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At each conference we publish a newsletter which we use as an opportunity for sharing good practice, examples in the areas of work that senior nurses and nurse directors lead on.

" Whilst it has been the most challenging two years, boy has it been productive."

Love Our People and Celebrate Them

"It is amazing how our nurses have stepped up to the challenge to support service users."

We are back! Welcome everyone to our 'Love Our People and Celebrate' conference. It has been a massive two years for us all and it is so good to see you all face to face to celebrate being here. We also recognise colleagues who are no longer with us and celebrate them also.

This year we asked for submissions about working practice, innovation, education, staff wellbeing and the response to the global pandemic. I am delighted with the response to this call and it is fantastic what has been achieved and delivered during this challenging time and I am looking forward to hearing the presentations at today's conference.

As we have just had Nurses Day, and reflecting on my 41 years in nursing, I have to acknowledge that the last two years have been the most challenging both personally and professionally. It has been a time to reflect on what is truly important to us as nurses and has given us an opportunity to strengthen our focus on person-centeredness for all service users and staff.

Whilst it has been the most challenging two years, boy has it been productive.

It is amazing how our nurses have stepped up to the challenge to support service users, to stay safe in everyday practice and the skills demonstrated in IPC practice has been enormous. In addition, the innovation shown in delivering care examples have included the development of wellbeing hubs and COVID-19 vaccination clinics. The work to support BAME staff and service users has highlighted our need to be aware of the importance of addressing health inequalities, and as a profession we are well placed to do so.

It has been an extraordinary time where the NHS has been at its best, pulling together with partners to support one another against COVID-19, particularly prior to the development of the vaccines. I am also acutely aware of the challenges our students have had during this time and we appreciate you and your contribution.

Well, enough from me. Have a great conference and catch up time. Thank you all for all you do.

Maria Nelligan
Chief Nurse Officer

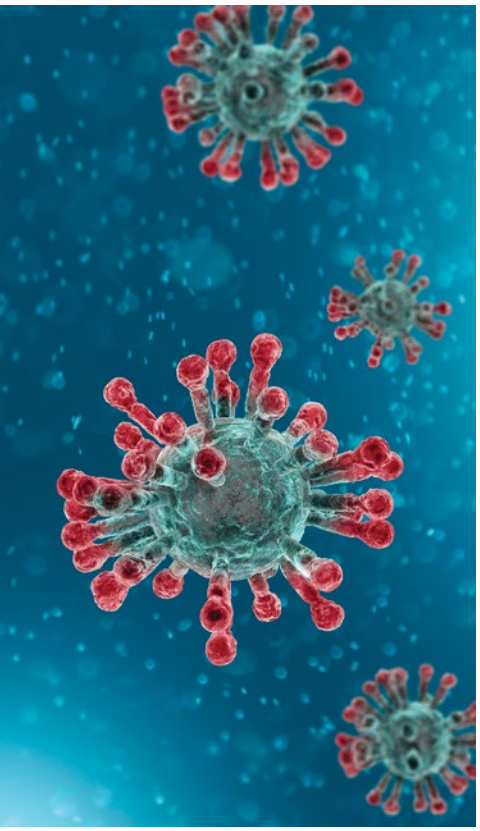
LeadingMinds

COVID-19: A systematic evaluation of personal protective equipment (PPE) performance during restraint

Roland Dix[1], David Straiton[1], Peter Metherall[2], James Laidlaw[1], Lisa McLean[1], Andy Hayward[1], Gary Ginger[1], Louise Forrester[1], Paul O'Rourke[1] and Rob Jefferies[3]

KEYWORDS

COVID-19, infection control, mental health, personal protective equipment, physical intervention, restraint



ABSTRACT

Background: Restraint is widely practised within inpatient mental health services and is considered a higher risk procedure for patients and staff. There is a sparsity of evidence in respect of the efficacy of personal protective equipment (PPE) used during restraint for reducing risk of infection.

Methods: A series of choreographed restraint episodes were used to simulate contact contamination in research participants playing the roles of staff members and a patient. For comparison, one episode of simulated recording of physical observations was taken. Ultraviolet (UV) fluorescent material was used to track the simulated contact contamination, with analysis undertaken using established image registration techniques of UV photographs. This was repeated for three separate sets of PPE.

Results: All three PPE sets showed similar performance in protecting against contamination transfer. For teams not utilising coveralls, this was dependent upon effective cleansing as part of doffing. There were similar patterns of contamination for restraint team members assigned to specific roles, with hands and upper torso appearing to be higher risk areas. The restraint-related contamination was 23 times higher than that observed for physical observations.

Discussion: A second layer of clothing that can be removed showed efficacy in reducing contact contamination. PPE fit to individual is important. Post-restraint cleansing procedures are currently inadequate, with new procedures for face and neck cleansing required. These findings leave scope for staff to potentially improve their appearance when donning PPE and engaging with distressed patients.

INTRODUCTION

The COVID-19 pandemic creates challenges for infection control in mental health inpatient units. One particular concern is the risk of infection when engaged in physically restraining a patient, often referred to in mental health practice as 'physical intervention' (PI). PI is a difficult area of practice which can be very distressing for patients and staff, with significant risks of injury. There are national programmes for reducing the need for PI.

At times PI is necessary to contain serious risks arising from acutely disturbed behaviour. Within the UK, there were around 60,000 episodes of restraint reported in mental health services between 2016 and 2017.[1]

Preliminary review of the literature indicates that there is a sparsity of evidence in respect of personal protective equipment (PPE) used during PI in mental health settings.

The majority of higher quality evidence for PPE used in health care is focused upon the effective use of PPE in general medical hospitals (GMH).[2–5] This paper describes a systematic evaluation of PPE undertaken to improve the understanding of the all around performance of PPE during episodes of PI. The project design was developed by the Gloucestershire Health and Care NHS Foundation Trust in collaboration with the National Association of Psychiatric Intensive Care Units (NAPICU), 3D

[1] Gloucestershire Health and Care NHS Foundation Trust, Montpellier Unit, Wotton Lawn Hospital, UK
[2] Sheffield Teaching Hospitals NHS Foundation Trust, Northern General Hospital, UK
[3] Avon and Wiltshire Mental Health Partnership NHS Trust, UK

Corresponding author: Roland Dix
Gloucestershire Health and Care NHS Foundation Trust,
Wotton Lawn Hospital, Gloucester GL1 3WL, United Kingdom of Great Britain and Northern Ireland. Email: roland.dix@ghc.nhs.uk

Imaging Lab, Sheffield Teaching Hospital NHS Trust and Avon Wiltshire Partnership NHS Trust.

Current mental health PPE guidance background

Public Health England (PHE) has issued guidance for PPE use in mental health settings.[6] However, no specific additional recommendations are made for the mental health procedure of PI.

NAPICU published guidance on managing acute disturbance in mental health which included recommendations for PPE in PI.[7] These recommendations were based on basic tests of PPE undertaken by PI training teams. The tests primarily considered which PPE was most likely to remain in place during PI.

At the time of writing, high quality evidence or evaluation of PPE effectiveness in PI procedures within the mental health setting is absent. This contrasts with general medical settings where specific types of PPE have been evaluated for use in specific procedures, e.g. aerosol-generating procedures.

The PPE currently specified by PHE for use in mental health inpatient settings is focused upon carrying out procedures that would also be carried out in a GMH setting. Examples of this include procedures which require staff to be within 2m or in contact with a patient, such as assistance with activities of daily living and recording physical observations.

There are procedures carried out in mental health settings that are comparable to general medical settings which require airway support, for example, resuscitation and electro-convulsive therapy, with the latter requiring an anaesthetic. For these procedures, current evidence supporting use of specific PPE is considered largely applicable to mental health settings.

PPE-relevant procedures specific to mental health inpatient settings

Providers of mental health inpatient services, particularly 'locked door services', have an authorised approach to managing disturbed/ aggressive behaviour which can extend to PI. For the UK, a broad description of PI is contained within Chapter 26 of the Mental Health Act Code of Practice (2015).[8]

Physical intervention

There are a variety of different systems for PI used by mental health service providers in the UK, although all share similar characteristics. These are:

- A team of staff (often three) with specific roles, i.e. number one responsible for supporting the head and numbers two and three assigned to securing the patient's arms.
- A defined series of techniques that can be employed by members of staff to physically intervene to restrict the movement and contain serious risk represented by the behaviour of a patient.
- PI for relocating a person presenting various levels of resistance.
- PI methods for containment of risk within a deescalation process resulting in the discontinuing of the need for PI.
- PI within which it is possible to administer medication parenterally.

Physical intervention and risk

PI carries its own risks of injury to patients and staff. These include uncertainty as to the level of control that can be achieved in any given situation. Furthermore, PI episodes can often be difficult to predict in terms of the levels of resistance, amount and nature of close contact, or the length of time an episode will take to conclude.

PI is considered amongst the highest-risk procedures used in mental health settings and is governed by law. It often causes distress and should only be implemented when there are no less restrictive alternatives. Reducing risk of injury for all those involved is a central international consideration for the application of PI.[9,10]

It has long been recognised that at times, additional risks to the staff can include increased possibility of infection from close proximity to spitting, biting and scratching.[11,12]

Physical intervention and risk to staff of COVID-19 infection

Since first being identified in December 2019, COVID-19 has proven to be highly infectious, leading to unprecedented measures of 'lockdown' and mandatory social distancing. Specific details of how COVID-19 spreads remain subject to study. It has been established that contact contamination represents a significant infection method. The extent to which COVID-19 can spread by aerosol remains subject to debate.[13]

Episodes of PI require very close physical contact between staff and patient. Within the process of close contact, there is also potential for physically challenging struggle during which opportunities for contact transmission of COVID-19 are increased.

The following are common characteristics of PI which may be considered to increase the risk of COVID-19 and other infections:

- Bodies are in physical contact with each other, particularly hands, providing direct opportunity for contact contamination.
- The extent to which any PPE will remain in place and able to withstand high levels of demanding physical activity.
- The potential for any PPE to be purposely damaged or attempts at removal made by the recipient of PI.
- Potential for very close proximity between the head/oral and nasal region between those involved in PI. This can range from 50 mm to 500 mm.
- Potential for very close-proximity directed projection of larger droplets of oral fluid, e.g. by spitting.
- Potential for very close proximity shouting, coughing and raised voice projecting smaller particles of respiratory and oral secretions.[14]
- Increased respiratory rate and depth resulting from physical exertion, increasing the possibility of secretion and/or inhalation of virus-containing material.

Evaluation questions

This paper aims to address the following questions:

- How does PPE perform in mitigating contact contamination during PI?
- What is the pattern of contact contamination arising from PI?
- What are the specific PI issues for the robustness and comfort of PPE?

This paper aims also to identify suggestions for improvement.

METHODS

Review of literature

We searched nine databases including BNI, PsycInfo, Cinahl, Embase, Medline, Emcare, Google Scholar, World Health Organization, Global research on Coronavirus disease (COVID-19) database and medRxiv/bioRxiv COVID-19 SARS-CoV-2 preprints. We searched for all published evidence within these databases before 6 May 2020. We used search terms of Coronavirus, COVID, infection, infection control and physical restraint, physical intervention, restraint, mental health, psychiatry. In total, 276 published papers were retrieved; however, none contained evidence specifically covering PPE and infection control during restraint in mental health.

Contact contamination

12 participants, divided into three groups of four, were used to undertake three episodes of simulated PI. Each of the episodes involved one participant representing the infection source (patient) and the remaining three representing members of a PI team (staff). In each episode the simulated PI followed a predetermined choreography, and in each episode the group playing the role of staff donned different PPE.

The participant representing a patient infected with COVID-19 had ultraviolet (UV) material placed in the areas of the body most likely to contain infectious material, i.e. lower face, upper chest, arms and hands Spitting of oral fluid was simulated using UV fluorescent material consistent with training aids for infection control. All three episodes were completed using different staff in physically separate areas to remove the possibility of cross-contamination between the three episodes.

Following the PI episode, the amount and location of contact transfer of UV fluid between simulated patient and staff was recorded by UV photography.

Non-contact contamination characteristics of PPE performance

The following was also subject to evaluation:

1. The extent to which the PPE remained in place.
2. Potential or actual hazards arising from the PPE.

3. The ease with which the different PPE sets could be donned and doffed.

4. Comfort of the PPE during use.

Criteria for selection of PPE sets evaluated in the PI scenario, the extent to which PPE will remain in place may be equally as important as the infection control specification.[7] Pre-evaluation tests determined that the following criteria for the selection of the PPE should be formally evaluated:

A. PPE generally considered mainstream with commercial mass production.

B. PPE items were likely to remain in place.

C. PPE items less likely to increase risk in the context of PI (e.g. slip hazard).

D. PPE items known to have some infection control value.

E. PPE worn as standard by staff during shifts. The items were likely to have differences in the PI context worthy of comparison. These included:

F. Efficacy in preventing transfer of simulated infectious material.

G. Time taken to don and doff.

H. Potential for cross-contamination while doffing.

Infection source test subject (ISTS) preparation

Under the supervision of an Infection Control Specialist Nurse (ICSN), the same amount of UV fluorescent substance was placed on three different participants assigned the role of patient on the areas likely to contain infectious fluid on a COVID-19-positive patient. These areas were hands, nasal and face region, and the anterior aspect of patient torso. The face and arms were contaminated using two different colours (hands and arms green coloured, face and torso blue coloured).

At two points during the PI episodes spitting was simulated. This was achieved by means of a spray bottle containing UV material of a third colour (red). This was directed towards a participant's face to simulate transfer of oral fluid by spitting.

- Point One: spray bottle 150 mm away from the target.
- Point Two: spray bottle 300 mm away from the target.

Test staff members (TSM) preparation

Pre-test donning and doffing preparation. After standard training following an Infection Control Action Card, nine participants who were staff from the Physical Interventions training team assigned to the role of TSM (staff members) donned and doffed the three different PPE sets in Figure 1.

Donning. Donning and doffing for all TSMs took place in an area of 4 square metres with two chairs present and a standard size peddle bin. Each team of three TSMs had a separate area. Time taken to don was recorded. Donning and doffing was observed by the ICSN, who recorded any issues against a standard checklist. Any correction advice needed or offered by the ICSN was also recorded.

Cleansing. In order to simulate the cleaning facilities available at the site of PI episodes in mental health inpatient facilities, universal wipes (branded Clinell) were used for personal cleansing.

PI simulation. The following PI procedures were choreographed and enacted in three episodes as a linear progressive sequence of similar time duration (4.5 min).

- Immediate containment of assault.
- Relocation.
- De-escalation.

