



National Mental Health Nurse Directors Forum

*Influencing and advancing care in
mental health and learning disabilities*

LEADING MINDS

Delivering quality care for people with Learning Disabilities #MHForum2018

Welcome again to the Forum Autumn conference - we have made it our tradition to return to Warwick University once a year. This is always combined with our main face to face steering group meeting the day before. It's a significant one as it will be the last main meeting with our Chair - Avril Devaney. I therefore wanted to pay tribute to Avril for her stewardship of the Forum over the last three years. There is no doubt that the Forum is significantly better linked in to the wider health economy and we are now routinely included in consultations and national strategy meetings. A big thank you Avril for all you have done and will continue to do I am sure to raise the profile of mental health and learning disability nursing.

We also welcome Mel Coombes to her new role as Chair which she will officially take over next year. This coincides with the appointment of a new Chief Nurse as Professor Jane Cummings retires after six years in her role.

It has been some time since our conference has focused exclusively on the world of Learning Disability services but for all Trusts and organisations who are members of the Forum this is fundamental to the work we do. It was a delight to have received so many submissions for inclusion in this newsletter and I am sure you will enjoy seeing the great work that is going on out there.

We have papers from Surrey; Tees, Esk and Wear; North Staffordshire; Hertfordshire; Berkshire; Essex; Sussex and Southern Health. There is also an update from Rob Tunmore on the Learning Disability Mortality Review (LeDoR) with a continued fight to address inequalities in health care for those with a learning disability. Finally, a report from Fiona Nolan on her work in Mongolia over the past four years - and the development of a post graduate diploma in mental health nursing.

PETER HASLER, NATIONAL MENTAL HEALTH NURSE DIRECTORS FORUM DEVELOPMENT OFFICER
AND GUEST EDITOR

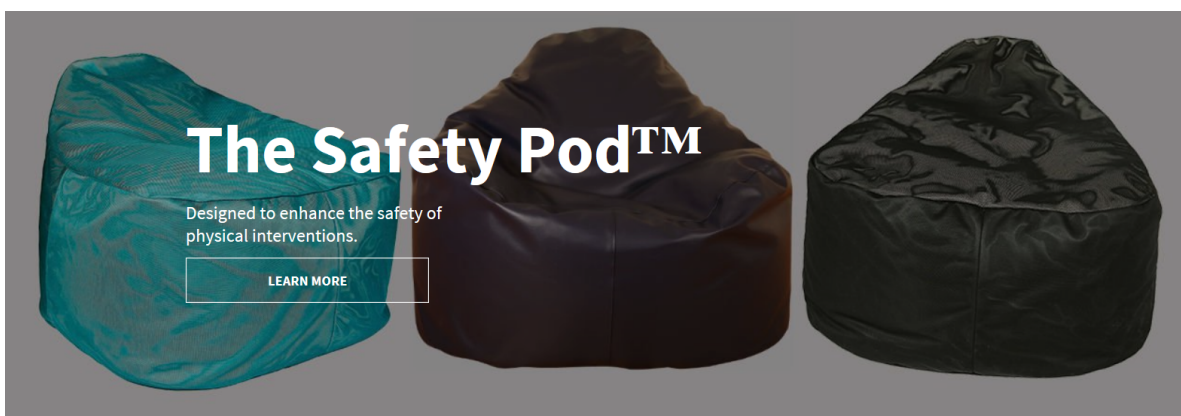
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Surrey and Borders Partnership NHS FT

The Deacon Unit (previously known as April Cottage) is an Assessment and Treatment Unit for people with learning disabilities with associated mental health needs. The Deacon Unit has undergone a service redesign to implement the Building the Right Support community care model (Transforming Care 2017, NHS England). This model includes expert inpatient care along with proactive preventive work looking to support people in crisis in the community. The Deacon Unit was accredited with good in all areas and outstanding for well led in their CQC inspection in January 2018. The team are striving to push the service forward to improve the care and treatment they provide to their patients and people who access support from the Intensive Support Service in the community.

The Surrey and Borders MAYBO team chose the Deacon Unit to implement an innovative new service enhancement call a Safety Pod. This was brought in to explore the impact it would have on patient and staff safety during physical intervention. Using the Surrey and Borders Quality Improvement programme we have implemented a project capturing the impact of the safety pod. We have reviewed the use of physical intervention prior to the implementation of the Safety Pod and since its implementation along with staff experience.

The impact of the safety pod has been significant. Since June 2018 there has been no supine (ground restraints) this has also reduced the number of standing and sitting restraints. The safety pod had significant impact on staffs confidence Staff Nurse Soji Fasanya stated "The safety pod encourages better communication and more positive interactions when a patient is being restrained. It enables you to have good eye contact at the same level as the person rather than looking down at them." Owen Kaseke Senior Care Support worker added "The safety pod has increased the safety for both the patient and staff during restraints and seems much more dignified than supine restraints." Whilst restraint is used as a last resort patients have chosen to utilise the safety pod during sensory sessions as it provides deep pressure feedback. Using the safety pod in positive ways ensure it does not get seen negatively by patients.



IF YOU WOULD LIKE MORE INFORMATION ABOUT THE ANALYSIS OR THE CATEGORISATION PLEASE CONTACT PHIL BOULTER PHIL.BOULTER@SABP.NHS.UK

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What is STOMP?

In April 2018 Tees, Esk and Wear Valley Signed up to the STOMP pledge.

STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a health campaign from NHS England involving many different organisations. STOMP is about helping people to stay well and have a good quality of life.

It is estimated that on an average day in England between 30,000 and 35,000 people with a learning disability, autism or both are taking prescribed psychotropic medication without appropriate clinical justification. Long-term use of these medicines puts people at unnecessary risk of a wide range of side effects including weight gain, organ failure and even premature death.

STOMP aims to:

- Improve the quality of life of people with a learning disability, autism or both
- Make sure people only receive psychotropic medication for the right reasons and in the right amount
- Improve understanding of psychotropic medicines and when they should or should not be given
- Improve understanding of alternatives to medication
- Make sure that people with a learning disability, autism or both are involved in decisions about their health and treatment.

People may be prescribed medication as a way of intervening when their behaviour is thought to be challenging, even though there are alternative evidence-based approaches available. NICE guidance states that the use of psychotropic medication should be the last resort for managing behaviour which challenges and should only be considered if:

- Psychology or other therapies do not help within an agreed timeframe
- Treatment for a mental or physical health condition has not improved the behaviour
- The risk of harm to the person or others is very severe

Our starting point for this work is to set up a trust wide STOMP steering group to develop an action plan to challenge the over medication of people with a learning disability, autism or both. The team will be led by a Consultant Psychiatrist and will include positive behaviour specialists nurses and pharmacists

NHS England has developed Guidance for prescribers on Stopping Over-Medication of People With Learning Disabilities and further information is available

<https://www.england.nhs.uk/learning-disabilities/stomp>

DR NEELAKANDAN MURUGESAN & JOHN SAVAGE, TEES, ESK AND WEAR VALLEYS NHS
FOUNDATION TRUST
NEELAKANDAN.MURUGESAN@NHS.NET JOHN.SAVAGE1@NHS.NET

“Lean Keen and Efficiency Seen”

Learning Disability Inpatient Unit Durham

Using QIS methodology and RPIW in specific, we were able to improve patient flow and ensure excellent quality patient care, whilst delivering a reduction in bed numbers and the realignment of psychiatrists capacity to support more community based activity enabling patients to stay in their own home.

