approved, one for Accident and Emergency (A&E) service-users and one for ward service-users. A questionnaire to evaluate service-users' anxiety and knowledge of the process following referral to liaison psychiatry was developed by the team. Service users seen in A&E were asked if they would be willing to participate in answering a questionnaire after the assessment by the mental health practitioner.

Forty questionnaires were completed prior to the introduction of the leaflet to provide baseline data. Following the introduction of the leaflet, 28 service users completed the questionnaires. We created a database and entered the data.

Results:

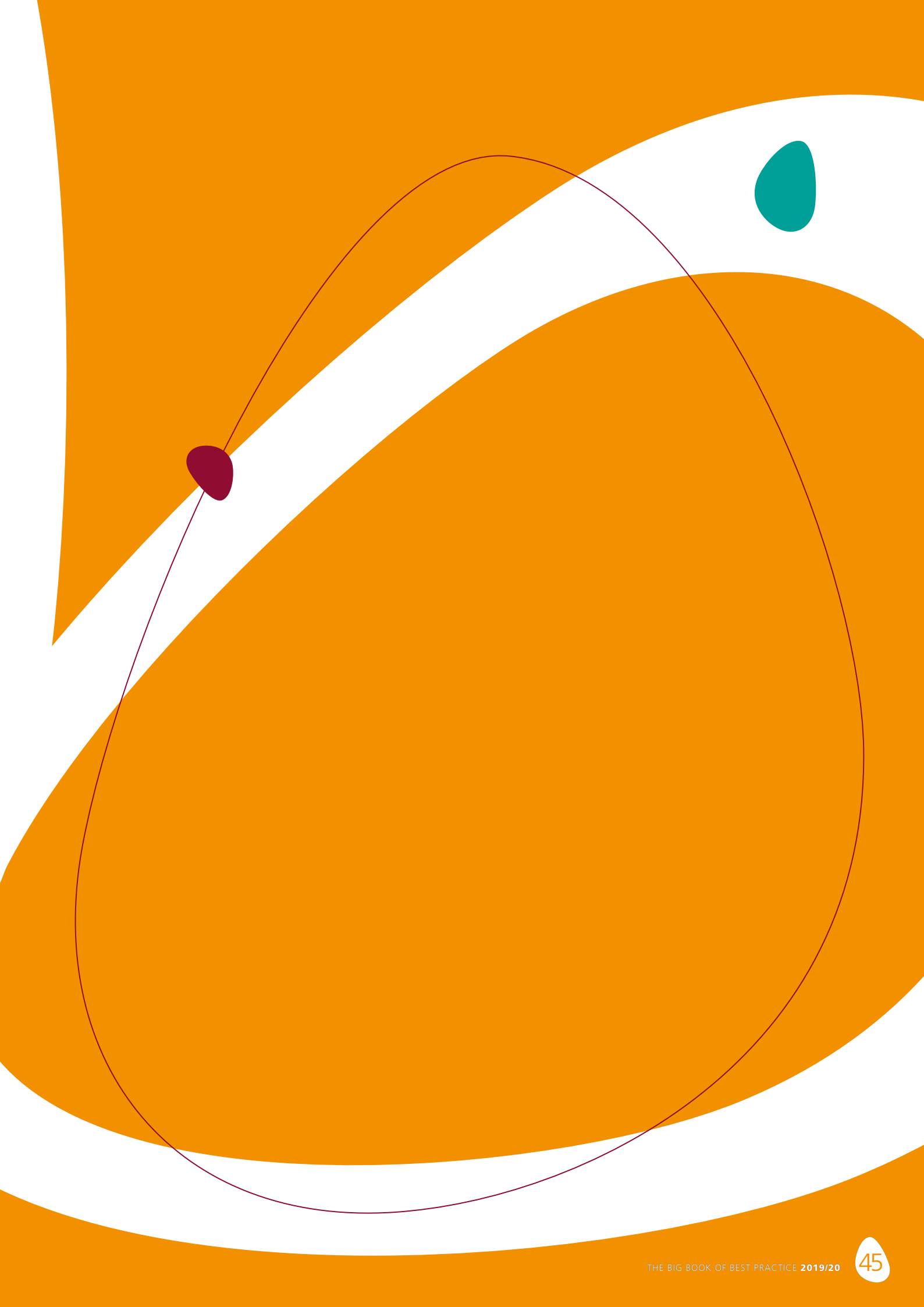
We have demonstrated the positive outcomes of this work by objective measures of change which have been subject to statistical analysis. The summary findings are that the mean scores for worry reduced and the mean scores for knowledge about the service and referral options increased. (mean differences [p-value]: -0.1 [0.81]; 0.4 [0.17]; 0.4 [0.13], respectively).

Although none of these differences were statistically significant, the sample size limited the power of the evaluation which was a pilot. The findings indicated a trend in a positive direction in all three areas. This project also demonstrated that it is possible to undertake outcome focused evaluation whilst carrying out clinical duties. Alongside these quantitative results, we took the opportunity afforded by the service-user questionnaires to obtain narrative feedback about our service. The vast majority of the feedback was very positive *(e.g. "Very good here", "expected it to be unpleasant in fact v relaxed").*

Next Steps:

To complete the same evaluation on the wards. As a result of introducing the leaflet, we started to develop a new way of summarising the plan given to service users.

Contact:
lindsay.nathan1@nhs.net



Honourable Mentions

With over 90 entries being submitted to the Big Book of Best Practice 2019/20, 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:
Recruitment Team and Organisational Development Team
Project:
Implementation of Values Based Recruitment (VBR) across CWP

Care group:
Specialist Mental Health

Team name:
Older People's Mental Health Service in Chester
Project:
Cognitive Stimulation Therapy programme reaps rewards for patients

Care group:
Children, Young People and Families

Team name:
Ancora House
Project:
Improving Access to Exercise for Young People In Hospital

Care group:
Children, Young People and Families

Team name:
0-19 Starting Well Health Visiting Service
Project:
Providing best practice via developmental reviews

The **Big Book of Best Practice** 2019/20

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

Contact

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

Tel: 01244 397397

@CWPNHS