Data collection and analysis

Contact contamination. A darkened photograph booth was constructed which was illuminated with visible and/or UV light. Within controlled parameters, full body photographs were taken of the test subjects at the following points:

1. Pre-donning PPE.
2. Post-donning PPE.
3. Post-PI simulation with PPE.
4. Post-doffing without PPE.

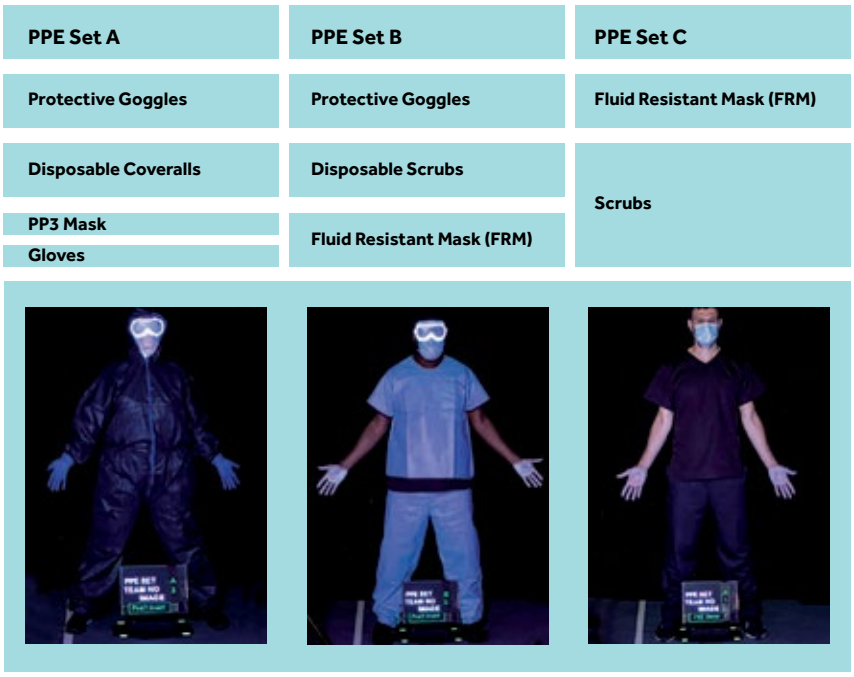


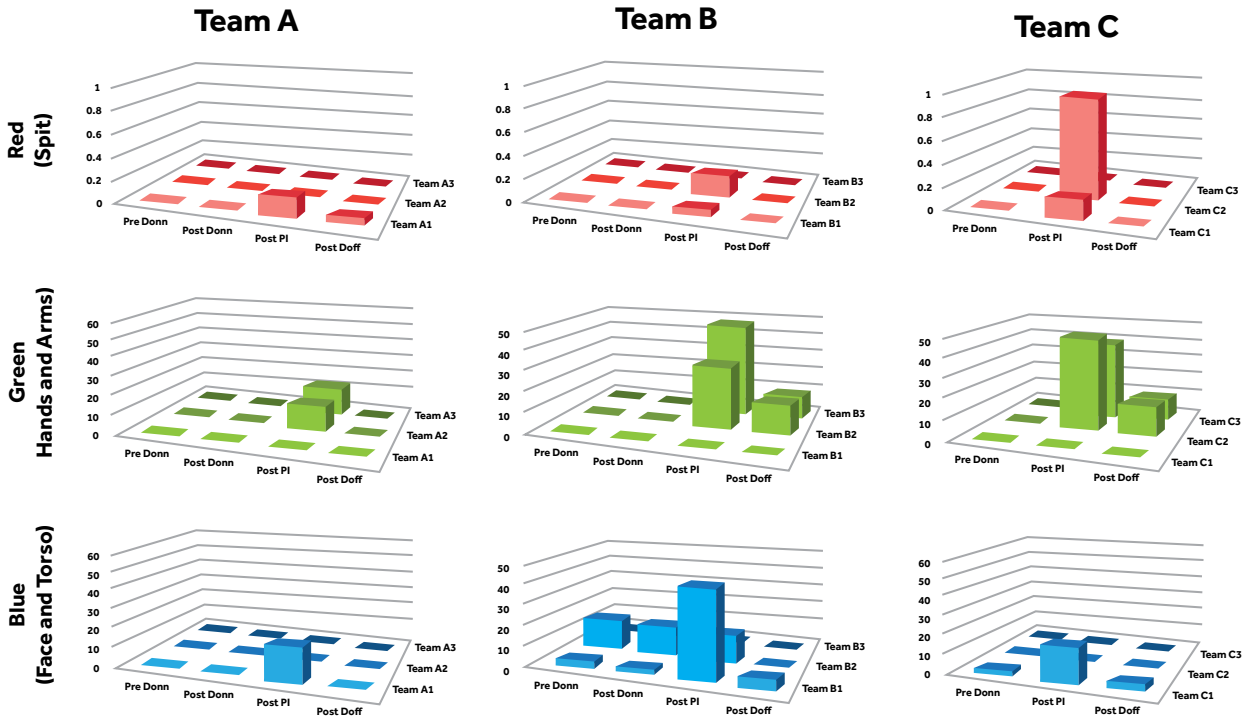
Figure 1. PPE sets donned.

PPE Set C did not require donning of PPE as they were already wearing scrubs and a mask, representing the standard uniform of a member of staff on an inpatient mental health ward. As such, there were only three sets of photos required for this group.

Image analysis. Comparison of the simulated contamination was made between the different PI episodes and contamination types using a standardised analysis of the UV photographs. Established deformable image registration techniques were implemented (MIM Software, Cleveland OH) to align all visible light photographs for the definition of nine standard regions (head, neck, four thorax regions, arms, hands and legs). These were then applied to the UV photographs to measure the regional distribution of the contamination.

Detection of the coloured dyes was performed by segmenting the UV photographs using a clustering methodology (k-means clustering with UV images converted to the CIE L*a*b* colour space).[15] Here, the dominant colour of each dye (and other background features) was found from photographs of the ISTS prior to the PI. These colours were then used to partition the TSM photographs to identify areas of contamination. Combining this segmentation with the regional body contours permits a zonal analysis. Some manual editing was required to exclude regions of clothing which appeared blue in the UV image. Non-contact contamination characteristics of PPE performance. Each TSM was observed during and interviewed following the three simulations. The three episodes

Figure 2. Graph to show the origin and total accumulation of UV material ('contamination') during the sequential experiment steps.



were video recorded (including donning and doffing). The videos were reviewed by a panel of Infection Control and PI specialists to identify any issues arising.

RESULTS

Determining the extent of contamination

There was evidence of contact transfer during the simulated episodes of PI (Figure 2).

For general reference, a participant not involved in the PI episodes was 'contaminated' in the same manner as the simulated PI patient with UV substance. Following this their general physical observations (blood pressure, temperature and O2 saturation) were taken. The same method for tracking contact contamination was applied. When compared with taking physical observations, 23 times more contact contamination occurred following an episode of PI (single observation subject compared with average of all TSM participants).

Figure 2 shows a series of graphs demonstrating the origin and total surface area of UV material (representing contamination) for each team member during the sequential experiment stages; pre and post PPE donning, post-PI and post-doffing. Area units are arbitrary as no calibration of the camera system was performed; however, the results can be compared between subjects owing to the strict experimental method.

In all cases the graphs show peak contamination post-PI, but there are several cases where the contamination persists post-doffing. For the face and torso contaminate (blue dye), there is some level of UV fluorescence similar to contamination detected prior to donning of the PPE. This was considered likely to have originated from the Clinell wipes used to clean prior to donning.

Using the standardised regions, the regional distribution of contamination is shown for each team in the schematic representation of Figure 3. A graded greyscale has been used to display the summed contamination for each team, normalised to the maximum level found in all three teams. Each contamination type is treated separately.

The spit contamination (red) is concentrated around the head for all groups, although for team A and B some was also deposited on the upper torso. Team A showed some contamination remaining post-doffing.

The contamination derived from the hands and arms (green) of the patient was spread much more widely, but none was detected on the face and neck for any team. Team A, post-doffing had virtually no contamination, with only a very small amount remaining on the hands of subject A2. Teams B and C, however, show contamination remaining post-doffing, and this is concentrated on the hands and to a lesser extent on the arms and lower torso (Team B).

The contamination from face and torso (blue) showed a wider distribution including the head and neck. Similarly, the post-doff distribution was also wide, with the highest level found in the hands, but for team B contamination was still detected on the face. In all teams it was found that the PPE and skin cleaning product was clearly visible in the UV images, which in some cases was difficult to differentiate from the contaminant dye.

By aggregating the post-PI results for team members one, two and three over all the three groups, it is possible to see where the contamination is predominately derived from (Figure 4). The red (spit) contamination was only detected on team members one and two, and this was concentrated around the head with a smaller amount seen on the upper torso. The green contamination, originating from the hands and arms of the patient, shows that this was spread mainly to the hands and to the torso. The distribution for team members two appears to be roughly a mirror image of team members three. The blue contamination appears to spread much more widely, with no clear pattern demonstrated.

Summary of results

All three PPE sets showed similar performance in protecting against contamination transfer. For teams not utilising coveralls, this was dependent upon effective cleansing as part of doffing. There were similar patterns of contamination for restraint team members assigned to specific roles, with hands and upper torso appearing to be higher risk areas. The restraint related contamination was, on average, 23 times higher than that observed for the recording of physical observations.

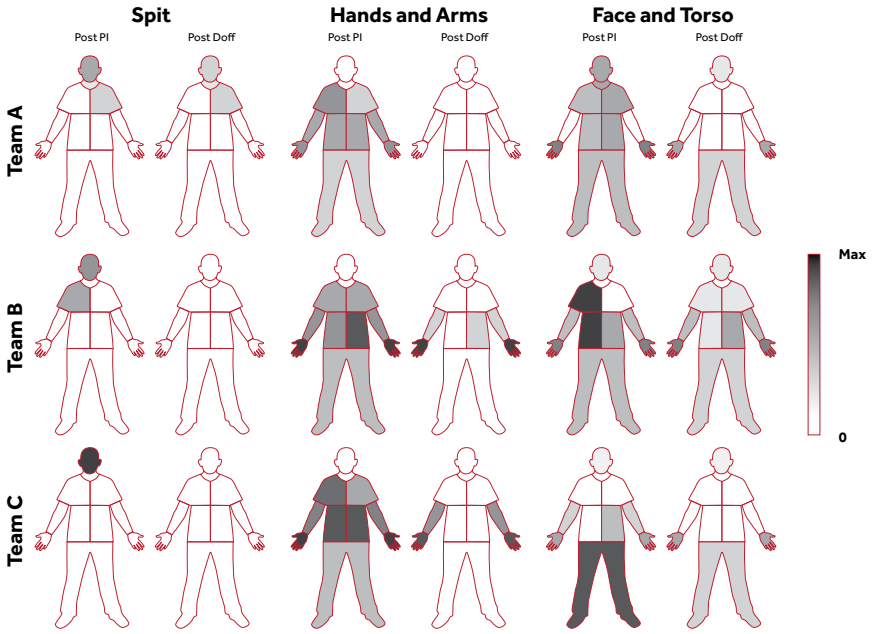


Figure 3. Regional contamination distribution. Comparison of post-PI to post-doff for each team. The totalised contamination for each team is shown normalised to the maximum in all three teams.

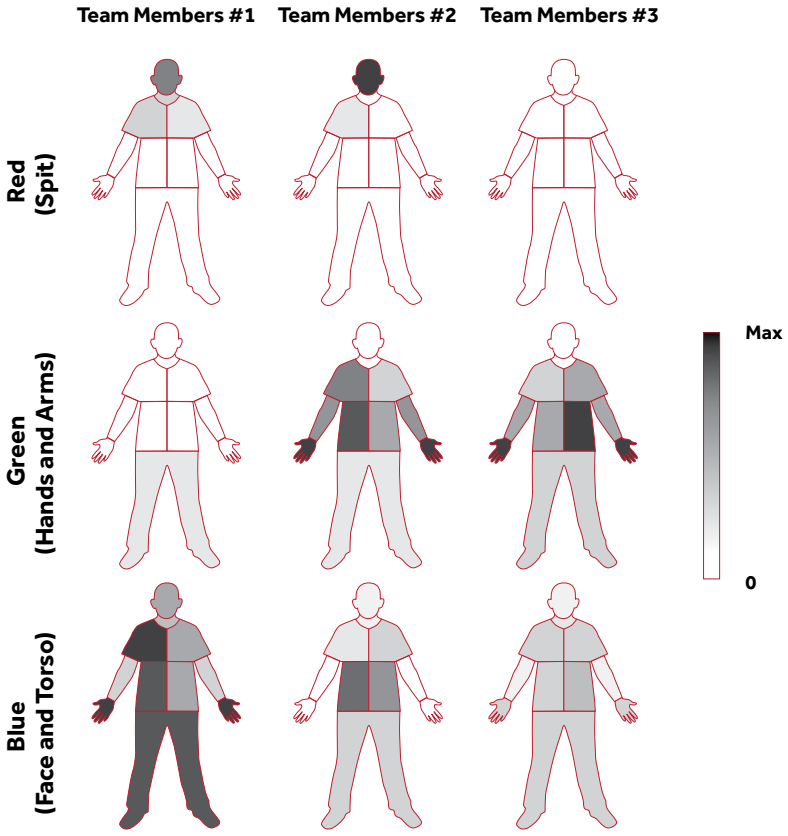


Figure 4. Regional contamination distribution, comparison of aggregate post-PI for team members one, two and three. The totalised contamination for each team member is shown normalised to the maximum for each contamination type.

Non-contact contamination characteristics of PPE performance

Goggles: The goggles remained in place, but on one occasion there was evidence of UV material breaching the goggles. The goggles quickly misted up and severely restricted vision. TSM reported some discomfort after 20 min.

Masks: There were no issues with FFP3 and fluid resistant masks in terms of comfort or hazards. They remained in place.

Coveralls: The zip marginally opening during the PI procedures caused high levels of heat and perspiration. TSM reported that the coveralls were very uncomfortable from overheating.

Disposable scrubs: There was one incident of the disposable scrubs ripping due to inappropriate sizing. However, they remained in place and were felt to be comfortable.

Scrubs: Remained in place, were comfortable, but had to replaced by alternative clothing post-doffing.

DISCUSSION

Contact contamination

All three of the PPE sets showed similar performance in the amount of transfer of contaminant. Pre-doffing, the location of containment was surprisingly similar between the teams.

Only PPE set A (disposable coveralls) provided protection of the arms. This set showed less UV contaminant in contact with skin in the arms area post-PI compared with Set B and Set C.

Of particular note was contaminant located in axilla region (coloured green) of numbers two and three in the PI teams (Figure 5). This arose from contact with the infection source hands and arms when they were secured using PI techniques. Numbers two and three (left and right side of the patient) in the teams received less contamination (coloured blue) compared with team member one originating from the face and chest area of the infection source.

Figure 5. Post-PI contamination of PPE Team C members 2 and 3.

Number one in the PI team (responsible for the controlling the head) had more UV material than the other team members on their hands and wrist which transferred from the face and torso area (coloured blue) of the infection source. Number one in the teams received less contamination from the hands and arms of the infection source (coloured green) compared with the other two team members.

Following doffing, all three PPE sets showed similar performance in protecting against contamination transfer. For teams not utilising coveralls, this was dependent upon effective cleansing as part of doffing.

One of the test subjects clearly missed cleansing an area of contact contamination in the arms. If the PPE had provided arm coverage, it is likely that this area would not have remained contaminated post-doffing.

Spitting

The spitting simulation (coloured red) presented particular challenges for the PPE. Both the fluid-resistant and the FFP3 mask were successful in preventing contact contamination. However, spit contaminant did breach the goggles and was found on the lower eye area of one of the test subjects (Figure 6). Contaminant was also found on the neck area, and automatic analysis identified small regions over the torso in a number of subjects.

Careful review of the video recording could not clearly establish how the contaminant breached the goggles. Theories include the front panel of the goggles becoming dislodged from the frame or the face seal of the goggles becoming displaced during the PI episode.

Spitting demonstrated the clear need for face and neck cleansing procedures that currently do not feature in standard cleansing advice for health care.

Non-contact contamination characteristics of PPE

This evaluation has demonstrated that PPE needs to be properly fitted to the wearer. Examples of this include the coverall zips travelling downwards during simulation as a result of being oversized for the individual. There was also an episode of disposable scrubs ripping on donning as a result of them being too small for the test subject's legs.

Two areas of major concern include the overheating experienced by the test subjects from the coveralls, and the goggles misting up to the point of severely restricting the vision of the PI team members.

Implications for clinical practice

It has been long established that donning and doffing PPE is crucial to its effective performance. This also requires PPE to be specifically fitted to the individual. Figure 5. Post-PI contamination of PPE Team C members 2 and 3. [8] Medicine, Science and the Law 0(0) rather than limited to a small number of sizing options. This evaluation showed diminished performance for some poorly fitting PPE.

For mental health inpatient practice, face and neck cleansing procedures are required and are possibly more important than previously thought. These are required to deal with the risk of spitting or experiencing pressure of speech while unable to observe social distancing.

Debate continues as to the extent to which COVID-19 is airborne, although this was not the focus of this evaluation. Given the specific characteristics of PI (physical excretion, very close contact, elevated voices), FFP3 standard masks would likely be preferable to fluid-resistant masks.

The specific context of PI involving high levels of physical exertion is a central PPE consideration. This requires PPE to be robust, comfortable and well secured. Of specific note is the need for eye protection to be robust and include mitigation against misting. This could be achieved by selecting robust goggle designs and preparing them with an anti-mist spray.