Following the Winterbourne View review, inpatient services for Adults with a Learning Disability have been under intense scrutiny. All services are aware of the need for admission to hospital to be a last resort. When it occurs, the admission should be effective and short.

This team applied QIS improvement techniques to Adult Learning Disability inpatient services across TEWW.

An RPIW is “is an improvement process that brings together a team of staff from multiple disciplines to examine a how a process flows, eliminate wastes, propose solutions, & implement changes”

The Current state:

Following a trust wide LD RPIW, the new process now sees 2 units, covered by one consultant psychiatrist. It also has a Daily ‘report out’ format, to summarise events of the previous 24 hours and select actions for the next 24 hours.

In County Durham community services are delivered in an integrated manner with Local Authority as the lead agency. The partner agencies were engaged and they signed up to the process.

Impact & results

Quantitative:

The impact of the RPIW is being felt across LD inpatient services and in addition to the results above the RPIW has delivered:

- Visual control boards reduced from 3 boards down to one making things more action focused
- 12 consultant ward rounds across 3 units reduced down to a daily huddle in the remaining 2 units
- Achieved 2018 Transforming care bed trajectory.
- 60% reduction in consultant time required in unit
- 100% reduction in non-productive meetings
- 100% patients now get a formal formulation (76% previously)
- Saving of 592 miles per week of community staff travelling to ward rounds

- 68% reduction in staff time spent prepping for and attending meetings (was previously 126 hrs per week)

Qualitative Results and feedback

- Timely care
- Governance compliance
- In line with transforming care-care is delivered in the community
- Generates Business for the trust
- Improved Inter-agency working and partnership working

Challenges

- Bed pressure in the context of lack of resilient community providers.
- Sustainability of model with ongoing improvement
- Strong advocacy of QIS principles and contribute to improved patient care in line with trust values mission and goals

Overall Impression

The Inpatient Review RPIW has been a resounding success and illustrates the efficacy of the trust's Quality Improvement System. It also demonstrates the continued commitment of the Learning Disability division to develop innovative treatments that avoid restrictive practices wherever possible and minimize them where absolutely necessary.

The results demonstrate that providing high quality and timely inpatient treatment reduces the length of stay considerably, allowing people to return to normal life as quickly as possible.

Consultants now have more clinical time within community services, allowing them to be more responsive to patients in crisis.

DR NEELAKANDAN MURUGESAN & JOHN SAVAGE, TEES, ESK AND WEAR VALLEYS NHS
FOUNDATION TRUST
NEELAKANDAN.MURUGESAN@NHS.NET JOHN.SAVAGE1@NHS.NET

Using positive behaviour support to inform resource allocation and facilitate progress with complex comorbid forensic learning disability patients: an exploratory case analysis.

Introduction:

The use of positive behaviour support (PBS) to reduce challenging behaviour via promoting increases in quality of life and positive behaviours is recommended by leading health and learning disability organisations in England (BILD, 2018; NICE, 2018; NHS England, 2015). Central to the Transforming Care agenda is a reduction in restrictive practices and restrictive care contexts. PBS is a recognised approach that can be used, not only reduce, but also potentially eliminate restrictive practice (NHS Scotland, 2014). The purpose of forensic healthcare is to maintain safety whilst also sufficiently mediating behaviours which challenge in order for people to progress onto conditions of lesser security. Yet research on the use of PBS in forensic contexts with people who experience complex comorbid presentations alongside their learning disability is limited. Within modern healthcare it also is imperative that resources are allocated in the most efficient and effective way.

Method:

A qualitative case study method and methodology were adopted. Sample selection was purposive, based on the criteria of the individual having a learning disability, experiencing complex, comorbid health needs and being detained with a forensic context. Pragmatic approaches were used to generate baseline data and subsequent evaluations. This included: direct observations in the form of bespoke behaviour charts, a records review, wider multi-professional discussion, and discussion with family members and with the person. A dynamic capacity assessment process involving the person was also initiated by the multi-disciplinary team and integrated into the evaluation process. A functional analysis of previous challenging behaviour and the individual's index offence was completed. A series of development days and reflective practice sessions were organised to support the PBS process. The emergent data set was then used to develop an initial PBS plan in accordance with the BILD criteria for good behaviour support (BILD, 2016). A 'best interests' PBS was developed due to the individual's limited capacity. Mediator analysis was then used to guide resource allocation (NHS Scotland, 2014). The evaluation took place over a three month period once the PBS plan was actioned.

Results:

The person selected had a learning disability, was also diagnosed with an autistic spectrum disorder and had a chronic history of treatment resistant schizophrenia as well as an extensive risk history. They were also subject to conditions of long-term segregation (DoH, 2015). ASD, mental health, risk related and positive behaviours were monitored using bespoke behaviour charts. Mediator analysis led to the

resourcing of a 1:1 healthcare professional five days a week in addition to usual care. This healthcare professional was supported by and fed back to members of the wider multidisciplinary team on a daily basis. Interventions by the dedicated healthcare professional were also supported by members of the wider team. Mediator analysis also led to operational investment to ensure the necessary availability of additional staff at key times during the course of a day to facilitate wider association.

Association opportunities and time significantly increased (by a factor of 6). Monitoring also indicated a reduction in association risk incidents to approximately 1 incident for every 25 association periods. The maximum period of association achieved by the person for any given session also increased to almost 2 hours. Frequency of association periods significantly increased (up to three per day). The following positive behaviours were also noted to increase in frequency (+ mild increase, ++ moderate increase, +++ high increase):

- Enhanced communication and conversation +++
- Awareness of self +
- Sense of empowerment ++
- Engaging in therapeutic sessions +
- Daily living skills +++
- Emotional expression +
- Pro-social behaviours ++

Discussion, Limitations and Future Direction:

Progress was achieved via the use of PBS, the allocation of a 1:1 healthcare professional above treatment as usual and operational support of staff availability. Resource allocation was guided by a mediator analysis linked to the PBS process. Improvements in quality of life, positive behaviours, association frequency and duration and risk were noted. Gains were made in a relatively short period. PBS is considered a long-term strategy and therefore requires sustainability. Current progress is dependent on the maintenance of key resources. Options to sustain and increase progress and incorporate this within treatment as usual must be explored. Frameworks such as the NHS Sustainability Model offer a systematic means of doing this. The evaluation process also did not include formal measures. There may be advantages and disadvantages to the inclusion of these measures. Permission to trial more formal assessment measures such as The Problem Behaviours Checklist (Tryer et al., 2017) has been sought and gained. A 'best interests' approach was also adopted due to the person's limited capacity. One of the five BILD criteria for good PBS is personalisation. The criteria stipulate that actions should be created or agreed with the person. Over the evaluation period a high increase was noted in enhanced communication and conversation. Further exploration to enhance the person's active engagement in the PBS decision making process is therefore warranted. Whilst the results are promising, further research is needed.

