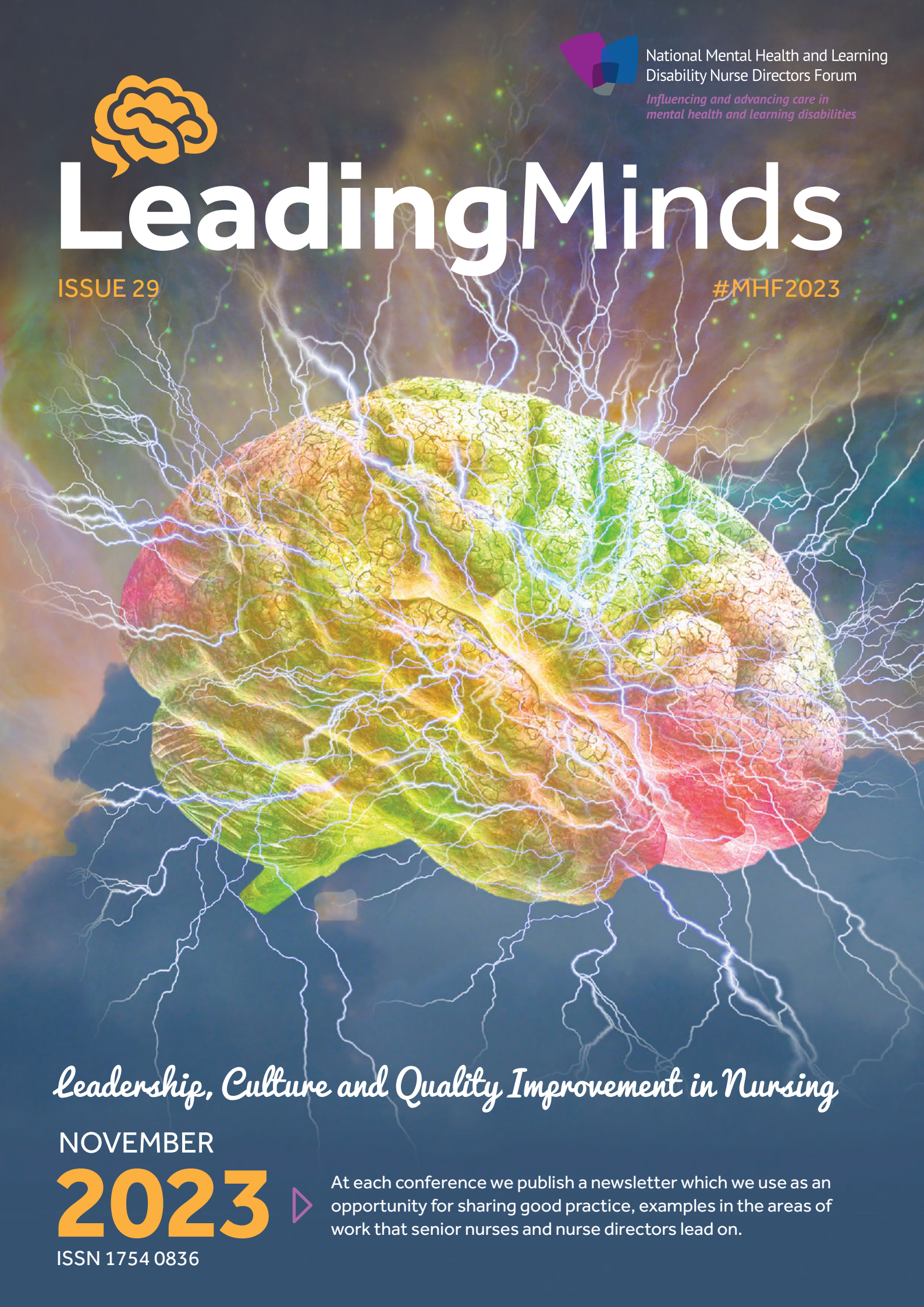

National Mental Health and Learning Disability Nurse Directors Forum

Influencing and advancing care in mental health and learning disabilities

LeadingMinds

ISSUE 29

#MHF2023

Leadership, Culture and Quality Improvement in Nursing

NOVEMBER

2023

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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.