While offering higher levels of protection, overheating caused by coveralls as well as more difficult doffing observed in this evaluation suggested that alternatives could return satisfactory performance while mitigating these problems.

The evaluation suggests that a second layer of clothing which can be removed can be effective in minimising contact contamination following PI. This is, however, dependent upon there being effective cleansing equipment and procedures available following PI. Exactly what the second layer is may be less relevant than its presence.

This could be an important consideration in selecting PPE, providing more options including those with improved appearance for patients who may already be anxious and frightened in the acute mental health context.

Figure 6. Post-PI contamination of PPE Team A member 1.

The role of each PI team member within the procedure was shown to be relevant to the higher risk areas for contact contamination. For the staff member in charge of controlling the head, the hand and wrist areas were at higher risk of contamination. For those assigned to each side of the patient, then the respective side of the axilla region as well as hands and wrist were higher risk areas.

This evaluation demonstrates the need for further high quality evidence which is derived from the unique characteristics of mental health inpatient practice. The simulated PI used in this study is specific to inpatient mental health services. However, our findings may also have relevance to other public service sectors such as the police, prison service, care home and residential settings where PI may be implemented.

Ethical considerations

Members of the local ethics committee were consulted. The evaluation design did not involve any patients or patient-related data and therefore is considered part of standard procedure and equipment evaluation not requiring ethical approval. Valid consent to take part in the evaluation was provided by all involved.

Limitations of evaluation

The evaluation was restricted to contact transfer of potential virus-containing material from the patient to the staff acting in the PI.

The evaluation did not consider the potential for infection to be transferred from the staff to the patient in similar circumstances. Nevertheless, the conclusions drawn may guide support for patients in the areas of cleansing and changing clothes.

The evaluation did not consider potential for aerosol transmission of smaller material.

The transfer of UV material cannot be considered as an accurate representation of the volume of potentially virus-containing material transferred, although it does give an indication of the contact transmission areas that could contain virus material.

Some items of PPE (notably gloves and goggles) and the universal wipe used to clean the skin were clearly visualised in the UV light photographs with a colour close to the fluorescent dye used to represent contamination.

This made automatic segmentation of the dye distribution difficult.

Regions of contamination appeared overexposed in the UV photographs, with a bright white appearance. This was difficult to distinguish from lower-level contamination of the blue fluorescent dye.

The high-resolution close-up photographs showed that some contamination was not detected in the 32 whole-body images, albeit only very small amounts.

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LeadingMinds

‘Innovation, commitment and brilliance to those who needed care’

West Mental Health Liaison Team – Initiatives during COVID-19

The buddy system has been a successful initiative within the team, with staff commenting:

“I have found the buddy system useful, in that all are conscious about each others’ welfare and what kind of day they are having. This is one of the things we often take for granted and disregard. The buddy system has certainly underlined how immensely beneficial this can be.”

“I hadn’t realised just how important the ‘water cooler’ conversations were until they weren’t there anymore due to working from home.”

“Having moved to the liaison team after the first lockdown, the buddy system has allowed me to get to know the team in a more informal way, which has facilitated me feeling part of the team.”

Supporting Those who Support Others

During COVID-19 the need to support staff has been more important than ever. The Mental Health Liaison Service (MHLS) in West Essex has implemented two innovative ways to offer support those who needed care. These two ways include the ‘buddy system’ within the MHLS and reflective spaces to our acute care colleagues working on the COVID-19 wards.

1. The Buddy System

Professor Neil Greenberg argued that staff can regain control of their mental wellbeing in the work environment by building a trusting relationship with colleagues and developing peer support when going through difficult times. This can then create a sense of inclusion and belonging in the workplace (NHS People Plan for 2020/21). He therefore proposed the idea of a ‘buddy system’ where staff can take a few minutes once or twice a day to check in on another member of their team.

Since November 2020, the MHLS have implemented the ‘buddy system’ in their team. This provides the team with the opportunity to have an informal conversation with colleagues and take a break from their busy schedule, focusing on their own care so they can continue to care for others.

As a result of its success, a video was produced to share the idea of the ‘buddy system’ throughout EPUT, the local acute hospital, third sector and voluntary agencies and Health and Social Care.

2. Facilitation of Reflective Spaces

In addition to this, the need was highlighted for staff working in the local acute hospital to have a space to be able to reflect on their experiences of working throughout COVID-19. Psychologists from the MHLS facilitated the reflective spaces.

A total of nine groups were facilitated with 50 participants across three wards. One-to-one follow up sessions were offered to staff depending upon identified symptoms of trauma, low mood and anxiety being expressed during the reflective sessions.

To evaluate the reflective space, a questionnaire was emailed to participants so they could rate their experiences of it. The reflective spaces were well rated, with 100% of participants ‘agreeing’ or ‘strongly agreeing’ that there was mutual trust between the members of the group and they felt that any confidences they shared were respected.

Dr. Claire Warner
Clinical Psychologist
Essex Partnership University
Foundation Trust

Additionally, 95% felt that the reflective space helped to identify stresses that they may have at work.

Additional qualitative feedback mentioned that the reflective space was "very good and useful". Staff found that the professionals leading the session were "very approachable" and wish to have "regular reflective sessions for all staff to alleviate any anxiety or stress encountering at work or home".

Based on the responses, the MHLS identified what might be helpful to implement in the future, including; a rest space 'chill out zone'; CPD around managing anxiety and distress; the 'buddy system'; managers to be regularly visually present and for all staff to be offered a reflective space on a regular basis.

My journey

Since my early teens and through to adulthood, I have struggled with anorexia nervosa, during which time I have experienced periods of respite in addition to episodes of illness.

I feel fortunate to work in Hampshire CAMHS, a team which has consistently made my wellbeing a priority and views my lived experience as not only something they accept and are supportive of, but actually consider it to be an asset to the service. In 2019 through to 2021 in my last journey through treatment, I started journaling as a way to keep track of the learning

I was taking from both group and 1:1 therapy, and also as a creative outlet to help manage some of the emotional difficulties that arise through the process of recovery. The more I realised the value of this, the more I thought it might be something that could benefit other people, so in late 2020, I started to pull together some exercises and activities that aided me through the most difficult parts of trying to recover, both that I had learnt in treatment and that I had discovered to be helpful independently.

As I added to this document and it began taking shape, I had the idea to turn it into a book that other people could use too, and I was approached quickly by a publisher who was interested. Jessica Kingsley Publishers are an excellent team, who are front runners in publishing authors and books specialising in mental health, neurodivergence and LGBTQ+ topics, in addition to other health and wellbeing related content. They accepted the bones of my manuscript quickly and I was offered a publishing contract, so we spent the next year working together on turning my small project into a resource available to anybody struggling with eating difficulties.

I was thrilled to have Dr Emily David, a psychologist in Hampshire CAMHS with extensive experience of working with people with eating disorders, to write the foreword, and to give me her professional expertise on the content I had compiled and created.

In April 2022, my self help book The Eating Disorder Recovery Journal was officially published and is now available internationally. It includes writing prompts, creative activities, colouring pages and CBT based skills, all of which have helped me with my recovery.

I started in Hampshire CAMHS as a nurse in 2017 after many years working in inpatient CAMHS, and was given the opportunity to do additional training in cognitive behavioural therapy. I have recently started working as a CBT therapist in the newly developed digital team which I am very excited about, and who again have been overwhelmingly supportive of the work I do to support people with eating disorders outside of Hampshire CAMHS.

I am hopeful that this resource can be beneficial to young people and adults alike and support them to progress in their recovery and develop freedom and a life outside of their eating disorder, just as I have been able to do.

Cara Sturgess
Specialist Psychological Therapist
Hampshire CAMHS Blended Digital Team
Sussex Partnership NHS Foundation Trust

A review of the human factors that impact on successful organisational mergers

Cumbria, Northumbria, Tyne and Wear Mental Health Foundation Trust (CNTW) is one of the largest Mental Health and Learning Disability Trusts in England. In 2018 CNTW Secure Care (Forensic) were successful in securing funding to build a new medium secure (MSU) unit in the Northeast. This provided opportunity to expand Medium Secure mental health beds to meet the increasing demand in the North identified by NHS England. This change additionally resulted in a retraction of bed-based Learning Disability services through the Transforming Care Programme.

The new build programme, named as CEDAR (care environment and development provision) provided the vision of creating a centre of excellence for the male secure in-patient provision supported by a clinical workforce and leadership team with both expertise in working with those with mental health difficulties and/or a learning disability. To operationalise the model there is a requirement for the relocation of mental health services and an integration of the mental health and learning disability workforce. It is recognised that, whilst such change may be perceived as creating initial disruption in ways of working, it is also an opportunity to further develop services and the workforce.

As identified by the NMC (2021) nursing shortages are a global problem. As a Nurse Consultant with experience of previous organisational change on a similar scale, I was aware of the impact such a change could have on the nursing and wider workforce. Reflecting on my previous experience and measures taken to support the workforce were considered although

"A qualitative approach was used to ensure that the voices of nurses were truly listened to."

I was mindful that the relocation involved the move of Mental Health staff to a site that had previously provided services for those with a Learning Disability. I considered potential emotional responses of staff within each base, cultural implications, and sense of belonging and ownership and loss. A personal initial response was to be protective of the nursing teams, although I channelled this response into ensuring that they had a voice and were heard, both prior to the merger, during transition and following relocation, allowing reflective space to consider the experience and aspects of process that may have been managed differently, during and at the end of their journey.

Allowing frontline nursing staff to have a voice prior to the merger was crucial, promoting containment, sense of value and stability, whilst modelling positive focus on future development and sustainability of Secure Care Services.

A qualitative approach was used to ensure that the voices of nurses were truly listened to. A secondary literature review focused on human factors that impact on successful service merges and from the findings a set of questions were prepared. The thematic review highlighted the top three themes as change, leadership and culture, informing the questions that followed. I aimed to offer and provide a platform for nurses to share their views and experiences informing both service development and professional growth. Therefore, a purposeful sampling approach was used with nurses from the Learning Disability and Mental Health pathways with 1:1 interviews conducted confidentially and the data analysis informing recommendations.

These recommendations provided a base as a starting point to ensure voices were being heard. The combined results provided extensive information to support secure care services through the pre-merger/ merger process, allowing the service to be proactive in implementing recommendations. It is notable

Helen Goudie
Nurse Consultant
CNTW Secure Care Services

that by having clear communication structures in place a model to support the change process with regular reviews is more likely to be successful and retain a high quality and committed workforce. The CEDAR completion date is January 2023 and therefore teams remain on a journey continuing to embed nursing views, whilst listening along the way.

The new build programme, named CEDAR (care environment and development provision)

LeadingMinds

Over and beyond - introducing the student corporate nursing placement

The pandemic necessitated much change across the entire infrastructure of healthcare. These changes were felt system-wide on a micro, meso and macro level. Services were redesigned, people expected to adapt like never before, and life was turned upside down. This proved challenging regarding student placements as our community trust was working very differently, and the pandemic created issues around safely placing students on the frontline. Herefordshire and Worcestershire Health and Care Trust rose to the challenge by innovatively designing a student experience to provide additional placements for our students. The pandemic provided an ideal platform to engage students in a placement that exposed them, as third-year students, to the complex world of strategy, policy and high level decision making.

The corporate student placement aimed to combine their practical experience with an opportunity to experience whole system leadership, giving them a chance to understand strategic influence on a bigger scale. In addition, they worked on a self-chosen project to demonstrate their understanding of how working in a role that was not directly clinical could help their development as a more insightful nurse. The ability to look wider than oneself and to work collaboratively was an asset to the experience.

The placement was delivered over eight weeks and involved traditional practice assessor oversight within a placement hub. 'Spoke' opportunities were offered with various teams within the corporate infrastructure, and this was determined jointly with the student to address their specific learning needs. A student's placement hub could be with the safeguarding team, for example, but they could get 'spoke' experience shadowing/working alongside the Deputy Director of Nursing.

This venture was not without challenge, as the students initially found it hard to grasp how a corporate placement would benefit them. In addition, they were working at home much of the time and so needed a lot of support orientating to their online meetings.

As a corporate nursing and quality team, we are committed to providing the future workforce with opportunity and challenge. Typically, students would not be involved at this level and are often not privy to the tremendous amount of work that goes on 'behind the scenes' when delivering high-quality patient-centred care. We wanted them to be immersed in the governance support systems that provide guidance to the frontline services with which they were familiar.

We feel this placement was an exciting first step in bridging the gap between delivering care on the frontline and delivering care at a strategic level. This placement provided a positive example of rising to the challenge of student facilitation during COVID-19 and provided an opportunity for involvement in a dynamic and tactical environment. Students gained first-hand knowledge of how services pull together and function in a crisis and, in addition, the purpose of the corporate nursing and quality team. The students evaluated the placement well, and it is hoped that this experience will motivate and enable those students to become the nursing leaders of tomorrow.

Kelly Hollier and Fran Tummey
Herefordshire and Worcestershire Health and Care NHS Trust

"As a corporate nursing and quality team, we are committed to providing the future workforce with opportunity and challenge."

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The impact of lived experience on health care workers' knowledge, attitudes and behaviour regarding mental illness

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Background/Aims

The literature suggests that many health care workers hold stigmatising attitudes towards mental illness. This study aimed to ascertain information regarding the impact of lived experience on health care workers' knowledge about mental illness, attitudes towards mental illness and intended behaviours towards people who experience mental illness.

Methods

This quantitative study used a questionnaire survey of health care workers (n=2073), including nurses, employed in four National Health Service Trusts which included validated tools that measured health care workers' knowledge about mental illness, attitudes towards mental illness and intended behaviours towards people who experience mental illness. Statistical analyses were conducted.

Results

Lived experience of a mental illness (self or family member) was associated with more favourable knowledge about mental illness, attitudes towards mental illness and intended behaviours towards those with a mental illness.

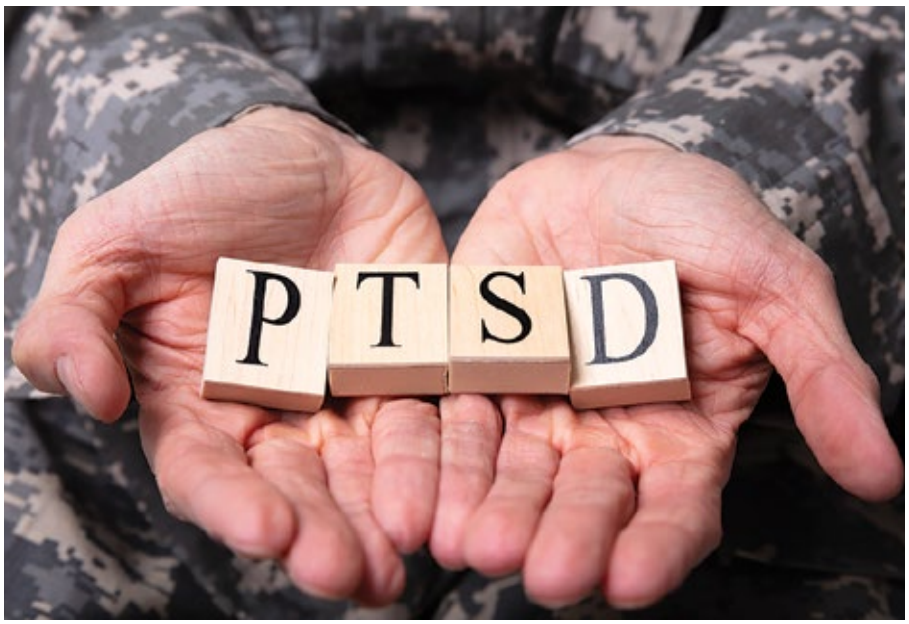
Conclusions

The lived experience of mental illness among health care workers could be harnessed as a resource to improve service delivery. There should be a long-term commitment to capitalising on the benefit to patient care of lived experience among health care workers.

Best wishes, Simon

Simon Sherring
Deputy Director of Nursing
South London and Maudsley NHS Foundation Trust
Maudsley Hospital, 111 Denmark Hill, London SE5 8AZ

The Veterans Mental Health Transition, Intervention and Liaison Service



The Veterans Mental Health Transition, Intervention and Liaison Service was commissioned by NHS England and became live on the 1st April 2017.