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JONATHON SLATER NURSE CONSULTANT – NATIONAL LEARNING DISABILITY SERVICE
RNMH, RNSP, BABCP ACC PSYCHOTHERAPIST
JONATHON.SLATER@NOTTSHC.NHS.UK
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST



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Incorporating Organisational Culture into “Lean” Thinking

Following in the footsteps of the Virginia Mason Medical Centre in Seattle, TEWW NHS Foundation Trust (a Mental Health & Learning Disability Trust) adopted the principles of the Toyota Production System. A fundamental principle of this approach is “Kaizen” - the elimination of waste. When this approach was introduced into TEWW’s community services (in order to help develop “Purposeful and Productive Community Services” and thus help the organisation achieve its cost saving targets) it happened a member of staff had a background in organisational as well as clinical psychology. As this staff member discussed with colleagues the PPCS initiative it was clear that Kaizens’ focus on reducing waste and increasing efficiency was both valuable, providing a set of useful tools but would also change organisational culture as a consequence of the focus on efficiency and cost savings. Potentially this could happen without reference to other important elements of organisational culture. The team therefore approached the Chief Operating Officer with their thoughts and made the case that organisational culture needed to be consciously managed. The psychologist in the team also described a framework for addressing culture change that he had previously used. This was Cameron and Quinn’s “Competing Values Framework”.

The COO could see the relevance of the case the team presented. However he was understandably cautious about starting something new when there were already so many initiatives underway. After two weeks’ reflection he came back to the team and asked if they would be willing to pilot the work within their Community Learning Disability Team. They agreed and before long the work attracted attention. Very quickly the whole of North Yorkshire’s LD Service was engaging, at least at a senior level, with this work. In parallel the local team pressed on beyond the “diagnostic” phase - where the current culture is compared with the culture we need for the future, with reference to the challenges the organisation faces. The local team developed action plans using the tools the framework provides and these proved invaluable in demonstrating the potential value of the work to others in the Trust.

The Operations Director for North Yorkshire then decided to expand this work and involve all specialties. An event was thus held in which the senior people were introduced to Cameron and Quinn’s model. Everyone had an opportunity in advance to complete the Organisational Culture Assessment Instrument that forms part of the model. At the event each Service could see how collectively the people at the top of their Service viewed the current culture. They could also identify those aspects of culture where it was felt more emphasis was needed if they were going to successfully achieve their strategic goals. It was clear that senior people across all specialties felt the focus on efficiency had become too great, to the detriment of other important values; particularly in regard to people and innovation.

From the event, each specialty developed concrete action plans to consciously address culture and avoid becoming overly focused on efficiency at the expense of additional important values. One year later we are repeating an assessment of North Yorkshire’s organisational culture and the results look promising. The feedback from the pilot team is that the work has given them a voice and having been encouraged to use that voice the Trust has listened – PPCS no longer feels like something being “done to them” but something they have a meaningful part in shaping.

TERRY SHANNON, CONSULTANT APPLIED PSYCHOLOGIST LOCALITY LEAD
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST JRICHARDSON1@NHS.NET

SEX!

Now we have your attention please read....

So we have seen the population of People with Learning Disabilities (PWLD) enjoy improvements in their opportunities, liberties and social inclusion in the last 60 years but have we considered the full implications of how this impacts upon the range of support we provide? We now proudly discuss adults having "their own front door", access to mainstream services/activities/locations and have closed the gates of the archaic institutions (in theory) but do we actually support holistically?

To be an adult human without considering sex and relationships would be a somewhat short sighted assumption, given the extent to which this is central to ones' self-identity, aspirations and expectations. It would be very difficult to ignore current research and the world around us which reinforces that sex and relationships are at the forefront of society, culture and our existence within the modern world, this modern world in which we now have PWLD whom are beginning to enjoy similar rights and freedoms.

There has been an increase in the recognition of these needs (which of course have always been there for PWLD) and the importance of a quality response in providing appropriate education and support for PWLD to enjoy more meaningful relationships and safer sexual expression rather than these being topics of taboo and disempowerment.

In response to this growing awareness and escalation in expression of these needs by PWLD and referrers the North Staffordshire Community Learning Disability Health Team have developed strategies to meet these needs including specialist risk assessment, bespoke one to one advice, Relationship Awareness Group, risk management plans, capacity assessments, consultancy for team members to develop their skills and to discuss cases of concern and care provider training to improve support approaches.

This multi stranded approach offers an opportunity for clinicians to work flexibly to maximise engagement and efficacy in an area of support that is inherently of a personal, sensitive and individual nature. A mixed gender group with a range of resources and a client led philosophy may be beneficial for some but a daunting and unhelpful experience for others whom a structured scheme of work on a 1:1 basis may more appropriately suit for instance.

The outcomes observed for and expressed by our clients have been:

Reduced vulnerability

Improved sexual health

Safer expression of sexuality

Reduction of sexually harmful behaviour

Improved social skills, emotional regulation and assertiveness.

By formally recognising the importance of safer relationships and sexual expression for pwld there have been opportunities for the support network around an individual to be engaged and committed to improvement in this area of life.

There are numerous challenges when working with individuals with a diagnosed learning disability without

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adding into that equation the wide spectrum of other factors and circumstances that inform what support may be effective and wanted/accepted. The emphasis on flexibility and creativity as a pre-requisite to achieving observable progress is no better exemplified than when providing non-judgemental support and advice regarding the complex world of relationships, sexuality and sexual rights to pwld and their support network.

WRITTEN COLLABORATIVELY BY: KATH SALT COMMUNITY NURSE
PHIL EMERY COMMUNITY NURSE MATT DOUGHTY OCCUPATIONAL THERAPIST
MATTHEW.DOUGHTY@COMBINED.NHS.UK

Further information can be found in the 2017 article: [Talking about sex: a relationship awareness group for adults with a learning disability](#). *Learning Disability Practice*. 20, 5, 17-22

The Learning Disability Mortality Review (LeDeR) Programme - What's Changed?

The Learning Disability Mortality Review (LeDeR) Programme was established following the recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD) (2013).

The LeDeR Programme aims to reduce health inequalities & premature mortality by:

- Reviewing all deaths of people with Learning Disabilities aged 4 years and over
- Sharing best practice
- Identifying areas for improvement
- A local responsibility to improve services via 'action plans' following completed reviews

Five years on from the publication of CIPOLD the LeDeR Annual Report 2017/18 makes the following recommendations:

Recommendations

1. Strengthen collaboration - information sharing, & effective communication, between agencies
2. e-integration of health and social care records
3. Named health care coordinator for those with two or more long-term conditions
4. Providers should clearly identify people requiring reasonable adjustments
5. Mandatory learning disability awareness training for all staff
6. National focus on pneumonia and sepsis in people with learning disabilities

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7. Strong governance & adherence to the Mental Capacity Act
8. Strategic national approach to training of those conducting mortality reviews

So – what's changed?

- The LeDeR Programme, the first national system for reviewing deaths of people with learning disabilities has been established and implemented across England from December 2017. Over 800 reviews have been completed with the recommendations and learning from those reviews now feeding into a national 'Learning into Action' initiative being led by NHS England across all regions.
- The recommendations from the LeDeR Annual Report 2017/18 have had stronger backing from the Government and All Party Parliamentary Group on learning disability and Learning Disability
- Learning disability is identified as a clinical priority in the NHS upcoming ten-year/long term plan to improve health services in England.

A number of high profile reports and family led campaigns continue to highlight the inequalities in health and care that are still experienced by people with learning disabilities and their families.

Anyone can notify the LeDeR Programme of a death, including people with learning disabilities themselves, family members, friends and paid staff.
Call 0300 777 4774 - or go on-line: <http://www.bristol.ac.uk/sps/leder/notify-a-death/>
To train as a LeDeR reviewer – via eLearning & local support visit: <https://www.lederlearning.co.uk/login/index.php>

ROBERT TUNMORE - LEDER REGIONAL CO-ORDINATOR (NHS SOUTH)

CONTACT EMAIL: R.TUNMORE@NHS.NET



CONSTIPATION

DID YOU KNOW THERE IS A HIGHER PREVALENCE OF CONSTIPATION IN PEOPLE WITH A LEARNING DISABILITY THAN THE GENERAL POPULATION? THIS CAN OFTEN BE MISSED DUE TO LACK OF UNDERSTANDING; FOR EXAMPLE LOOSE STOOLS CAN BE A SIGN OF CONSTIPATION! UNKNOWN CONSTIPATION OVER A LONG PERIOD CAN LEAD TO DEATH!

FACTS	CAUSES	WHAT TO LOOK FOR	RISKS
<p>A systematic review of 31 studies; published between 1990 and 2016 show:</p> <p>25.7% of people with learning disabilities received a repeat prescription for laxatives in one year compared to 0.1% of the general population.</p> <p>In one year, 18.8% of people with Down syndrome were prescribed laxatives compared to 3.4% of people without learning disabilities. Constipation was registered as a health problem for 59.8% of people with profound intellectual and multiple disabilities and 65.0% had been prescribed laxatives in the previous year.</p> <p>Inactivity was associated with constipation, age was not consistently associated with constipation.</p>	<p>People with learning disabilities mainly get constipated for the same reasons as other people. These include:</p> <ul style="list-style-type: none"> • inadequate diet and fluid intake • reduced mobility and lack of exercise • side effects of certain medications • anxiety or depression <p>People with learning disabilities may have conditions that make it more likely for them to have constipation such as:</p> <ul style="list-style-type: none"> • poor diet • reduced physical mobility • being prescribed medication such as antipsychotic, antidepressant and anticonvulsant medication that can all have a negative effect on bowel movement 	<p>Symptoms can include:</p> <ul style="list-style-type: none"> • abdominal pain • cramps • bloating • loss of appetite • nausea • overflow diarrhoea • faecal impaction • faecal vomiting • twisting of the bowel leading to ischaemia and septicaemia <p>Symptoms of constipation can be overlooked, with resulting behaviours being attributed to the person’s learning disability; this can include self-harm.</p> <p>It’s important that physical problems such as constipation are considered if someone suddenly starts exhibiting challenging behaviour.</p> <p>Staff do not always know what symptoms to monitor for so it is important to ask the right questions.</p>	<p>In extreme cases, the symptoms of long-term constipation can lead to death...</p> <p>In 2014, the Safeguarding Adults Board in Suffolk commissioned 2 Serious Case Reviews into the deaths of 2 people with learning disabilities. Their deaths occurred in the same hospital within a 6 month period. Their deaths were a result of complications related to faecal impaction.</p> <p>In 2018 there have been 2 deaths, of people with learning disabilities, within Surrey due to complications of chronic constipation.</p> <p>IT IS NOT OK THAT THIS IS STILL HAPPENING!!!!</p>

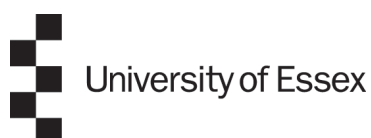
If you would like further information or support on this topic, please contact your Primary Care Liaison Nurse:

KATIE HOUGHAM – 07557204607
GUILDFORD & WAVERLEY AND SURREY HEATH

COLLEEN CALVO -07799478806
EAST SURREY AND SURREY DOWNS - EPSOM

ABIGAIL HASLAM – 07717541035
NORTH EAST HAMPSHIRE & FARNHAM, NORTH
WEST SURREY – WOKING.

HOLLIE ROBERTS -07799581566
NORTH WEST SURREY – SASSE & THAMES
MEDICAL AND SURREY DOWNS – ELMBRIDGE &
DORKING.



Mongolia leads the way in mental health nursing in Asia

Nurses working in mental health services in many low income countries do not have access to specialist training in mental health, compromising the care of service users in already poorly resourced systems. Mongolia, as an example, has 0.5 psychiatrists and 7.7 nurses per 100,000 population compared to 14.6 and 67.6 respectively in the UK (WHO, 2014). Government spending on healthcare is around 4.7% of GDP, of which 2% is allocated to mental health (WHO 2017), compared to the UK spend of 9.8% of GDP of around 13% was on mental health for the same period.

Fiona Nolan has been visiting Mongolia since 2014 to facilitate mental health service development and education for staff. She was awarded a visiting professorship at the Mongolian National University of Medical Sciences in 2016 in recognition of this work.

She was recently awarded EU funding of €1 million to lead an international team of six universities to develop a new 18-month postgraduate diploma in mental health nursing in Mongolia – the first course of its kind in Asia.

The Mongolian Mental Health Nurse Training (MoMeNT) project will involve Finland's Turku University of Applied Sciences and Utrecht University of Applied Sciences in the Netherlands, along with three Mongolian partners: the Mongolian National University of Medical Sciences, Enerel Medical Institute and Etugen University. The team will engage non-government agencies, healthcare providers, the Mongolian Ministry for Health and the World Health Organisation's in-country office, all of whom provided support during the project's development. The British consulate has also been a consistent and strong source of in-country support for Fiona since 2014, and was an important factor in the success of the funding proposal.

The programme will entail an 18 month development phase, during which mental health nursing curriculum content will be collated from the EU partners. The process of agreeing the content will be interesting given the differences in legislation and culture which affect care provision between the UK, Netherlands, Finland and Mongolia, including use of mechanical restraint and medication. Tailoring the content around an absence of community mental health services, restricted formulary of psychotropic medication and entrenched professional hierarchy in clinical practices in Mongolia may also present considerable challenges.

There has been enthusiasm for this work from other countries, and universities in Canada, Australia, New Zealand, France, Ireland, Qatar, Korea and China have already volunteered to contribute their curricula. A full report on this component of the project should be available by June 2019.

A pilot group of 12 registered nurses from the National Centre for Mental health in Mongolia will undertake the post graduate programme. A series of visits to clinical services are planned between 2020 and 2021 during which the 12 students and a comparable number of university lecturers will visit London, Utrecht and Turku. The project kick-off meeting will take place in the Mongolian capital of Ulaanbaatar from 7th to 10th January 2018. Interested UK staff and agencies will be invited to attend sections of the 3 day meeting through a skype link, which will enable participation from around the world. A project meeting is also scheduled for London in April 2019 and participation from representatives of the MHND forum will be welcomed.

An independent project steering committee will be set up before January 2019 with international membership to include clinicians, service users and carers. This will meet (mainly virtually) 4-5 times in the course of the project. Engagement and participation of UK mental health nurses UK will be encouraged in aspects of the programme such as hosting site visits, meeting with Mongolian colleagues, observing meetings, and contributing to an online forum. Information and updates will be disseminated through the Forum when available.