The team are commissioned to provide a three part service looking after military veterans and those who are transitioning out from Her Majesties Armed Forces with a mental health difficulty or associated problems. The team consist of seven clinicians, Nursing and Ots and covers seven counties across East Anglia.

It was highlighted very early on within the service that there was a very real difficulty in accessing NICE Guideline approved therapies for Post-Traumatic Stress Disorder due to a number of factors. Historically, the Murrison report 2010 'Fighting Fit' identified major barriers with military personnel and veterans in accessing appropriate mental health care. The difficulties encountered were that NHS provision failed to take into account military culture and stigma in this client group. As a result the TILS services were commissioned and became very successful, treating over 15,000 individuals over the last three plus years. Of those over 2,000 received treatment for PTSD.

EPUT TILS team covers East Anglia and are in partnership with the military charity Walking with the Wounded to provide NICE Guideline approved therapies, namely Trauma Focused CBT or Eye Movement Desensitization and reprocessing therapies. Therefore, if an individual is assessed as requiring PTSD treatment, we have a clear pathway into therapy with waiting times down to two weeks on initial referral to assessment.

OpCOURAGE

IAPT, who are ordinarily our initial go to service for therapy have excluded Complex PTSD as a treatment option, and so our options for referral were limited. Long waiting times within NHS psychology has restricted our referrals into those service despite the Military Covenant highlighting the need to prioritize those with a military condition. Our Charity partners WWTW then became overwhelmed with the number of referrals, and have had from September 2020 restricted those referral to seven per month. Within TILS we then faced the dilemma of assessing clients with military induced PTSD and very limited options about where to obtain treatment. In addition the Military Covenant is clear in that those injured in line of duty are entitled to priority treatment.

The solution.

TILS completed a scoping exercise as part of our yearly review to identify spare capacity within the service and redirect that spare time in enabling us to provide EMDR in-house. The initial view was that this would benefit both the patients, in that they would not have to wait for treatment capacity to become available from our charity partners or psychology, and it would benefit our staff, in that they would then upskill to enable the team to initiate EMDR Clinics within the service.

It was clear after looking at referral rates and clinical caseloads that clinicians could offer one session per week per clinician to start.

During COVID -19 our referrals reduced due to multiple factors and so we utilised time to initiate training with EMDR training providers and to date we have managed to get over 50% of staff through training with two staff due to initiate training towards the end of summer.

We initiated an EMDR Clinic within the service in February and are the first TILS in England to provide additional therapy as part of our service provision.

In terms of Governance, all our clinicians have EMDR clinical supervision with the training providers and will be initiating a peer supervision model on completion of training.

This additional service provision has enabled the team to provide timely therapy with a team that are fully veterans aware, enabling our patients to complete their treatment pathways in a timely manner, with clinicians who have already started work with them through assessment and therefore reducing the anxieties of having to retell their stories to a new clinician. Additional benefits are that we have reduced the referrals into our charity partners and thereby reducing further waiting lists for treatment. We currently have seven clients undergoing EMDR, who would otherwise have had to wait for treatment.

As a service it also strengthens the team's portfolio in delivering Trauma Informed Care and will ensure in the future that EPUT has a pool of qualified staff that are able to deliver NICE approved therapy.

David Powell RMN MSc
Regional Lead
Veterans Mental Health

Health Outreach Vaccination Service

This service has been run by Adrian Kirkby and Lidia Woods and their fantastic team of assessors, immunisers and admin. Since the 8th March 2021 they have reached out to, and vaccinated, approximately 8800 vulnerable adults across Essex and Suffolk. Approx 3600 people for the first vaccinations, 3000 for the second vaccinations and 2200 booster vaccinations.

They have worked with various community groups and the voluntary sector, including the Salvation Army, food banks and the YMCA, to identify sites to set up satellite vaccination clinics, which are accessible to their client groups.

Initially, the team reached out to the homeless community and drug and alcohol service users. Vaccinations are now being offered to other vulnerable groups such as travellers, refugees, seafarers, the BAME community, migrant workers, sex workers and ex-offenders.

The service have been creative in a number of ways. These include; successfully managing storage and transportation of vaccines and management and registration of individuals without GP surgeries or NHS numbers. EPUT pharmacy and IT services have been a massive support throughout.

The service also anticipated the challenge of getting people back for their second dose and has arranged identical clinics in the same locations 28 days after the first vaccination. This has increased the likelihood that people are still in contact with these services, such as hostels and foodbanks, and increased the opportunity to have their second dose.

Having worked in a variety of these clinics it has been an amazing experience and the gratitude from our clients has been overwhelming. We often use solo workers, with appropriate lone working assurances, to run clinics in food banks or hostels. We have been supported by businesses, such as garden centres, to produce 'pop up' clinics needed to cater for larger cohorts, such as traveller sites.

All our vaccinations have followed national protocol and all our clients get the same service they would receive at established vaccination centres. This includes experienced staff who can give expert advice and alleviate any concerns.

The service continues to have clinics in all types of locations all week, including weekends if the need is identified, and are continually looking at ways to reach more people.

The outreach team service will go to the members of the public no matter where it may be. This has been gratefully received and the members of the public have been very appreciative. They feel the staff show respect, are non-judgemental and very flexible.

Essex Partnership University NHS Foundation Trust

Scott Huckle: Service Development and Assurance Lead for Specialist Services. scotthuckle@nhs.net
Adrian Kirby: adrian.kirkby@nhs.net
Lidia Woods: lidia.woods@nhs.net
Denise Cook: denise.cook1@nhs.net

LeadingMinds

Philippine Nurses Association UK

Building psychological resilience to the Filipino health care workforce in the UK throughout the pandemic

Oliver is our Associate Chief Nurse Officer in South London and Maudsley (SLaM) NHS Trust, providing oversight leadership on the Trust's vaccination programme as well as on the Trust's physical health strategy. Oliver always goes above and beyond in everything he does and continued to do this throughout the pandemic. Oliver has been inspirational to his work colleagues and has extended his clinical expertise and knowledge to the wider Filipino nursing community across the UK, facilitating programmes to develop their psychological resilience during and beyond the COVID-19 pandemic.

In his commitment in supporting his fellow Filipino colleagues across the UK throughout the pandemic, he has voluntarily taken the role as the president of the Philippine Nurses Association UK (PNAUK), a registered charitable professional association. It has been reported that Filipinos had the highest death rate of any ethnic group in the NHS, and around January this year, official reports indicated that nearly 130 Filipino NHS workers had died after contracting COVID-19, though unofficially that figure is estimated to be far higher.

Staggering reports of how the pandemic impacted the wellbeing of the wider population shows that it has also taken its toll in everyone's mental health. More so to our frontline health workers, as they were faced day in, day out in dealing with the uncertainty in contracting COVID-19, and within the Filipino health care community - it's the thought of fearfully dying from it.

In South London and Maudsley (SLaM) NHS Trust, Oliver has been part of delivering mental and emotional support to our frontline staff and coordinated effectively in accessing the Trust's Staff Support services that was put in place in the early stage of the pandemic.

The skills and knowledge he learned from this translated on his action to offer a similar provision to support the mental wellbeing of the Filipino health care community via the PNAUK

In October/November 2020, he co-led in facilitating a short survey within the Filipino health care community to ask questions on how the COVID-19 pandemic had impacted both in their physical and mental wellbeing. The survey also looked at the different coping strategies that they have used in reducing their stress level.

This has given him the platform in identifying a specific, targeted approach in delivering a mental health focus programme to the members of the PNAUK.

In January 2021, he has organised their association's first webinar looking for ways in building psychological resilience within the Filipino health care workforce. This has now rolled into a webinar series looking into helping individuals in improving their sleep during the pandemic (Webinar Series 1: March 2021), to identifying the effects of exercise and activities in someone's wellbeing (Webinar Series 2: April 2021) as well as topics in healthy eating (Webinar Series 3: May 2021). This was all made possible by coordinating and collaborating with his SLaM colleagues who supported him to provide mental wellbeing programme to the wider Filipino community.

Oliver, via the PNAUK channel, has supported individual Filipino nurses on their emotional wellbeing and crisis-facilitating counselling and guidance support.

"Oliver has been inspirational to his work colleagues and has extended his clinical expertise and knowledge to the wider Filipino nursing community across the UK."

He has successfully received grants from the NHSE/I Health and Wellbeing team, and starting in May 2022, he will be facilitating a free Mental Health First Aid training course to a cohort of Filipino nurses working across different NHS trusts. The overall aim for this is to have more Filipino mental health first aiders who can provide their time to volunteer in the PNAUK support helpline.

Additional to this ongoing work, he is also actively involved in facilitating a 'Welcome to the UK' informal webinar to newly arrived, and soon-to-arrive Filipino nurses to the UK. This is to provide supplemental information in adapting to the UK way of living, but more importantly highlighting the mental health support that they can receive from the Trusts that they will be working in as well as from the association and different Filipino networks that they can access.

The above work has also led to him supporting and coordinating this work with KWEL (Keeping Well in South East London) – a partnership between the Improving Access to Psychological Therapies Services provided by South London and Maudsley NHS Trust, Oxleas NHS Foundation Trust, Bromley Healthcare and Mind (Bexley).

He also volunteers in the NHSE/I Next Gen Nurse Speakers for School, sharing his nursing journey and experience to young people i.e. students 16-18, to encourage and motivate them in taking the nursing profession.

In addition, Oliver has been an instrumental leader in our COVID-19 vaccine programme leading on the training of vaccinators, the patient vaccine programme and encouraging and supporting frontline colleagues to have their vaccine.

Oliver Soriano
Associate Director of Nursing, SLaM

COVID-19: A phenomenological exploration of the experience of ethnic minority student nurses

Clare Scott
Deputy Director of Nursing
Darren Savarimuthu
Consultant Nurse
Barnet, Enfield and Haringey Mental Health NHS Trust

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Student nurses were pivotal in providing essential care and support to various health organisations during the COVID-19 pandemic. Many student nurses, particularly those in the final six months of their programme, were identified as competent to undertake extended placements to support services while also completing their learning. However, as the effects of the pandemic gradually unfolded, it became apparent that the pandemic does not have the same effects in all layers of society. In fact, reports from Public Health England (PHE) and evidence from other literatures have explored the impact of COVID-19 on ethnic minority community as a whole while also emphasising the effects on ethnic minority health care workforce (Fenton et al., 2020). It is found that individuals of an ethnic minority background are indiscriminately affected. This is equally true for frontline workers in healthcare.

At Barnet, Enfield and Haringey Mental Health NHS Trust (BEH), on average 95 % of the students who opted for the extended placement during the pandemic were from an ethnic minority background. These students were from the fields of mental health and learning disability nursing. As a supportive mental health organisation, we have embarked in a piece of research to explore the lived experience of ethnic minority student nurses who worked during the COVID-19 crisis.

A literature review and a scoping exercise seems to suggest a lack of research that explores the experience of ethnic minority mental health and learning disability student nurses who supported health services during the pandemic.

Aims of the study

- Explore students concerns (if any) before the start of their extended placement and whilst working during COVID-19
- Explore the support (or lack of) that students received in practice and how that could have been different.
- Identify any difficulties/challenges working during the pandemic
- Explore the impact of ethnic minority experience on their learning.
- To explore personal challenges that may have impacted on professional life and their own mental health
- To provide recommendation for improving ethnic minority staff and students' experiences in the clinical environment.

Methodology

A phenomenological approach is taken in this study and the method for data collection is through semi structured interviews. In a nursing context phenomenology is described as a theoretical framework that

helps to understand the experience of individuals (Van Manen, 2016). So far, the purposeful sample has consisted of 10 student nurses who have participated in this project.

Findings so far

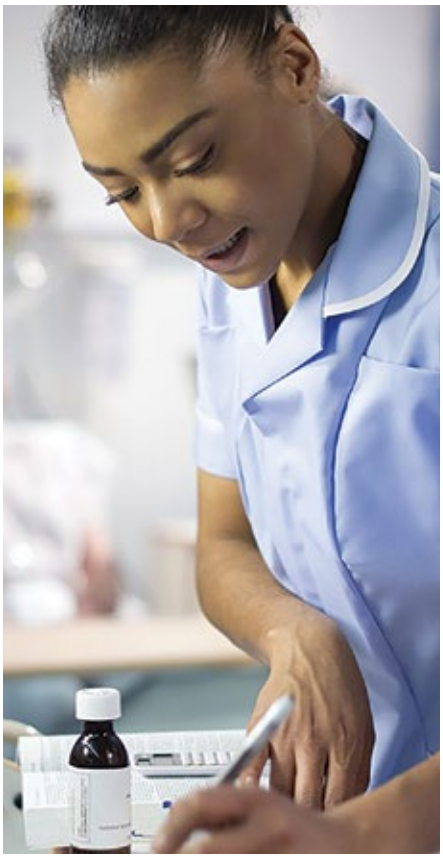
Although the study is ongoing the following themes have emerged from the data:

- Altruism
- Sense of connectedness
- Support
- Learning opportunities/role clarity.

Plan

Once the study is complete, we intend to share and disseminate at a local level and consider the recommendations.

The Full publication can be found here British Journal of Mental Health Nursing | 2022 | https://doi.org/10.12968/bjmh.2021.0028



Nursing achievements

We would like to highlight the invaluable contribution that Lyndsey Taylor has made to services over this challenging year. Lyndsey is the Team Leader for Family Group Conferencing. She works at both a frontline level with teams and service users, and on a strategic level, promoting the FGC model in a range of contexts nationally and internationally. Lyndsey is a Team Leader who cultivates a culture of positivity, communication and collaboration, and does so through role-modelling best practice.

This year, Lyndsey has successfully established family group conferences over Microsoft Teams. What initially seemed like a barrier has meant that peoples' networks can be involved in their recovery planning regardless of geography. The team have also offered technical support to family members, combatting loneliness by increasing peoples' access to virtual interaction.

Lyndsey recognised early on some of the specific challenges that teams faced due to COVID-19. During the first lockdown, FGC welcomed referrals for carers' assessments specifically for COVID-19-related anxieties and difficulties. As pressure on services grew, Lyndsey made herself even more available and adaptable. She has recognised the needs of both service users and staff throughout this time, and has continued to monitor individuals' emotional wellbeing while maintaining service delivery. Lyndsey has a person-centred approach with everyone she works with. She is passionate about maintaining an open-door policy, and welcoming of discussions about cases prior to a referral. Her team feel valued and understood.

Lyndsey has endless capacity for ideas. Throughout this year, she has developed a number of new initiatives to promote the FGC service. These include Consultation Clinics, the team website, joint team meetings with Children's FGC, creating links with the Perinatal service, and participating in the Multi Agency Conference with Parental Mental Health. In addition, Lyndsey established a Learning Forum for the FGC team. She observed the increasingly complex cases being referred to the service, but also the diverse skillset of her team. In response, she created a space for complex case discussions alongside the sharing of skills and knowledge. This exemplifies Lyndsey's approach to work. She fosters a supportive culture that discusses challenge and risk openly and compassionately, whilst constantly seeking to highlight the assets and contributions of her whole team.

Lyndsey promotes co-production wherever possible. Despite the restrictions of the last year, Lyndsey has continued to involve service users at every level of the FGC process, be it in developing their own Recovery Plans, or contributing to training, recruitment, and ideas about FGC. She has ensured that every step in the FGC process has been possible via Microsoft Teams: care-planning, meeting members of the network individually, and giving private time to the family during the conferences.

In addition to her work with FGC, Lyndsey has dedicated her weekends to the COVID-19 vaccination programme. She has spoken of requesting a joke from each person as they come for their vaccination, serving to ease anxieties in typical Lyndsey fashion. Her commitment to providing the best level of care is tireless and impressive, and she deserves recognition for her outstanding efforts over the last year.

Alivia Bray
Family Group Conference Coordinator
Pronouns: she/ her
Essex Partnership University NHS Foundation Trust (EPUT)

LeadingMinds

Patience, perseverance and personalised care - a spotlight on nursing across North London during the pandemic

Background and context

North London Partners is one of five Integrated Care systems in London representing a population of 15 million across five boroughs (Camden, Islington, Barnet, Enfield and Haringey) employing over 70,000 people. Mental health care is delivered through three NHS mental health Trusts and in one of our three specialist providers (Great Ormond Street Hospital) as well as in our four acute and community service providers through a large number of primary care, local authority, voluntary and independent providers. 60% of our population is under 30 years of age.