A project website will be set up in early 2019, but in the meantime, for further information or to discuss participating in the programme, contact details are below:

FIONA NOLAN

CLINICAL PROFESSOR OF MENTAL HEALTH NURSING, UNIVERSITY OF ESSEX
DEPUTY DIRECTOR OF RESEARCH, ESSEX PARTNERSHIP UNIVERSITY NHS TRUST
HONORARY CLINICAL PROFESSOR, TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
F.NOLAN@ESSEX.AC.UK

University of Essex article: <https://www.essex.ac.uk/news/2018/09/07/mongolia-leads-the-way-in-mental-health-nursing-in-asia>

Sepsis awareness for people with learning disabilities, their carers and health professionals

Sepsis is a potentially life-threatening condition that arises when the body has an abnormal response to infection and damages its own tissues and organs. Sepsis affects more than 250,000 people a year in the UK and is responsible for at least 44,000 deaths ([UK Sepsis Trust, 2018](#)). The LEDER annual report found that Sepsis was the immediate cause of death for 11% of the deaths reviewed in 2016-2017.

Sepsis always starts with an infection, most often a bacterial infection, but the signs and symptoms of infection may not be obvious when sepsis develops. This highlights the importance of good hygiene, particularly hand washing amongst carers and people cared for, to prevent infection. Respiratory tract infection is the most common trigger for sepsis. Research by Hosking and others (2016) found people with a Learning Disability are five times more likely to be admitted to hospital with a lower respiratory tract infection than someone of the same age & sex without a Learning Disability, suggesting people with a Learning Disability are at high risk of developing sepsis during these hospital admissions.

In the early stages, sepsis is difficult to identify with certainty – symptoms such as vomiting, diarrhoea and flu symptoms may be dismissed as insignificant or over-shadowed by other medical conditions or disabilities. This difficulty is compounded when people cannot articulate how they are feeling or maybe can't interpret the sensations in their body. Raising awareness of the early signs and symptoms of sepsis amongst people with learning disabilities, their families and carers will help them know what to look for & seek medical attention without delay. Behavioural change such as fidgeting, sleep disturbances, changes to appetite & thirst may not always herald sepsis but should be treated as significant until proven otherwise. If a carer says 'he's not right' or 'she's not herself today' that should be a signal to start looking for infection and monitoring vital signs – breathing, heart rate, conscious level, urine output and skin colour require no special equipment to measure.

Easy Read Sepsis Symptoms leaflet produced by Hertfordshire Health Liaison Team & the Sepsis Team at East and North Herts NHS Trust (Attached) conveys the danger signs.

The learning disabilities liaison nurses and sepsis nurses educate health professionals at ENH NHS Trust to improve assessment of patients with learning disabilities. The aim is to keep the suspicion of pneumonia and sepsis high given that these are the leading causes of death in this vulnerable population. The importance of working with carers and families who know the patient best and using the health passport to understand each person's baseline is key to interpreting deterioration from that baseline. As a safety net, the Sepsis Team monitor the vital signs and blood results of any in-patients with learning disabilities ready to intervene at the first sign of deterioration.

More information about sepsis amongst people with learning disabilities is available on the @WeLDnurses chat archive <http://wecommunities.org/tweet-chats/chat-details/4167>

ANNE HUNT | SEPSIS LEAD NURSE
EAST AND NORTH HERTFORDSHIRE NHS TRUST
ANNE.HUNT1@NHS.NET

Learning from our journey from “Requires Improvement” to “Outstanding”

Campion Unit at Prospect Park Hospital is Berkshire Healthcare’s nine bedded specialist inpatient assessment and treatment service for adults with learning disabilities. In December 2015 the Care Quality Commission (CQC) inspected the service and unfortunately found that the service “required improvement” (and was found inadequate in one domain) – this was a particularly challenging outcome for the team and the learning disability service as a whole.

However following a period of review, the management team were supported by the Regional Director and Clinical Director (with oversight and support from the Executive Directors and corporate services) to establish a Senior Overview Group which set about monitoring and supporting the action plan that had been developed to improve the service in line with the CQC standards. There were changes in unit management, and interim arrangements were put in place to push forward with service improvements required. The other inpatient service (Little House in Bracknell) was suspended as part of a wider (national Transforming Care) programme and this enabled the staff from these two services to be consolidated into a single inpatient service at Campion.

As a result of the structured action planning aimed at improving the service delivered at Campion, when the CQC re-inspected the service in December 2016, the service was rated as “Good” overall and also across all 5 domains. This was a very good achievement with progress seen to be made in all areas, but there was still more to do. The unit management was still interim and there was an ambition to continue to shift the culture and morale within the service to really embed the changes that had just begun to be realised.

Since that time there have been a number of lessons learnt as the service has continued on its journey of improvement. A fundamental lesson learnt has been the importance of ensuring we get the right people in the right roles. With the right people in place this can really help begin the process of building relationships & a more robust feeling of mutual respect and trust across the team. There has been a remodelling of the unit management team – with new roles established and additional deputy managers recruited to provide hands on leadership within the unit. Another important part of building this trust within a team is also holding people to account (in a consistent but fair approach) – while also supporting and developing individuals to enable them to bring the best version of themselves to work each day. Achieving this balance is a constant challenge and one that requires careful and thoughtful reflective practice from all members of the management team.

Following the appointment of new permanent recruits into the unit and service management team, this has really helped with building up the morale and confidence of the whole team – sustained by the culture of the service being further developed in practice – with the aim to provide the best care in the right place for people with learning disabilities. One of the first positive effects of this change was evidenced quickly when the service achieved accreditation under the Royal College of Psychiatry accreditation of inpatient learning disability services (QNL) in January 2018. The service, under the direction of the Service Manager and unit leadership team achieved 100% of the standards – which was a remarkable achievement and helped provide the team with a really good level of assurance and encouragement about the progress being made.

The learning disability service overall has also been through a transformational process – with a new community based service (the Intensive Support Team (IST)) established to help community services avoid all but the essential admissions into inpatient services. The IST has also helped develop the skills and practice within the inpatient services – the IST has been developed to work seamlessly across inpatient and community services – and the level to which this has been achieved is a mark of the collaborative approach adopted by the IST team members, who have worked in a mutually respectful manner with the inpatient staff team and the wider MDT.

With another inspection anticipated, there was significant planning for the CQC inspection – it was recognised that this needs to be achieved over the long term with improvements evidenced and sustained. As a result it is important to ensure the evidence of good practice and effective governance is in place well before the inspection (as the CQC look for evidence over previous 6-12 months), and this also allows time to also build up staff confidence in what they are doing and why it is important. It also enables the team time to explore how they can more effectively communicate this well with visitors and stakeholders. This has resulted in the team presenting a much more transparent approach when welcoming visitors to the unit and a more conducive and relaxed atmosphere on the unit has been described by both staff and visitors alike.