North Central London has an established reputation for collaborative working, and specifically in nursing, through the CapitalNurse initiative. During the pandemic we have supported each other to respond to the demands of COVID-19 at all times with the service user always at the centre of our efforts. In this session we would like to share a selection of this work to gain feedback from others and to enable us to continue to learn and improve.

Mental Health Crisis Assessment Unit

The Camden and Islington Mental Health Crisis Assessment Service (MHCAS) was established on the 23 March 2020 in response to the COVID-19 pandemic. Its core purpose is to provide an emergency department (ED) diversion service for those with urgent mental health needs that don't require acute medical intervention.

The service was mobilised quickly and had a 24/7 unit fully functioning in temporary premises on the St Pancras site at the beginning of lockdown. The complexities of the locality with three busy central London acute providers meant that this represented wholescale system redesign and deployment of three independent teams into one location almost overnight.

To meet the needs of a greater proportion of those in mental health crisis the ambition broadened to include provision for managing minor medical interventions with a primary mental health need.

Now at its first anniversary, the MHCAS continues to achieve its core aim of keeping patients out of ED. An average of 60% of all emergency mental health assessments now happen within the MHCAS building. Key achievements of the model to date include:

- Average of 120 referrals a week
- 60% of all emergency mental health referrals now seen in MHCAS (40% of activity continues in ED)
- 92% reduction in 12-hour trolley breaches in ED
- Average length of stay (LOS) in MHCAS of 5.2 hours
- 5% reduction in mental health inpatient admissions (formal and informal)

Emergency Department avoidance Crisis Hub for Children and Young People

"Government data shows that people with learning disabilities and serious mental illness have been among the groups most impacted by COVID."

NCL in Mind – our Mental Health & Wellbeing Hub.

Acute NHS services in North Central London were heavily impacted with COVID-19 admissions in both waves pacing significant pressure in ED and on ward and ITU beds. This necessitated a reconfiguration of children's services so that ED and in-patient facilities for children were concentrated into two sites, one in the north and one in the south of the borough. To keep young people in mental health crisis away from ED and complementing the MHCAS for adults in crisis, two CYP crisis assessment hubs were established along with an associated short stay mental health assessment unit. Nurses and therapists from across NCL volunteered through our the pandemic to return to practice, to work additional shorts or to be redeployed to support the hubs with a very positive outcome.

Nursing leadership to ensure children with complex emotional needs can continue school.

Gloucester House is an independent special school with an integrated CAMHS team. It is part of the Tavistock and Portman NHS Foundation Trust, working with children aged 4 – 14 with complex social emotional and mental health needs, many of whom have experienced complex trauma. Specialised education is complemented by personalised therapeutic care which is led by nurse Kirst Brant.

As these children and young people were all 'vulnerable' and have EHCP plans we were required to ensure the school stayed open throughout the pandemic. We created a hybrid service offering both on site and remote provision – adapting to collaboratively meet the needs of different children and families. Within this we had a number of periods of moving to a fully remote service (for short periods) due to COVID-19 cases on site. Due to the nature of the virus, such decisions were sudden which was not ideal for our children and demanded an innovative and adaptive approach to service delivery accounting both for educational, social and clinical needs and risks.

We continued to adapt and develop the service within this blended model throughout the process and we still continue to reflect and learn from the adaptations made. We completed a QI project regarding blended delivery and are in the process of retrospectively reviewing both our qualitative and our quantitative educational and clinical outcome data. We continue to engage in a recovery phase both from an educational and therapeutic perspective.

Alongside the work with children and families we also needed to be mindful of the impact of the pandemic on our staff from a holistic perspective and to adjust and adapt our debrief, reflective and team containment spaces accordingly.

Vaccinating North London - Providing a bespoke and safe environment to support the COVID-19 Vaccinations for Learning Disability, Autism and Serious Mental Illness.

Government data shows that people with learning disabilities and serious mental illness have been among the groups most impacted by COVID-19. They had a 2.3 times higher death rate than the general public and are more likely to be affected by issues such as isolation and wider mental health impacts.

Understanding the scope and need to support patients to have equal access to care led to the development of our

Specialist Mental Health Vaccination Hub in Enfield. The vaccination clinic has been a real collaborative effort between the Barnet, Enfield and Haringey Mental Health Trust, London Borough of Enfield, our Clinical Commissioning Group (CCG) supported by North Central London Partners ICS.

We have worked with volunteers including local Learning Disability and Mental Health Nurses and redeployed staff from across the Integrated Care System.

The staff in the vaccination hub have made adjustments for longer appointments, additional space, quiet areas, sensory equipment, easy to read and pictorial consent and patient information forms, plus a dedicated telephone booking service for those who struggle to book online.

Staff working within the specialist vaccination hub are a combination of mental health and learning disability nurses who are specially trained to support individuals with complex needs – using their skills to assess and support verbal and non-verbal cues, needle phobia, distraction and de-escalation techniques.

Front of house there has been support from London Borough of Enfield staff who work in the Integrated Learning Disability Service to book service users in, talk and interact with them and their carers to keep them calm and support them with any adjustments that are needed.

The collaborative work across North Central London to provide this service has meant that we have been able to work to address the health inequalities often experienced by our most vulnerable people by providing a service that is accessible and caters specifically to their needs to ensure equal access to COVID-19 vaccinations.

NCL in Mind – our Mental Health & Wellbeing Hub.

NCL in Mind originated at the beginning of the pandemic as the three mental health Trusts came together to create a network across all employers in north London in our collective effort to support the wellbeing of staff and has since morphed into our Mental Health and Wellbeing Hub. The aim of the Hub is to provide additional organisational support, advice and guidance across the sector, outreach to organisations and groups of staff to identify need and help to signpost to local resources, and to develop processes that can provide screening, assessment and access to specialist services where needed. It includes a web-based resource 'Keeping Well NCL', training, reflective spaces, coaching and supervision, and a system for access to assessment and treatment for those presenting with more complex symptoms in response to trauma.

Authors

Kirsty Brant
Lead Nurse & Clinical Lead, Gloucester House School Tavistock & Portman NHS FT

Emily Burch
Head of Physical Health, Barnet Enfield & Haringey Mental Health NHS Trust

Michelle Johnson
Chief Nurse and Director of Allied Health Professionals, Whittington Health NHS Trust and Chief Nurse, Camden and Islington NHS Foundation Trust

Tafadza Mugwagwa
Deputy Chie Nurse, Camden & Islington NHS FT

Amanda Pithouse
Chief Nurse, Barnet Enfield and Haringey Mental Health NHS Trust

Chris Caldwell
Director of Nursing, Tavistock & Portman NHS FT, and Chief Nurse North London Partners

'Honour the spirit within.'

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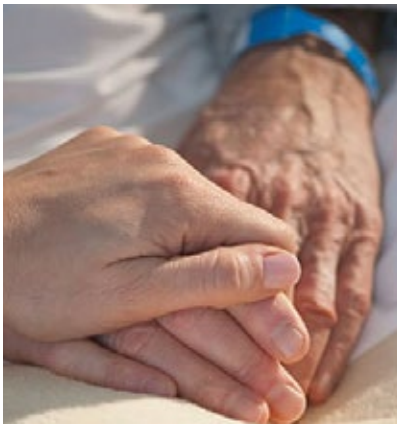
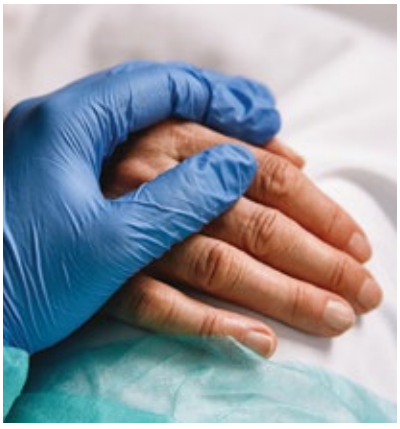




Namaste care

'Namaste' is a wider concept meaning to "honour the spirit within" and has been adopted into clinical work with the Namaste Care Programme Approach (Simard 2013) a structured programme incorporating compassionate nursing care and individualised activities for people with advanced dementia in a group setting (Simard 2013). Namaste reflects the philosophy of good person-centred dementia care considering the needs of the individual, their likes and dislikes and personalises the care to their needs (NICE 2018, Kitwood 1997). The principles of Namaste care have been introduced as an intervention on an inpatient organic assessment ward,

Core elements of Namaste care:

- A person centred approach
- Explaining the approach to the family engaging their support
- Completing Life story
- Addressing issues around comfort and pain management
- Creating calm peaceful environment
- Use of a room spritz or an aroma diffuser to scent the room
- Music playing which is meaningful to the person
- Use of loving touch
- Celebrating the seasons bringing outdoors inside
- Reminiscence activities
- Offer drinks and snacks through the session
- Encouraging the person's range of movement
- Having fun
- Feedback to the family and their involvement in sessions

Aims of Namaste Care on Woodhorn

- For respect and dignity
- Comfort
- For enjoyment and pleasure
- For company
- To feel safe
- For families to have meaningful visits

From mental health perspective:

- To improve mood through engagement
- To enable assessment of mental health
- To de-escalate potential anxieties and aggression

For staff:

- To offer staff skills to improve communication skills and sensory approach

Four staff attended a course at Saint Christopher's Hospice (London) to be able to implement the Namaste approach on the ward.

From the evaluation of this trial, the following benefits were identified:

- Provides positive time for carers to spend with the person with dementia
- When it was used prior to mealtimes it improved the person's diet and they gained weight
- It improved a patient's mood as they would actively seek out the Namaste Lead to have their hand massage and they had previously been very withdrawn
- Meets the sensory and emotional needs of the person, via a needs-led care plan
- Improves wellbeing
- Families have purposeful and structured visits

- Gives structure and purpose to 'empty time' (i.e. time where no personal care tasks are undertaken)
- Allows further assessment of mood, through 1-1 sessions
- With the current COVID-19 situation, the Namaste approach has been used at end of life, providing meaningful touch and support to people at this time
- Improved sense of job satisfaction with staff members delivering this care

Summary

Person-centred interventions using a Namaste approach have helped patients on Woodhorn Ward. It has offered staff a sense of achievement and improved their connection with the person with dementia. During the COVID-19 pandemic it has supported the palliative nursing care delivered by the staff. This in turn supported families who could not visit due to restrictions but were aware of the care that was being delivered.

Engagement during the COVID-19 crisis

My name is Sibusiso Mudimbu, known as Busi. I am a qualified Mental Health Nurse. I currently work as a Service Manager for Residential Home with Nursing for people living with Learning Disabilities, Autism and Mental Health difficulties. It is a six bed male service called Old Leigh House.

The pandemic period has been life changing, challenging for so many and due to this change everyone's routine has been affected significantly. I have accepted the challenge and welcomed the adaption to a new way of living and working. I have positively impacted this for our residents and staff.

During this pandemic period I have supported our residents to live their lives as normally as possible and alleviated any anxieties that may occur. Throughout the pandemic, I have ensured that the residents are well informed and equipped with the information that is frequently released as Government guidelines.

I have ensured that the residents are educated on what to expect regarding COVID-19, the impact that it will have on people's lives to make life much easier in these difficult circumstances. In the beginning of the pandemic, I had to ensure that relevant support was sourced from other team members such as the Speech and Language Therapists. They supported us to have easy read material so that the residents who needed communication support were well equipped with appropriate and relevant information of what is going on in the world affected by the pandemic. We had to use resources such as YouTube, newspapers and TV programmes to raise the awareness to our residents. I had to strive to constantly educate and support each and every resident. Not every day has been the same, some have been challenging as some residents with regular contact with their families have been missing their loved ones. Also, doing their normal daily meaningful activities such as home visits, shopping, going to cinema, bowling, theatres, church and college etc.

To ease the anxieties I made sure that the residents had regular contact with their Advocates, Social Workers, families and friends via Zoom, Skype and via telephone. I ensured that families continued to be the significant part of our residents' lives for the welfare. I am always a high believer of working in partnership with families as this always brings a significant impact to the residents' moral and overall engagement with their support plans. The families have been encouraged to come and drop their snacks and so on to the door so that there is no complete breakdown of contact. We also work closely with the external agencies such as the GPs, Opticians, and Dentist etc.

Times like this can be very daunting and confusing, especially for people with autism as any break in the routine can cause significant individual challenges leading to the endless incidents. However, this

has been well under control due to the comprehensive communication channels used in the service and robust activities offered.

We had a significant reduction of incidents as staff utilised the individuals' Positive Behaviours Support plans robustly. Residents are regularly engaged in their planned activities such as Therapeutic learning activities, including washing the home car, church attendance via Zoom, clearing the garden litter, going out for regular walks, productive cooking, room management, indoor activities such as board games and movies watching. All our service users are engaged in activities that are meaningful to them.

Residents have regular Empowerment Meetings and 1:1 nursing sessions and these are the platforms where they can ventilate on how they feel about the impact of the pandemic. If any anxieties are raised they get appropriate guidance and support.

In the middle of the pandemic I managed to move our service from CQC rating Requires Improvement to Good. This was due to that the service is safe and well-led. No outbreaks of COVID-19 infections or residents were affected and ill due to COVID-19. This shows that I have put robust infection controls in place and staff were well educated to follow these. Also, regular testing in place has helped to keep the infection at bay.

These were some of the quotes from CQC inspector regarding Old Leigh House:

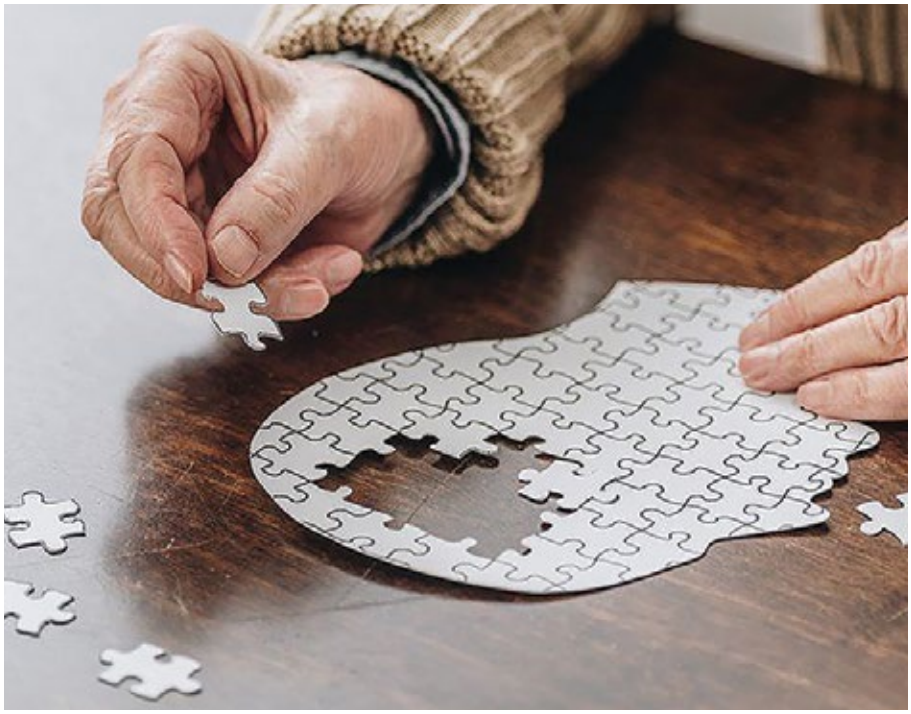
- Managers and staff are being clear about their roles, and understanding quality performance, risks and regulatory requirements
- People were fully engaged in their care and support needs. People had key workers who worked with them to achieve their goals. People had regular meetings with their key workers to discuss their progress and what support they needed. One person said, "My key worker helps me make lunch, we go out together and I can talk to them privately."
- Each week everyone living at the service met with staff and an external advocate to take part in what they called an 'empowerment' meeting During these meetings people shared their opinions on the running of the service and if they had any concerns or worries. They also used the meetings to discuss keeping themselves safe during COVID-19.
- The registered manager also used questionnaires for people, relatives and staff to gain their feedback. Where needed, following this feedback, actions plans were put in place to address issues. We also saw positive feedback. One relative had written, "I feel the staff caring for my son are very competent and they go over and beyond in order to do their job in the best way."
- The registered manager and provider had good oversight of the service through the auditing systems they had in place. The provider had an auditing team which went into all their services to provide quality audits. Where issues were identified, action plans were put in place and followed up.
- The registered manager worked closely with other health professionals such as GPs, speech and language therapist and occupational therapist to promote good outcomes for people.