Then, in the shorter term, once an inspection is known, there is still an opportunity to plan to ensure the best representation of the service, ensuring staff are available and on duty, making sure they are well prepared and there are contingency plans for managing unforeseen events that might happen. It's useful to have staff than can respond flexibly, ensuring that other wider team members are also ready and prepared and willing to be involved to support the process (particularly the wider MDT). Ensuring there is a plan for how the inspection team will be accommodated – office/meeting space etc is also crucial – so that teams and inspectors can undertake their respective roles without getting in each others way.

Then during the inspection visits – ensuring staff are clear about their roles, encouraging them to be positive and engaging. Ensuring the meeting spaces set aside are ready and available, with refreshments – and take account of any safety factors to ensure the inspection team feel safe and know how to adhere to any events or incidents.

When the CQC inspected the service for the third time in June 2018 we were delighted that the CQC rated the service as "Outstanding" overall, and "Outstanding" for Effective (which initially had been inadequate), and Well Led, and "Good" for the remaining domains.

Campion has since undertaken their Quality Improvement training and have been working on implementing the trust's Quality Management and Improvement System (QMIS) which is already having a positive impact. The team believe this structured approach to quality improvement will be crucial in sustaining and further developing our position in the months ahead – gaining even more insights and learning based on good quality data and practical improvements. The team are now taking a more proactive approach to regularly monitoring their performance against their agreed local drivers, experimenting with improvements and working in a more standardised way, with more effective communication regularly happening across the team. We hope that this will help further embed our Outstanding performance for the future. If you would like to know more please contact:-

KATALIN.WALSBY@BERKSHIRE.NHS.UK (CAMPION UNIT MANAGER)

RALPH.CHANANDA@BERKSHIRE.NHS.UK (SERVICE MANAGER)

COLIN.ARCHER@BERKSHIRE.NHS.UK (HEAD OF LEARNING DISABILITY SERVICES)

Introducing Active Support within an inpatient ward for people with learning disabilities in Berkshire

The idea of using Active Support was developed as part of a service improvement plan for our inpatient services for people with learning disabilities, aimed at ensuring people were offered and involved in more meaningful activities, while also promoting people's independence and opportunities to help learn and develop new skills.

Active Support is a concept that was initially developed in the 1980s and 1990s looking at the levels of engagement for people with learning disabilities in residential care. It starts with the idea that "If I do something for a person I rob them of the opportunity to participate in that activity" so we need to cease to make assumptions about what people with learning disabilities can and cannot do but find ways of adapting tasks so that they can do them safely and to the best of their capability. (Bradshaw et al 2004).

Having something to do is important for people, without activity we become bored and can start to behave in ways others find challenging (Ockenden 2016). Active Support can reduce challenging behaviour and should form part of an individual's positive behaviour support plan (Toogood 2016, Ashman and Beadle-Brown 2015, Beadle-Brown et al 2012).

There are four components to Active Support:

- People are offered opportunities to take part in everyday activities – these activities need to be real and meaningful to that person.
- Staff work as a team so that they can schedule and co-ordinate the choices and opportunities they offer
- Tasks are broken down into component parts so that the individual with learning disabilities can undertake the parts they can do
- Staff need to monitor and keep records of what they do and how to support the individuals with different tasks. (Mansell et al 2002)

The concept of Active Support is that people are encouraged to participate in activities with just the right level of support for them. This could be taking part in the whole activity or just a specific part. The aim is to support each person across a range of different activities from the everyday chores e.g. making their bed, making a drink to more pleasurable ones such as going out shopping (or other activities an individual particularly enjoys or is motivated by). Using this approach has the potential to build up individual feelings of self-worth and achievement that benefit emotional wellbeing.

It was accepted that Active Support was transferable into the inpatient setting and having meaningful activities would give the people staying within the service the opportunity to have more choice, independence and control.

To be effective the implementation of Active Support needs to be truly person centred, ensuring that activities are tailored to both the person's own interests and strengths, while also taking account of their current needs and circumstances (including their learning disability and mental health at the time). This is

skilled work and requires insight, creativity and imagination. On admission the knowledge of an individual's ability to perform tasks needs to be determined in order to gain an accurate picture of each person's interests and abilities. Activities should dovetail with their life at home e.g. continuing skills and activities (wherever possible) that the individual was doing when at home and in their community. And these should then also form part of any discharge plans so that when they return to their home there is again continuity.

The key to Active Support is the staff team working in a planned and deliberate approach to support the person in each of the designated activities – and in fact to aim to be more active in all their communications. To support the team there were four day long training sessions established to enable the whole team to be involved in learning more about the Active Support model. The training used a mixture of discussion, practical activities and PowerPoint presentations.

Evaluations of the impact are still in the early stages but by introducing person centred Active Support it is providing an opportunity for people within the service to have more involvement and engagement in both everyday and more significant activities, and this was recognised in our recent inspection by the Care Quality Commission. Furthermore, involvement and engagement is important for good mental health and therefore can have a pivotal role to play in helping people to recover and support their return to their community, helps to foster a greater self worth and promotes independence. So while this project is still in its early stages, with the on-going support from the staff team and management it can continue to develop further and thrive to positively impact on the experience of people using our services.

MARY WAIGHT IS EMPLOYED BY BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST AND IS CURRENTLY UNDERTAKING A SECONDMENT AS A TRAINEE CONSULTANT PRACTITIONER (OCCUPATIONAL THERAPY) WITH HEALTH EDUCATION ENGLAND

RALPH CHANANDA IS A REGISTERED NURSE AND THE SERVICE MANAGER FOR BOTH THE SPECIALIST INPATIENT SERVICE AND THE INTENSIVE SUPPORT TEAM PROVIDED BY BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

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Implementation of STOMP at Hertfordshire Partnership University NHS Foundation Trust (HPFT)

STOMP, launched by NHS England in 2016, has the key aim of addressing the overprescribing of psychotropic medicines in people with learning disability, autism or both without a documented diagnosis of mental illness.

Many of these medicines have adverse effects which may increase the health inequalities currently experienced in people with learning disability and this is a key driver behind STOMP.

STOMP at HPFT

The following approach is being developed in HPFT Essex Learning Disability Services:

- Service users that qualify in this STOMP cohort have been identified by psychiatry.
- A Positive Behaviour Support (PBS) pathway for people with learning disability presenting with behaviour that challenges has been devised.
- A dedicated STOMP clinic will be set up in order to optimise medication.
- Service users and their carers will be given a STOMP passport, which will include information on STOMP, use of off label medication and information about the particular medication in an easy read format to help them engage with the process
- The nursing team with pharmacy input will deliver a programme of training to stakeholders such as social workers and care providers
- A baseline Behaviour Problems Inventory for Individuals with Intellectual Disabilities (BPI S) has been performed on all patients to assign the STOMP cohort to the behaviour groups , denoted as stable/mild, moderate and severe problems
- A Quality- adjusted life year (QALY) and a Clinical Global Impression (CGI) will be carried out for all service users assigned to the STOMP cohort when they embark on the pathway and at the end of the intervention in order to provide evaluation.
- Prior to optimising their medication all service users will have their physical health needs assessed, identified and supported. A risk assessment and management plan will also be developed and implemented
- The people assigned to the 'mild' group may have little or no involvement from the wider team. The people assigned to the 'moderate' group can be taken through the STOMP clinic via a standard PBS approach mode. Service users in the severe group will require a full PBS approach.
- The outcomes are assigned as successful discontinuation, partial reduction and inability to reduce.
- If the inability to reduce is due to issues identified in the social environment, this will be flagged up in a multi-disciplinary team (MDT) meeting and commissioners informed of the same. This group of service users will need to be re referred on resolution of the issue. Any destabilisation of the service users whilst

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on this pathway that led to a Community Care Treatment Review or hospital admission will also be recorded. We will create a 'pathway tracking' tool for the people assigned to the STOMP Clinic programme.