"I am always a high believer of working in partnership with families as this always brings a significant impact to the residents' moral and overall engagement with their support plans."

Sibusiso Mudimbu
Regional Peripatetic Manager
South Social Care, Cygnet Health

LeadingMinds

West Essex Specialist Dementia and Frailty Service COVID-19 Response



The West Essex SDFS service is an assessment, diagnostic, treatment and support pathway for patients having difficulties with their memory as well as patients over the age of 75 who are suffering from functional mental health conditions and associated age-related frailty. The Multi-Disciplinary Team consisting of Doctors, nurses, healthcare assistants, OTs, psychologists and administrative staff work alongside our community nursing colleagues and primary care to wrap care around the patients and their families.

In March 2020 it became clear to our service that as we were heading into the first lockdown that this would present significant challenges to our team supporting the most vulnerable in society.

Vulnerable Adult List

The service always keeps a VA list as part of business continuity plans. As COVID-19 hit we reviewed the current list and added any other patients who had vulnerabilities specific to COVID-19, this list was used as a framework to ensure regular contact was made with all patients open to the service.

Activity Packs

We were very aware that social isolation and boredom would be a significant issue for our patients and we therefore started making and sending out activity packs on a monthly basis. The packs contained approx. 50 pages of themed puzzles, stories and suggested activities that could be completed whilst adhering to the lockdown rules. We produced two packs for differing abilities every month. These proved extremely popular with patients and families. We also sent electronic copies to all the care homes and the local community hospital.

Dementia Care Pathway

It was vitally important to us that we continued to accept referrals for all patients but especially patients with concerns for their memory. We were concerned that any backlog caused by the pandemic would put additional pressures on the pathway going forward and this would have an ongoing impact for patients due to delays in getting diagnosis, treatment and post diagnostic support, thus increasing the risk of carer breakdown and premature need for full-time care.

Due to the increased risks of infection, patients shielding and social distancing requirements we developed a process for assessing patients remotely by telephone and video calls. We quickly adapted the ACE -111 assessment tool to enable it to be used over the phone and in virtual consultations. This amended tool was later adopted by all memory services.

Virtual assessments and consultations proved popular with patients and their families as it reduced travelling time and allowed appointments to be held in the patients familiar environments. We are returning to face-to-face appointments as it is considered best

" We were very aware that social isolation and boredom would be a significant issue for our patients and we therefore started making and sending out activity packs on a monthly basis."

practice, however, the capability and option to offer virtual appointment in the future will continue.

IT Audit

We conducted an audit to establish what technology our patients and carers had access to and their abilities to use. We had assumed that our patient cohort would have limited access to equipment and low levels of abilities or willingness to embrace technology. We were surprised to find that 83% had access to some type of tech i.e. phone, laptop, computer, and 69% were willing to try virtual CST. There was also interest from 10% of patients with no access or previous experience with IT.

For those patients without access to equipment, or who were reluctant to try to utilise tech or who had a higher degree of cognitive impairment, we trialled 'carephones' as entry level equipment which enabled us to introduce the concept of technology without pressure of purchasing expensive equipment.

We also put in a successful bid for charitable funds to purchase iPads to loan to patients to enable them to access virtual therapy groups.

Online Cognitive Stimulation Therapy (CST)

CST is a NICE recommended treatment for patients diagnosed with mild to moderate dementia. It is normally delivered in group settings and runs for 14 weeks. The aim of the therapy is to teach patients how to preserve their cognitive abilities and levels of functioning. It is a treatment that is as effective as pharmacological treatment for dementia.

Pre-COVID-19 we were delivering CST to between six and eight groups per week and we needed to maintain the access to the therapy as we were concerned that patients would deteriorate and no longer be eligible for the therapy.

To support the online delivery we researched the best tech platform that had the functionality required to deliver the CST sessions. We then had to adapt the content for better virtual delivery.

The adapted sessions reflected the key principles of CST by utilising interactive games, multi-sensory stimulation using video and music clips and interactive imagery and reminiscence experiences, linking to the here and now to form new ideas and opinions. The group were introduced to chair yoga and the use of music through the group song and also used prompts to promote orientation and discussion in a sensitive manner such as discussions about current affairs.

Prior to COVID-19 the team were also offering iCST for patients who were not engaging with the CST groups. iCST involves educating and upskilling the carer to provide CST on an individual basis for the person they care for. As a result of COVID-19, iCST was also offered to those patients who could not, or chose not, to attend virtual CST with a clinician taking the place of a carer where there was no carer.

We have found that the CST and iCST has been very well received by patients and their relatives and to our surprise we have enabled patients to attend that would not have engaged in group work previously for a variety of reasons. There are additional benefits of the patients being in their home environment as they are more comfortable and relaxed and therefore benefit more.

The team will continue to offer a range of interventions post COVID-19 utilising some of the technological resources that we have discovered as part of the virtual rollout.

We are currently undertaking a research project with UCL to compare the effectiveness of face-to-face CST versus virtual CST.

In Summery

All the staff in SDFS pathway worked creatively and collaboratively to ensure that not only were we able to continue to provide our normal services throughout the pandemic but also delivered service improvements, many of which will be retained as we come out into the new norm.

Liz Carlisle
Essex Partnership University NHS Foundation Trust
liz.carlisle@nhs.net

LeadingMinds

Older Persons Mental Health Intensive Support Service

Older adults living with mental illness often experience crisis. Assessment, care and treatment provided at home as an alternative to admission to hospital often has better outcomes. Our project aim was to implement a clear and contemporary model of OPMH treatment and care with a recovery-focused service in the community, meeting complex mental health needs in the patient's own home.

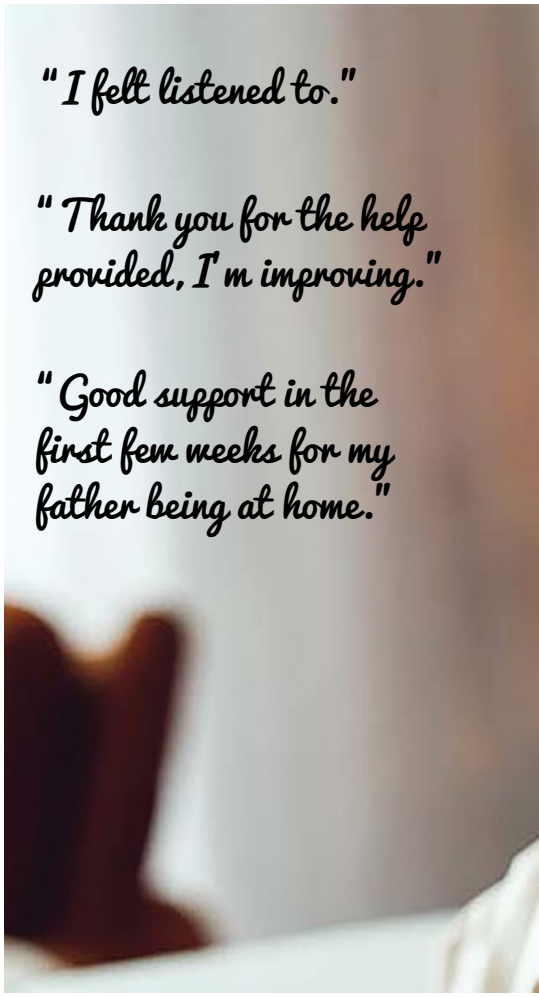
This project had been on the horizon for years. However, due to budgets we never had the opportunity to put it in place. A temporary ward closure for refurbishment gave us this opportunity. The pandemic, whilst frightening and exhausting, allowed us to take nine staff, three Registered Nurses and six HCSW from an Older Persons In-patient ward. They all had very little community experience but as well as them taking a leap of faith, we took this with them and amalgamated the IST team within three community mental health teams. At first there was reluctance from all three teams to refer. Questions were daily and when you bring in a new service without consultation and a very quickly written standardised operational procedure you could understand why. Faith and trust played a big role in the project and we needed our colleagues to have both very quickly.

Through a multi-professional team model of compassionate leadership, we wanted to improve training, educate and upskill the new team, with improved communication and collaborative working between professionals. Additional objectives focused on reducing reliance on in-patient services, with reduced admission rates, reduced in-patient times, and improved patient flow, improved cost effectiveness and better patient, relative and carer experience. The IST provide intensive, regular and emergency support for the individual and their carers in mental health crisis that cannot be facilitated through the CMHT.

Over the four months from October 2020 until January 2021, IST assessed and provided care, support and treatment for 54 patients with an average age of 72 years. There were 30 functional patients and 24 dementia patients referred by the CMHT, OPMH Liaison team within the acute general hospital and the OPMH functional in-patient assessment ward.

Reasons for referral included, suicide risk/self harm, delirium, behavioural and psychological symptoms associated with dementia, (including physical and verbal aggression, resistance to care, desire to leave the house, sexually disinhibited behaviours), vulnerability, carers stress/burden, facilitated early discharge from hospital both acute and functional ward, preventing displacement from care/nursing home and medication titration.

There were eight admissions to the acute psychiatric wards through the IST, three individuals living with dementia, and five functional patients. These patients were assessed and detained under the Mental Health Act (1983) due to the severity, frequency and intensity of the risks to their health safety and others associated with their mental health deterioration that could not be mitigated in the community.



However, there were 46 of the 54 patients seen that were not admitted. This showed service that outcomes for people with mental illness in later life whilst achieving significant health economy cost savings.

" We will continue with the exercises to turn this anxiety into a memory."

With wider organisational support we are developing a business case to present to the local Clinical Commissioning Group (CCG) to secure funding for the IST to be a permanent, sustainable service. There is also the opportunity to share learning from this project and potential for the IST model to be explored and implemented across the Trust, as it is an approach that we have comprehensively demonstrated makes a positive contribution to the experience for the patients, families and carers when being supported with mental health crisis.

"Our nurse Lynn tried really hard with our mum to see the positives and not the negatives. She was professional and caring and an asset."

"We will continue with the exercises to turn this anxiety into a memory."

"Carers took forever, Social Services took too long to respond to her needs. I'm very thankful for all the IST help."

"Good support in the first few weeks for my father being at home."

"Thank you for the help provided, I'm improving."

"They are friendly and I can talk to them. They are polite and make me feel okay."

"Very pleased with the IST service. Glad to get bloods sorted. So happy had double amount of sleep last night."

"I felt listened to."

"A very reliable service, at times of crisis and intervention a must to prevent admission to hospital or care. Dad needs 24 hour care support before ongoing care was sourced in the community. I was starting to struggle and almost gave up. The team were a gift and came out at the right time. The team were a marvellous bunch of professionals who made my life more manageable and able to continue my role as a carer. They have a great understanding and compassion."

"The staff were friendly and approachable. Easy to talk to and helped my husband stay chatty and relaxed whilst they were here. Their visits have been very welcoming."

Ian Douglas

Area Matron OPMH Southern Health Foundation Trust

Dr Aileen Murray-Gane

Nurse Consultant for Older Person's Mental Health

PSEH Divisional Clinical Lead for OPMH

South East Essex Mental Health Partnership Forum

"Our innovation has led to improved patient care as staff are better informed of available services which are more relevant for their patient's needs."

Southend is a seaside resort with a high level of deprivation and a wealth of services offering health and social care interventions. A large part of Simone's role as a Primary Care Mental Health Nurse working within GP practices across Southend in Essex involves signposting patients to community support and improving social inclusion. She found that service specifications were constantly changing, services would close, but we often didn't know about these changes until they had already taken place. There was no mechanism or meeting to share this information and ensure relevant referrals and signposting for patients. Referring to the wrong place is an added upset and frustration for service users. With services often working with many of the same people, we realised that the more we worked in partnership rather than in isolation, the better the journey and outcome for the individual.

Simone decided to bring services together to introduce each other; learn about provision and their referral criteria; to update on new services and to network. In 2016 we started with nine services to test and assess whether this networking approach was beneficial to the organisations and ultimately the people that we serve. Each service found it incredibly helpful and it led to some never before seen joint working such as the First Response Team (assessment team for Secondary Mental Health Services) performing joint assessments alongside the substance misuse provider in the area which meant that patients were no longer being asked to repeat their, often traumatic, history for different assessments. It also led to a housing association's floating support service offering a drop in at a local mental health charity to be able to offer information and advice to their service users.

The developments in collaborative working which came out of the Forum meant that more organisations wanted to join. Just before lockdown we had around 80 members and we evolved to offering free training on mental health. This led to a more skilled and informed workforce across the area. Since lockdown and our daily information updates, we have grown to 550 members from statutory council and health services, the voluntary sector, grassroots organisations and peer support groups.

COVID-19 and lockdown has meant a greater need for this network; we quickly recognised the gap that we could fill in terms of information sharing across our member list. We sent daily information on service provision for the network: we focused on what services were moving from face to face interventions to telephone or video working, which were closed and later which were reopening and in what ways. The network itself provided these updates and were soon being forwarded to new people who would request to receive these updates. We then compiled a South East Essex Directory of Services collating all of the data we had captured that also offered links to any national services that we could find that were relevant. We encouraged all members to share this resource with service users and you

can see from our submitted evidence that the impact on the whole local system has been significant.

Our innovation has led to improved patient care as staff are better informed of available services which are more relevant for their patient's needs. For example, an Independent Domestic Violence Advocate wasn't aware of the out of hours crisis service or who to call:

"This information is going to be so beneficial to us and our clients, especially out of hours which is always difficult for people. I do look forward to being updated on all the forthcoming events and further schemes that are put in place."

The MHPF has led to an improved experience for people due to the resources that are shared between partners. For example, Michelle Matthew, Essex Disability Employment Adviser and Autism Specialist at the Department for Work and Pensions found breathing and relaxing worksheets that had been shared helpful in supporting a social group that she runs. She had positive feedback from the group members saying how helpful they were.

Social Prescriber in a local Primary Care Network made a pack of information for her colleagues from the updates we sent:

"They are very grateful for the links as patients calling into the surgeries have been in dire need of support ranging from boredom, mental health and wellbeing ideas, a kind person to chat to and support for essential items e.g. shopping and prescription pick ups. Well done ladies for collating, truly appreciated and you're total stars."

Best practice on a range of issues across mental health has been shared across the network. This has been via in-person sessions and via Mircosoft Teams which enabled us to record the sessions and disseminate them even further to members of the network who could not make the session. We have delivered training sessions on:

- Early Intervention in Psychosis Team delivering on 'What is Psychosis?'
- Adult Community Psychology Team delivering on 'What are Personality Disorders?'
- Drug and Alcohol Team delivering on Co-Existing substance misuse and mental health issues ('Dual Diagnosis')
- Dementia and Older People's Teams delivering on Older People's Mental Health
- Various teams delivering on medication choice, physical health and wellbeing
- Various teams delivering on Autistic Spectrum Disorder and Asperger's
- The Specialist Perinatal Mental Health Team delivering on Perinatal Mental Health
- Various teams from the local council speaking about their work that touches on mental health e.g. the Early Help Team that work with families, to name just a few.

Various information has been shared via our daily and weekly updates, for example, national guidance from the NHS, NICE and the British Psychological Society on various topics from COVID-19 updates to how to offer psychotherapy safely over the phone.

Evidence from the people within the network and the people that they support has shown us that there is potential for positive outcomes elsewhere. Various other areas in Essex and further afield are reporting that they are developing a similar Directory of Services such as we have developed. We have also created a slimline version of the directory for GP surgeries which allows pressed Primary Care services to identify suitable services for people quickly. In 2016 we started as just a Southend CCG footprint initiative which then grew to also cover the Castle Point and Rochford CCG and is now slowly expanding into another CCG area of Basildon. We have had visitors from other areas visit our sessions to see how we do what we do so that they can implement something similar in their area (Chelmsford).