This STOMP project is an example of collaborative working within a mental health community learning disability team. Once fully implemented it is hoped that clinical audit and evaluation will demonstrate improved health outcomes for people with learning disability, addressing the health inequalities that currently exist.

DANIELLE ADAMS, PRINCIPAL CLINICAL PHARMACIST
DR INDERMEET SAWHNEY, CONSULTANT PSYCHIATRIST
EDWARD JONES, COMMUNITY SERVICE MANAGER

Restraint Reduction toolkit

The Selden Centre, an inpatient assessment and treatment unit for people with learning disability, has developed a system level programme to reduce the use of restrictive physical interventions. The 'Restraint Reduction toolkit' includes a range of interventions in different areas of the healthcare service that we deliver. Some areas of intervention include; workforce development (with managing challenging behaviour meetings and yearlong support working PBS training) and care planning processes (with PBS plans including planning for non-physical responses, noticing early warning signs and restraint protocol). Part of this toolkit, is a quarterly audit to monitor the use of restrictive practise (both physical and chemical). This includes a range of data including:

- Time of day that restraint occurred.
- Different types of restraint holds used (categorised by their restrictiveness).
- Length of time in holds.
- Staff members and client involved in restraint.
- Injuries to staff and clients.
- Number of holds in relation of bed occupancy of the unit.
- Overtime comparison of data (looking for trends and patterns of the above).

The audit also looks into the accuracy of recording; looking at how well incident forms/case notes have been completed and accuracy of reporting; ensuring every use of restraint is shared at the client's weekly 'My meeting' (MDT meeting). The audit is then shared at a restrictive physical intervention meeting, attended by the Risk team, LD Director and the 'prevention and management of violence and aggression' team. This meeting adds context to the data and enables the team to look for trends and patterns and to understand how we can further use proactive strategies and only use restraint as a last resort. Any actions are named and dated and the

Since recordings began (October 2011), the numbers of restraint incidents have reduced from around 70 incidents a quarter, to around 20. Similarly the use of more restrictive restraint (such as prone) has shown

a decrease during this time and behaviours that can challenge are being managed with less restrictive interventions.

This knowledge has allowed the service to produce some targeted pieces of work, further reducing restraint usage. For example, the peak time of day for incidents to occur was during the lunchtime period. Following further data analysis, observations of lunchtime and discussing with client around their views the general atmosphere of the unit at lunchtime, a 'Lunchtime analysis report' was developed. This had some clear actions for improving the lunchtime environment for all staff at the Selden Centre, including offering more food choices to clients, re-arranging the setup of the environment to reduce how busy/crowded it could be and making sure noise levels were kept to a minimum.

Similarly, the audit concluded that debriefs were being routinely offered to clients after incidents, however, this was done in a verbal way. Following this, we have developed some debrief tools, names 'My Restraint story' and 'Seeing Restraint story'. These are easy read and interactive communication tool which facilitate a conversation following the use of restrictive interventions, for clients who have been restrained, or who have witnessed restraint.

SUSSEX PARTNERSHIP TRUST
MURRAY.KIDGELL@SUSSEXPARTNERSHIP.NHS.UK
SAMUEL.COE@SUSSEXPARTNERSHIP.NHS.UK

Development of the Nurse Prescribing Role in Learning Disability Services.

A pilot project was developed in 2014 to support development and implementation of a nurse prescribing role. Following completion of the pilot a review was undertaken and information and feedback was gathered from a variety of sources including service users, carers, other professionals and clinical audit in order to inform role evaluation. Responses were overwhelmingly positive from all participants identifying positive benefits for service users, and resulted in approval of the role on a permanent basis. The role has continued to be developed as an extension of the Community Nurse role, the focus being medicines rationalisation, with positive outcomes and improved quality of life having being realised for many service users as a result of significant reductions in, or discontinuation of Psychotropic medication.

The role supports the application of specialist knowledge, in depth pharmacological knowledge and advanced clinical decision making skills to mitigate the risk of over use of medication. Holistic biopsychosocial nursing assessments are undertaken which enables more accurate clinical formulation, informs decision making and supports evidence based prescribing rationale. The role ensures medication is not prescribed or reviewed in isolation but is considered alongside other non-pharmacological nursing interventions which reduces the risk of behaviours which challenge services being managed through psychotropic medications alone.

The increased time and flexibility available versus that of medics enables more frequent contact with service users and carers, supporting an enhanced therapeutic relationship and allows for the provision of information to be tailored to meet individual need. This increases service users' participation in decisions concerning their care and treatment, in turn supporting concordance and improved physical health monitoring. Increased contact additionally ensures more frequent review of efficacy and monitoring for adverse effects, and allows changes to be initiated in a timely manner.

Although there are many examples of positive outcomes for service users the following case studies provide a general overview.

Case 1 – on referral - prescribed BNF maximum daily adult dose of antipsychotic medication

62 year old gentleman who has a Moderate Learning Disability, Autism, significant communication difficulties, and a long history of behaviour which challenges services in the form of physical aggression. Inability to participate in health examinations/ investigations and risk of placement breakdown was high.

Holistic biopsychosocial nursing assessment informed the development of communication and hospital passports, positive behaviour support plans and enabled attention to be given to positive occupation and engagement. There was a large focus on training and education for the support team and as consistency in approach improved, partnership working with the GP enabled underlying physical health needs to be identified and appropriately managed. Medication has been slowly reduced and discontinued.

Case 2 – on referral – prescribed two antipsychotics, one anti-depressant, one benzodiazepine, one mood stabiliser and anticholinergic medication.

62 year old lady with Moderate Learning Disability , Emotionally Unstable Personality Disorder , Dementia, history of Depressive Disorder and Type II Diabetes. Longstanding history of self-harm and absconding requiring a guardianship order to be in place. Concordance difficulties were present with both medication and diabetic management resulting in hospitalisation. Restricted opportunities and experiences were evident due to risk behaviours.

Again a range of non-pharmacological interventions have enabled a number of medications to be discontinued. One antipsychotic and one anti-depressant medication remaining, further reductions are pending. In addition the diagnosis of Dementia has been revisited and removed. The guardianship order also has been able to be removed as no longer required. There are no longer concerns with concordance and physical health needs have been identified and are appropriately managed.

There is little doubt that the nurse prescribing role is a positive one, which can only serve to improve service user outcomes and patient safety through holistic assessment and nursing intervention which directly supports evidence based medicines rationalisation. There are currently plans to further enhance the role of the nurse prescriber across the service through inclusion in the workforce strategy and by supporting the development of others into these roles.