The patient experience has improved by more joined up working between organisations. For example, from meeting at the MHPF and building relationships between workers, initial mental health assessments are now completed within the local homelessness shelter for the rough sleepers there, as opposed to those people having to get a bus to the hospital over 3.5 miles away. This freed up capacity for the assessment team as going to the patients meant less chance of a DNA and rebooking. The IAPT team met Age Concern at the MHPF and then started working out of Age Concern's building to offer a one-stop shop for older people with their mental health needs. This has improved efficiency as IAPT are now able to improve their targets around supporting older people, especially those with loneliness and depression. Freeing up working space at the IAPT location and using rooms for free is just one of many examples of getting value for money from our IAPT service.

Patients now have access to resources shared through the network and via whoever is supporting them (whether a mental health worker, an adviser at the DWP or a peer at a support group) that they may never have come across before. For example, we have shared a booklet created by the Health Psychology team on recovering at home from COVID-19 and looking after your mental wellbeing that would only have ever have previously made it to the patients working with that team - possibly some other teams within secondary mental health services - but not to those outside of the mental health system. Additionally, we have shared information to aid staff in this difficult time. Our Adult Community Psychology Team offered sessions for free for any staff needing psychological support during COVID-19 and offered to open this out to any staff, even in the charitable sector and at councils, to support them. This was disseminated to the network and our area has the highest take-up of referrals across the STP (including five CCGs).

Our members tell us about the gaps and barriers in their knowledge base so that we can put on relevant training, for example. They ask us for contacts in organisations that they don't know that well and they put out pleas for help regarding complex cases and room availability, and the MHPF is now part of several organisations' induction process for new staff.

The innovation culture created by the development of the forum goes well beyond the team that facilitates the forum. The co-chairs have closely listened to the needs of the forum itself to inform its direction and its outputs. The group said they wanted to link more with ASD workers and to know more about the subject so we brought key players together to co-deliver what the forum needed. Additionally, this collaborative partnership has helped to inspire other collaborations between members. We take the approach that all members are stakeholders in our mental health system and have something to contribute and gain from working together. Although the co-chairs work for different organisations, they have almost daily contact which keeps the momentum of the work progressing. We don't set ourselves limits for where the forum could progress to and are looking at developing a website and branding to ensure that the forum is recognised as an entity in its own right and not just an arm of the CCG or Trust.

Patient and carer involvement has been minimal as we have wanted to ensure the space was for staff and workers and that they could ask questions, share concerns and explore gaps in their knowledge without having to have a 'professional face' on. We do have peer support groups represented, carers and volunteer Trust Governors as members, and will be linking with Expert By Experience Groups, such as the one being developed for people with a diagnosis for Personality Disorder, as they are created. We want to ensure that people with lived experience are feeding into the forum so that we can hear about any gaps and barriers as they have experienced them and work as a community to address them.

Collaborative training delivery across Devon

(Community Mental Health Framework)

"The patient experience has improved by more joined up working between organisations."

Our co-chairs, and members themselves, are always on the lookout for new services and new workers within organisations to invite along to the forum. We prioritise those organisations whose attendance declines to find out what's stopping them from accessing the forum and ensure that we rotate the days and times of meetings so that as many members can join as possible. We work hard to influence those organisations that haven't joined us yet and explain the benefits and outcomes from being a free member of our network.

Simone Longley

Operational Manager of the primary care mental health team working across the Southend area.

South East Essex Primary Care Mental Health Nurse Team

Over the past 18 months, Devon Partnership NHS Trust and Livewell Southwest have come together to survey, collate, plan and implement the training needs of community mental health teams across Devon as part of the Community Mental Health Framework (CMHF). By harnessing the expertise of clinicians, service users, managers and educators a detailed training plan has been created based on specific service needs. The training needs analysis is grounded in the principles of Self Care, Personal Community, Communities and Community-Based Health and Social Care as well as Acute Health Care Services.

Initially, both organisations identified their own training needs, and in August 2021 the team commenced the development of a shared plan for training provision. The team meets for two hours each week to process data, plan training and action each implementation phase. Most meetings have been online given the constraints of pandemic restrictions, as well as the geographical diversity of the team. Given the project is Devon-wide, team members have been drawn from different parts of Devon, often hours away from each other.

The team developed a narrative document and established a project blueprint to ground the project and provide a check-in point throughout the project's lifespan. All team members shared workload which allowed the continuation of business during periods of individual absences.

Carer and service user consultation and participation was embedded in the project. Members of the DPT and Livewell co-production teams consulted on training needs early in the project, and then later joined the core team to explore co-delivery of training and establish ongoing training requirements.

There were three significant measurable achievements. These were:

1. The creation of a detailed Training Needs Analysis spanning two large organisations in Devon, across multi-professional teams, numerous pathways and multiple career stages.
2. The creation of six new digital learning packages specific to the CMHF, addressing the unique needs of this cohort.
3. The planning, sourcing, funding and commencement of the Priority One phase of training. The high priority offerings represented the most critical requirements of clinical leads, subject matter experts and leads across both organisations.

The delivery of these outcomes on time and on budget was testament to the negotiation and organisational skills of the collaborators. The team worked with multiple stakeholders to listen, reflect and action wide ranging training requests in a way that was fair, open and achievable.

The impact on patient care is demonstrated by the cross-organisation, cross-profession engagement with their own training needs.

The community teams have participated in deep reflection about the future development of their services, the skills and knowledge required for excellence in patient care, and the right training, for the right people, at the right time. A number of new service models and therapeutic interventions are now earmarked for community teams, allowing both organisations to offer their patients contemporary, evidence-based and timely care by well-trained staff.

The project demonstrated how two very different organisations can work together, sharing resources, skills and expertise. This both reduced duplication of work and revealed to both organisations the number of transferable project and practice skills across DPT and Livewell.

Finally, a reflection from a team member on the project from inception to today:

"Mind over matter and sharing challenges with a small working group of like-minded colleagues across two organisations through regular weekly meetings, has shown what can be achieved through collaboration, shared passion and enthusiasm."

Dr. Floraidh Rolf
Head of Education and Training
Devon Partnership Trust
Adjunct Senior Fellow (UQ)

" We all value the work we do and understand the positive difference we can make to the NHS mental health workforce and ultimately the care of our patients."

Our work

Listed below are a few examples of our recent projects:

- Diversity - improving access to development and career progression for minority ethnic and disabled groups
- Building on the mental health support workforce to meet service requirements
- Stress and resilience framework piloting
- Retention of experienced mental health nurses
- Developing mental health nursing post-qualification training and development standards
- The Chief Nursing Officer's Learning Disability Nursing Enhanced CPD Scheme
- Maximising AHPs contribution to mental health and learning disabilities
- Children and young people's mental health in patient workforce development strategy
- Preparing the workforce for the proposed Mental Health Act reform

A summary of each of these projects can be found on our website: https://bit.ly/38Zq4ss

The National Workforce Skills Development Unit

About us

This April marked the fifth anniversary of the National Workforce Skills Development Unit (The Unit). The Unit was established by Health Education England (HEE) in collaboration with the Tavistock and Portman NHS Foundation Trust to support the development of the nation's mental health workforce.

We are a small yet diverse group of staff based at the Tavistock and Portman NHS Foundation Trust. We all value the work we do and understand the positive difference we can make to the NHS mental health workforce and ultimately the care of our patients.

Our projects aim to address different workforce-related issues which include retaining mental health nurses; access to continuing professional development (CPD) training for disabled staff and staff from an ethnic minority; development opportunities for the mental health support workforce and preceptorship for newly registered nurses. The mental health workforce is at the centre of all that we do.

We engage with stakeholders across the system, enabling us to achieve strategies to support services delivering the care and treatment to meet individual, family and community needs. Our work supports HEE in providing experts with a framework to find solutions to existing gaps within their services.

We take pride in the planning and management of our projects. The work we do with our partners helps develop education infrastructure, delivery mechanisms and skills. This is necessary to improve mental health services for people throughout England.

Connect with us

To learn more about our work visit our website: https://bit.ly/38Zq4ss

Join our live updates on social media

Twitter @NWSDU

Facebook @NWSDU

LinkedIn @NWSDU

Raleen Fernandes
Senior Project Manager
rfernandes@tavi-port.nhs.uk

Meet our team

Prevention of suicide in nurses and midwives

The office for National Statistics published data on suicide by occupation in 2019 which highlighted the elevated risk of suicide in female nurses as being 23 times higher than for the general population. In response the Chief Nursing Officer for England, Ruth May, commissioned a thematic review to be undertaken by The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH 2020). Following a national round table to discuss the findings an Oversight Group was established in Autumn 2020 to oversee a 12 month project on the Prevention of Nursing and Midwifery Suicide.

The Oversight Group was formed of key stakeholders, including nurses with lived experience of suicide, regulatory bodies and staff side groups, Health Education England and academics, to review the ONS data and agree next steps. These included raising awareness of the issue, developing a consensus statement and the commission of a systematic review of the nurse and midwifery suicide literature.

The initial 12 month project has now been completed but work continues to be led by the Deputy Director Mental Health Nursing: NHS England and NHS Improvement and has been extended to include the prevention of suicide for all NHS staff.

" As a public health issue, employers have an obligation to their staff to optimise health and wellbeing, including mental health."

The most recent review of suicide by occupation was published in 2021 by the ONS which reported that female nurses continue to be the only healthcare staff group to have a statically significantly higher rate of suicide than that of any other occupation. The areas of work currently underway are the development of NHS Postvention Guidance, NHS Suicide Prevention Guidance and oversight of several commissioned research projects.

NHS Postvention Guidance

Postvention is an organised response in the aftermath of a suicide to accomplish any one or more of the following: To facilitate the healing of individuals from the grief and distress of suicide loss; to mitigate other negative effects of exposure to suicide; to prevent suicide among people who are at high risk after exposure to suicide. NHS England and NHS Improvement, NHS Employers and NHS Confederation are working with Samaritans to develop an NHS-wide Postvention Guidance which will offer advice and guidance on supporting colleagues after a death by suicide. The Samaritans have been speaking with colleagues across the NHS who have had their own experience of supporting colleagues, or needed support themselves, following the suicide of a colleague, to inform the content plan and help adapt sections for NHS settings. Publication is planned and on target for June.

NHS Suicide Prevention Guidance

As a public health issue, employers have an obligation to their staff to optimise health and wellbeing, including mental health. The reduction of death by suicide fits in with work proposed by the NHS Long Term Plan, People Plan and The National Suicide Prevention Strategy (DHSC). Evidence identified by NCISH also suggests that approximately two thirds of people who take their own lives are not in contact with mental health services, meaning workplaces can provide ideal opportunities for suicide prevention, especially for high risk occupations like nursing. A Task and Finish Group has been established to oversee the development of the guidance with publication planned to coincide with Suicide Prevention Day on 10th September 2022.

Research

Oxford Health NHS Foundation Trust and University of Oxford Centre for Suicide Research have been commissioned to undertake several strands of research which includes a systematic review, a review of media coverage of nurse suicide in partnership with the Samaritans and a review of self-harm. The overall aim of the study on media coverage is to examine news reporting of suicide among nurses, midwives, and students. The final study will describe the characteristics of nurses and midwives who presented to the Emergency Department of the main general hospital in Oxford after a self-harm episode between the years 2010 and 2020. Data analysis is underway and includes 106 self-harm episodes, involving 81 nurses. Outputs from this work is estimated to be finalised in Summer 2022.

References / Links

Appleby, L. Kapur, N. Turnbull, P. Rodway, C. Ibrahim, S. Graney, J. Richards, N. (2020)
Suicide by Nurses: A brief report. National Confidential Enquiry into Suicide and Safety University of Manchester.
ONS by occupation 2021
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/

Dr Emma Wadey PhD RN
Deputy Director
Mental Health Nursing
NHS England & NHS Improvement

North Cumbria support to care homes during COVID-19

Care Homes and Dementia:

People with dementia living in care homes and assisted living communities have seen a significant impact from COVID-19 during the last six months. There has been a distressing effect on daily living, understanding and coping with COVID-19 restrictions on people living with dementia leading to an increase in negative symptoms and behaviours. In most cases, people with dementia were unable to see family and friends, or even their informal carers and healthcare professionals due to no visitor policies. There has also been a huge impact on families unable to visit as well as significant concerns regarding care home staff dealing with psychological trauma.

Care Home Education & Support Service (CHESS) is a dedicated specialist care home service provided within the Older Adult Community Mental Health Teams in North Cumbria.

Onset of COVID-19:

The CHESS service quickly identified the likelihood of there being a significant impact on care homes from COVID-19 due to the high level of vulnerable older people, number of people with dementia, number of people relying on close family visits as well as the impact of restrictions.

Adopting a very proactive approach, CHESS quickly established a number of supportive measures in March 2020 and carried on throughout the pandemic to work closely with care home staff, as well as patients and their families to offer bespoke support.

"The CHESS service quickly identified the likelihood of there being a significant impact on care home's from COVID-19 due to the high level of vulnerable older people."

This included the following:

- Each Care Home was offered a nominated CHESS Key Worker to provide daily contact, coordinate any communication, interventions, advice, and support. This also included facilitating mutual aid where needed regarding PPE, support with individual patients with increased needs due to the COVID-19 restrictions.
- CHESS via CNTW have offered Care Home's access to CNTW testing (both testing centre and mobile) to help identify staff needs and also access to the Trusts staff wellbeing support line to offer additional support with staff experiencing psychological factors in dealing with the effects of COVID-19.

"These 'sharing sessions' provide staff with a safe place to share how they are feeling and talk through some of their anxieties."

- CHESS has implemented weekly virtual and face-to-face support around the psychological distress, providing advice around care planning, behaviour management and intervention, while also offering enhanced face-to-face support to care homes where patients have developed specific behaviours in relation to COVID-19 or due to COVID-19 restrictions.

Supporting the psychological Impact of COVID-19:

With substantial numbers of residents sadly passing away from April due to both COVID-19 and non-COVID-19 reasons, there has been an unprecedented impact on care home staff.

Around 660 care home residents sadly died between April and December 2020 with some care homes seeing numerous deaths across a short period of time.

To assist with care home staff's psychological wellbeing the CHESS service has developed facilitated debrief sessions initially in care homes. These 'sharing sessions' provide staff with a safe place to share how they are feeling and talk through some of their anxieties, as well as helping to signpost staff to other agencies that may offer extended help. This approach has been hugely successful.

Wellbeing support for whole system during COVID-19 - getting CEWT

" We set up a searchable resource directory called AWISH to help staff access links to the wellbeing support which would best meet their needs."

During the first lockdown, a multidisciplinary group of clinicians and corporate services staff came together in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) to set up a COVID-19 Emotional Wellbeing Team, otherwise known as CEWT. We also brought together an external network of representatives from Acute Trust partners and the North East Ambulance Service (NEAS) to explore staff wellbeing needs and what CNTW could offer to colleagues on the frontline, as a leading provider of mental health and disability services. Through our colleagues across the Trust footprint we also heard about the specific needs of partners in primary care, care homes, schools and the voluntary sector. And of course we were also focusing on the needs of our own staff in CNTW, and developing and co-ordinating our responses to support each other.

We combined multidisciplinary clinical, HR, chaplaincy and communications expertise to develop wellbeing support offers for the whole health and care system in the North East and North Cumbria (NENC), and we later extended this offer to education, police, fire and prison services. Our work received regional and national interest, including presenting it as part of webinars and hosting a virtual ministerial visit. We have continued to make our whole system offers available throughout the pandemic, more recently integrated into the NENC staff wellbeing hub.

AWISH (Advice, Wellbeing, Information & Self-Help) Resources

An early difficulty in the pandemic was that there were so many different resources and self-help materials available - it was a bit overwhelming and difficult to navigate. We set up a searchable resource directory called AWISH to help staff access links to the wellbeing support which would best meet their needs.

Psychological Wellness Training

We co-produced with Experts by Experience an adapted form of Psychological First Aid training, which includes issues specific to the pandemic such as moral distress and BAME issues. This training has been taken up by large numbers of staff from across NENC.

Livecasts, Wobble Rooms and Team Time

We have organised and delivered 10 livecasts to staff on a range of topics, from sleep to burnout and BAME conversations. The livecasts are available to watch on the Trust YouTube channel.

Our Schwartz Round team of senior medical, nursing and psychology staff launched online 'wobble rooms' to support staff wellbeing, offering them a way to articulate how they feel about the pressures they are dealing with.

The Schwartz Round team have also supported external organisations to set up reflective team sessions.

Psychological helpline and staff support

We set up a psychological helpline to provide additional support for staff across NENC. People have been able to talk through many issues such as mental health, bereavement, family and work-related stress, anxieties, low mood and moral distress relating to the pandemic.

Underpinning all our work have been principles of outreach and inclusion, supportive and accessible communications, and normalisation of common responses to an extraordinary situation.

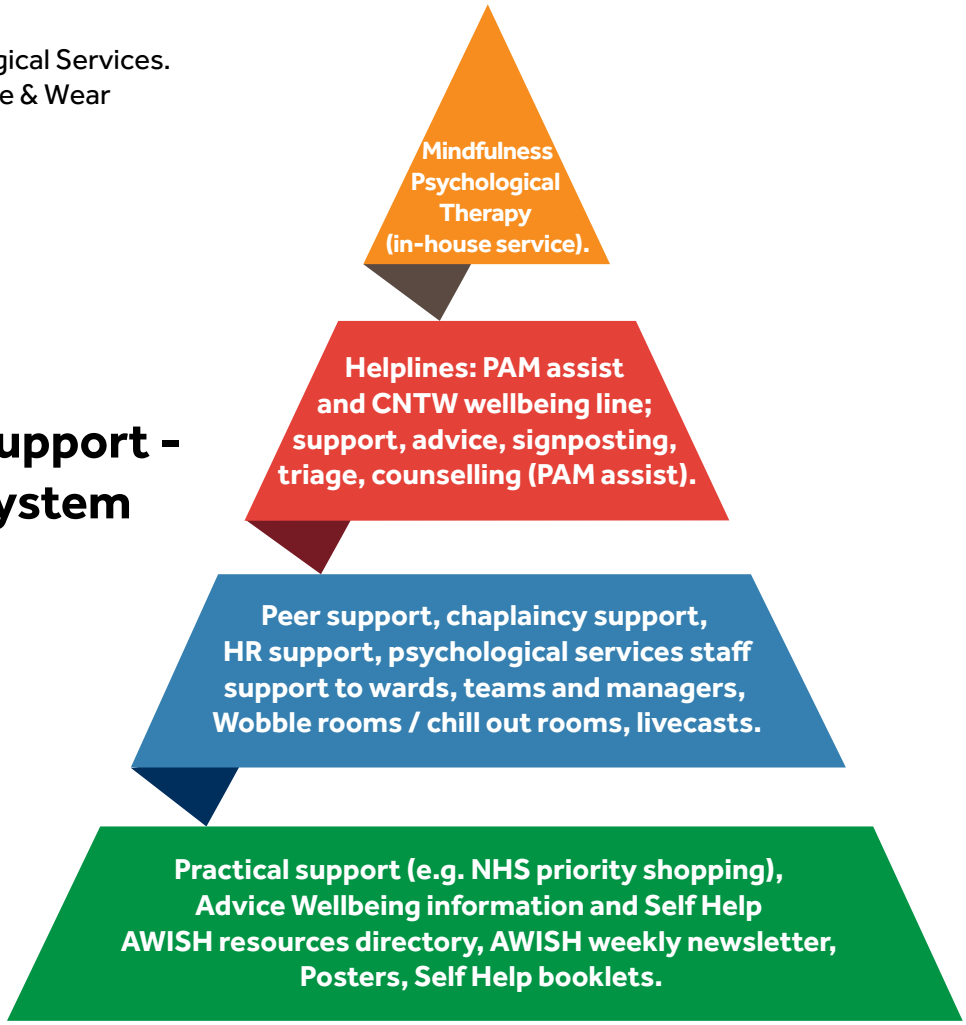
Significant numbers of staff from the health and care statutory and voluntary sector, education sector and beyond have accessed our support offers, and colleagues in our clinical services have also reached out proactively to support partners particularly in care homes.

Although integrated now with our ICS resilience hub, we have done much of this work over the past year pro bono, in order to support the wonderful staff working in a wide range of roles across the system in NENC, for the ultimate benefit of the people we are all here to serve.

"Our work received regional and national interest, including presenting it as part of webinars and hosting a virtual ministerial visit."

Esther Cohen-Tovee
Director of AHPs and Psychological Services.
Cumbria, Northumberland, Tyne & Wear
NHS Foundation Trust.

Staff Wellbeing Support - NENC Whole System



LeadingMinds

Available wellbeing resources

Key NHS support services all critical care staff should be made aware of:

- **Staff support and text line** delivered by the Samaritans, with trained advisers to help with signposting and confidential listening.
- All staff can access talking therapies on the NHS. Staff can be referred by their GP, or they can refer themselves directly to an **NHS psychological therapies service (IAPT)** without a referral from a GP.
- If a staff member is experiencing a mental health crisis, they can call a local NHS mental health helpline for 24-hour advice and support.
- **40 local staff mental health and wellbeing hubs** have been set up to provide health and social care colleagues rapid access to assessment and local evidence-based mental health services and support where needed. The hub offer is confidential and free of charge for all health and social care staff.
- A small proportion of staff may be referred onto **NHS Practitioner Health** by their local hub as clinically indicated. This is an enhanced mental health service, which has been commissioned nationally, to support staff whose needs cannot be met locally. Doctors, dentists, and senior leaders also have the option to self-refer to this service.

NHSE/I health and wellbeing resources

- There are a range of **health and wellbeing resources and professional line manager support** available online from NHSE/I.

Some of our key offers of support for colleagues include:

- Staff support line.
- Free access to a range of mental health and wellbeing apps for NHS colleagues (Headspace and Unmind).
- Signposting to a range of suicide prevention resources, including the Stay Alive app and Zero Suicide Alliance training.
- **A dedicated staff mental health hub** where colleagues can seek a clinical assessment and referral to local services enabling access to support where needed, such as talking therapy or counselling.
- A free service developed and funded by the Association of Christian Counsellors, who are offering up to 10 online or telephone counselling sessions.

Support within organisations

- Most NHS organisations offer their teams support through Occupational Health and Wellbeing services and Employee Assistance Programmes. You can speak to your line manager or HR team to understand how to access this.

- We would also encourage that all line managers hold wellbeing conversations with their colleagues to identify if there are areas of support needed, and share resources with colleagues that may support their wellbeing. Line managers can read more about how to approach a wellbeing conversation here: **https://www.england.nhs.uk/supporting our-nhs-people/health-and-wellbeing-programmes/wellbeing-conversations/**
- Many NHS organisations have rolled out Health and Wellbeing Champions to offer an alternative route into seeking support. Speak to your local HR team to understand who your Champions are locally, and for further reading, visit: **https://www.england.nhs.uk supporting-our-nhs-people health-and-wellbeing programmes/health-and-wellbeing-champions/**

Support from other sources

- Staff will also have access to local services provided through local communities and charities.
- Nurse Lifeline: www.**NURSELIFELINE.org.uk** Tel: 0808 8010344
- Samaritans Tel: 116 123

Peter Hasler, Development Officer to the Forum

At one point I was beginning to think we would never meet face to face again but I'm delighted that finally we have made it back to Warwick.

The NHS and care services had to adapt very quickly to find new ways of doing things during the COVID-19 pandemic – digital technology has without doubt changed the way we work forever. Equally, and despite the lack of conferences, the Forum was incredibly busy since April 2020 and I wanted to take this opportunity to give you some of the highlights.

We are very pleased to have re-established our co-production work with the CQC and are now looking forward to a conference together in London on the 24th June. This will be an opportunity to launch and share the amazing work that has been happening on ligature harm minimisation.

In 2021 we started another Aspiring Director programme jointly with the NHS Confederation. 15 people commenced this year long programme of masterclasses and group and personal support. We will be publishing an evaluation report but we are already being approached with potential attendee names for the next programme starting in autumn.

In 2021 I did the census of nurse consultants; this is something we complete every two years. There was a significant increase in posts to 205 – an increase of 26% since active nurse consultant group that we are supporting in the Forum.

There have been several workstreams that have been taken forward over the last year, many of these were generated by the discussion on the Forum emails. Some examples of these are:-

- The workforce pressures being experienced by organisations has been a real source of concern. We have linked into the work on international recruitment which many organisations have benefited from. The Forum wrote to the secretary of state to voice our support for the Lord's amendments to the Health and Care bill.
- Oxevision and vision-based monitoring systems – a working group is now meeting with the aim to review how vision-based patient monitoring systems are being used across the country and to make recommendations that will support safe use for patients, staff and organisations. We are aware that 23 Trusts use Oxevision and others are considering it. The group will be reporting in the summer.
- Headbanging protocol – a working group has been meeting to produce a protocol on headbanging following a great deal of interest from forum members. We hope to see this work completed very soon.
- We worked with our medical director colleagues to produce a joint statement on the pressures being experienced within children and young people's services which have seen unprecedented numbers of referrals.

The Forum is able to be more responsive to the clinical and service needs that are identified by our members, and we will continue to use 'Teams' as a way to move things ahead quickly. However, it feels it's absolutely right that we now have the opportunity to meet in person for the first time in over two years.

Peter Hasler
Forum Development Officer

National Mental Health and Learning Disability Nurse Directors Forum

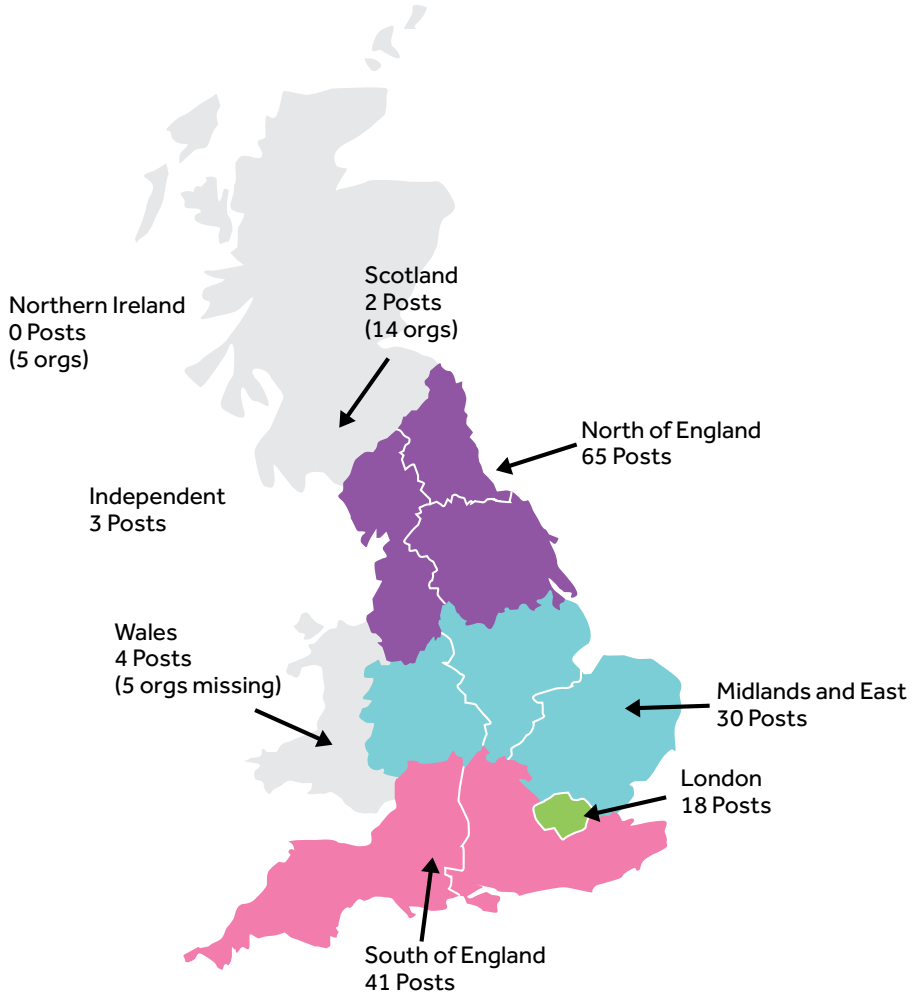
Influencing and advancing care in mental health and learning disabilities

LeadingMinds

Nurse Consultant Census

Mental Health, Learning Disability and Community 2019

This census is carried out every two years by the National Mental Health Nurse Directors Forum.



Total: 163

Specialities

Adult Mental Health/Psychosis	48
Learning Disabilities/Autism	25
CAMHS	18
Physical Health Care/Wellbeing	11
Older People/Dementia	16
Forensic Mental Health/Prisons	12
Drug and Alcohol/Duel Diagnosis	8
Low Secure/PICU	3
Primary Care	3
Eating Disorders	3
Infection Control	4
Safeguarding	4
Suicide Prevention	2
Patient Safety	2
Liaison Psychiatry	3
Perinatal	1
Total	163

Branding Grades of Posts

Band 8A	15%
Band 8B	67%
Band 8C	17%
Band 9 (1Post)	0.50%
Under Review (1Post)	0.50%

Peter Hasler
peter.hasler1@nhs.net
Version 006-01.03.19

"In 2021 I did the census of nurse consultants; this is something we complete every two years. There was a significant increase in posts to 205 – an increase of 26% since 2019."

National Mental Health and Learning Disability Nurse Directors Forum

Influencing and advancing care in mental health and learning disabilities

Love Our People and Celebrate Them

09.15-09.30 **Welcome by Chair**
Melanie Coombes, Chief Executive.

09.30-10.15 **Building our future workforce: what have we achieved so far during the pandemic?**
Ellie Gordon, Senior Nurse for Mental Health, Health Education England.

10.15-11.15 **How to be the very best that you already are**
An inspiring, inclusive and interactive session that will unleash the strengths, passions and genius that you already have - based on real life science, research and evidence.
David Taylor, Naked Leader.

11.15-11.45 **Break**

11.45-12.30 **To provide insight on the cultural and national contribution of our diverse society**
Professor David Olusoga OBE.

12.30-13.00 **Year of the Nurse Award - modern slavery and human trafficking**
Bonita Sparks Named Nurse for Mental Health and complex social needs, West Hertfordshire Hospitals NHS Trust.

13.00-14.00 **Lunch**

14.00-14.10 **Caring for those who care for others: the buddy system and reflective spaces**
Claire Warner, Clinical Psychologist, Essex Partnership University Trust and Dr Manal El-Maraghy.

14.10-14.20 **Engagement during COVID-19 crisis**
Sibusiso Mudimbu, Regional Peripatetic Manager, South Social Care, Cygnet Health.

14.20-14.30 **Philippine Nurses Association UK: building psychological resilience to the Filipino health care workforce in the UK throughout the pandemic**
Oliver Soriano, Associate Director of Nursing, SLaM.

14.30-14.40 **Nursing leadership to ensure equitable access to COVID-19 vaccinations across the system for people with LD and SMI**
Clare Scott, Interim Director of Nursing, Quality and Governance and Emily Burch, Associate Director of Physical Health, Barnet Enfield and Haringey.

14.40-14.50 **Older persons mental health intensive support service**
Ian Douglas, Area Matron OPMH and Michelle Duke, Team Manager for the IST service.

14.50-15.00 **Wellbeing support for whole system during COVID-19 - getting CEWT**
Esther Cohen-Tovee, Director of AHPs and Psychological Services, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust.

15.00-15.10 **Mental health cohort of the 70@70 research leadership programme**
Dr Anita Green, Director of Nursing Research, Education and Development Visiting Professor, School of Health Sciences, University of Surrey, Sussex Partnership NHS Foundation Trust and Fiona Nolan, Clinical Professor, Chair of Mental Health Nurse Academics UK, HEE.

15.10-15.20 **Closing Comments**
Close

Mel Coombes, Chief Executive Officer, Coventry & Warwickshire Partnership Trust.