MELANIE WEBB CONSULTANT NURSE: LEARNING DISABILITIES
SOUTHERN HEALTH NHS FOUNDATION TRUST MELANIEWEBB@SOUTHERNHEALTH.NHS.UK

Stop overmedicating people who have learning disabilities, Autism or both with psychotropic medication (STOMP)

STOMP is a national campaign that followed the Winterbourne view scandal. Led nationally by an expert reference group, local actions are required to improve the quality of life for people with learning disability (LD), by reducing the harm of inappropriate drugs which are used as a 'chemical restraint' in place of other more appropriate care and treatments.

In Derbyshire the LD Strategic Health Facilitation Team (SHFT) are learning disability nurses that support GP practices with their LD Annual Health checks, and work to reduce health inequalities. The team are supported by 3 people with learning disabilities employed as Assistants.

The aim of the STOMP campaign is to make medication a last resort and supports NICE guidance. The SHF Team have:

- Told carers and people with LD e.g. LD Partnership Boards, Carers forums
- Raised awareness in Care services e.g. Council Care Home Forum
- Talked at Medicines Management Teams in 4 CCGs
- Informed GPs and Practice Nurses
- Added to the specialist NHS LD service Clinical Reference Group work plan
- Informed Community Learning Disability Teams
- Provided resources e.g. easy read workbook
- Worked with CCG LD GP Lead and Pharmacy Teams on auditing GP practices, resulting in review prompts within the GP system

Created new resources e.g. video for NHS England https://www.youtube.com/playlist?list=PL4shZXQ9YqmIFPJX02IWJvhHqdrMf_EkO

Future plans include:

- Web pages aimed at Pharmacists to support reasonable adjustments.
- Pod cast with CCG Safeguarding due for release
- LD Nurse led clinics with GP Practices.

In addition our Consultant Nurse who works across Learning Disability and Mental Health Service supports the service to subscribe to the POMH-UK (prescribing observatory for mental health) antipsychotic audit. The aim is to help specialist Mental Health Trusts improve their prescribing practices. Performance is benchmarked against other Trusts and identify where prescribing practices meet nationally agreed standards.

FOR FURTHER INFORMATION CONTACT: GAYNORWARD1@NHS.NET JACKIE.FLEEMAN@NHS.NET

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CAMHeleon Award Development

Northumberland, Tyne and Wear NHS Foundation Trust is a large mental health and learning disability trust. The Trust has an ongoing service improvement programme to reduce the application of restrictive interventions, Talk 1st, the programme takes an inclusive approach and includes all its inpatient services and some community services.

Learning disability services have from the beginning of the programme played an integral part within the programme, often adapting techniques and interventions from other specialities within the trust.

One such intervention is Star Wards initially designed for adult mental health environments is now being adapted right across our LD and Children and Young Peoples services (CYPS)

All of our inpatient wards and two community teams have fully embraced the Star Ward 75 ideas, to promote a better experience of our services for people that engage with them. Our CYPS wards all either had their Full Monty award from Star Wards, this award says that all 75 ideas are embedded on the ward.

Leaders within the CYPS services realised that often they were adapting some of the ideas to better reflect the needs of the young people in their care. This then led to a conversation with Star Wards and it was agreed that a new set of criteria would be developed.

The CAMHeleon award is attained by wards that show at least five examples in the COLOURFUL themes that are;

1. Caring Relationships
2. Opportunity and Expression
3. Leisure and Therapeutic Activity On and off the Ward
4. Understanding
5. Relational and Physical safety
6. Family and Friends
7. Unique Recovery Journeys
8. Learning and Growth

All of the CYPS wards in the trust have successfully attained CAMHeleon Colourful Award status at the first time of asking and continue to develop their CAMHeleon action plans. Our Learning Disability (LD) wards within the CYPS service have had particular success in supporting young people to make positive changes to their ward through art. There has also been great success in supporting the young people in the LD setting to discuss amongst their peer group and with staff the types of activities and additions that will make the ward a better place to be.

The staff team at Lennox ward have supported their young people to challenge restrictive practices that have prevented types of activities and games from happening through a process of identifying a restriction, challenging the merits of the restriction and then taking their suggestions to the relevant management meeting, for example the trust wide safety meeting. The outcomes of these challenges are then fed back and the appropriate changes implemented.

Stephenson ward are a great example of supporting the young people to make positive changes to their environment through expressing themselves in art projects that are to be permanent additions to the ward. Not only does this make the ward environment less clinical, it also builds the self-esteem of the participants and makes the ward a friendlier place for future admissions.

This window was created by a very talented young person, this is one of the first things you see on arrival to the ward and is far nicer than a large blank window. The example below is art produced by another young person, this art has positive messages and turns a plain white wall into something fun. Both of these examples have had a positive impact on the artist themselves, to be trusted to create something permanent, to have your skills recognised and nurtured can only be positive as these young people develop into young adults.

The great thing about CAMHeleon is that it fosters the sharing of ideas. This happens through CYPS Talk 1st meetings as well as Talk 1st cohort review days. The cohorts also allow these ideas to be cascaded across adult services with great results.

CAMHeleon will continue to develop in our LD CYPS services as there is a continual drive to create the best possible environments and experience for young people dealing with circumstances that anyone would find difficult. The development of ideas captured in CAMHeleon action plans is enhancing the day to day experience of these individuals.



ANNE MOORE GROUP NURSE DIRECTOR SAFER CARE
 DIRECTOR OF INFECTION PREVENTION AND CONTROL
 NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST
 ANNE.MOORE@NTW.NHS.UK



Report from Peter Hasler – Development Officer

Avril Devaney will step down as Chair of the Forum next year and Mel Coombes has been elected to take her place. Thank you Avril for all you have done to raise the profile of the Forum and lead it so brilliantly.

The Forum continues to go from strength to strength and hopefully responding to the memberships needs and requests. We have maintained our 100% membership of NHS providers in England and strong membership from Wales and the the majority of private/charitable sector providers. As many of you will know, we have a number of senior Nurse Directors retiring this year and next - so it will be vital that we welcome and support those who take on these posts.

I wanted to give a brief summary of some of the work we have done in the last year - and continue to work on going forward:-

- The commissioned policies guidelines on "Observation" was completed and is now being used by organisations. The "Search" policy is now being circulated as a final draft.
- We have a proposal to work with Sean Duggan at the NHS Confederation to provide a series of masterclasses in 2019 for our Aspiring Directors.
- The third Ward Manager/Team Leader conference was held on June 22nd 2018 and extremely well attended with a range of fantastic speakers.
- The 4th Mental Health Student Nurse Conference is now set for the 13th May 2019 to be held in Edinburgh. The Chief Nurse of Scotland - Professor Fiona McQueen will open the event as keynote speaker. We expect about 400 students - and recruitment stands at £3000 are available to book.
- Nurse Consultants - we are looking to celebrate the 20th year of the Nurse Consultant role being created in July 2019. Please keep me informed of new posts and also those that have been lost.
- We have a "Supporting Families" event on the 7th March 2019 as a result of the one day session we held this year on the 30th May with the Coroners office relating a suicides and untoward deaths which was able to produce new practice notes for Trusts.

We have more work to do in supporting our colleagues in the community health services within organisations - a network has been set up and we plan to held an event in the new year.

The Forum provides fantastic value and I am personally looking forward to the forthcoming year of activities.

PETER HASLER
PVHASLER@GMAIL.COM
07777661716



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