LeadingMinds

"I particularly want to shout out the great work I have seen recently by LD Consultant nurses."

Maria Nelligan

Executive Director of Transformation/ Interim Chief Nurse, GMMH

Dear Colleagues, welcome to this conference which will focus on Patient Safety.

Twelve months on from the Panorama concerns at Edenfield, collectively what have we achieved? Where have we focused our attention? It is encouraging to see the number of initiatives of important reading in this newsletter. There is a great diversity in topics to support improvement in patient safety up and down the country - you should be so proud. As a MH and LD Nurse how do we now see our role in patient safety evolving? There are a number of big programmes here looking at reducing restrictive practice and a really good read, well done everyone.

Reflecting on how we facilitate our new generation of registered nurses, what role do we have as experienced registered nurses supporting the next generation of nurse leaders? Have we as DON's led the development of the senior nurse roles, indeed we count how many consultant nurses we have nationally every year, but how committed are we in embedding these roles and making them the foundation of our nursing careers? This role was introduced in 2002 - how has it fared? I believe these are essential in supporting patient safety and experience of our future nurses. In times of pressure, it is easy to remove what may seem to be desirable rather than essential roles.

As I come to the end of 42 years as a nurse, I am reflecting on what we have achieved practically in the space of professional and workforce development. I particularly want to shout out the great work I have seen recently by LD Consultant nurses in developing a framework to develop future LD consultant nurses. The framework includes examples of people in roles including approved clinicians with high impact on patient care and practice.

"There is a great diversity in topics to support improvement in patient safety up and down the country - you should be so proud."

RRP work is particularly important and essential for future approach to care and interventions. This work with patients has the opportunity to change how we deliver care in inpatient settings. This work is led by NHSE with people with lived experiences and will be immensely important in delivering person- centered care to people.

Maria Nelligan

This of course needs to go hand in glove with a greater value in working with inpatient facilities that demonstrates investment in senior roles, therefore having the greatest skills and resourcing services working and focusing on people with the most complex needs.

Well that is all from me, have a great day!

LeadingMinds

Additional Support Unit (ASU) Zones of Regulation Project

A multi-element approach of bringing together sensory friendly environmental design, education and co-production to promote regulation, increase occupational participation and reduce restrictive practices in a learning disability inpatient unit.

The project aims to utilise a multi-element approach of bringing together sensory friendly environmental design, education and co-production to promote effective regulation of arousal, increase occupational participation opportunities and reduce restrictive practices. The presentation will share how the project formed, measured change and how it became part of the National Reducing Restrictive Practice strategy.

Many learning disability inpatient units don't have suitable environments to facilitate opportunity for individuals to proactively participate in occupations to self sooth or self regulate, creating a melting pot for triggers of distressed behaviours and resulting restrictive practice. We designed a multi-element approach that encompasses change to a physical and social environment to include co-education of staff, enabling individuals to improve in participation, self-management and reduce restrictive practice.

This project is underpinned by commitment to the **Long Term Plan**, addressing further prevention of mental health crisis for adults who have a learning disability in addressing issues raised about unsensory friendly environments impacting on poor quality care.

The Care Quality Commission published a report, Out of Sight-Who Cares? reviewing the use of restrictive practice in hospitals and concluded that many ward environments are chaotic and non-therapeutic, often triggering behaviours that necessitated the use of restrictive practice. Staff are often not skilled in the knowledge of sensory needs or patients are not given autonomy to make changes to self regulate. Collectively, the lack of understanding can result in mental health deterioration and increased restrictive practices.

"The multi-disciplinary team need to work together in order to improve services, participation and reduce restrictive practice."

Results: Focus groups with patients and their families clearly requested adaptable environments they could control depending on their individual needs at the time. Based on this we created different zones where people could be guided to depending on their state of arousal.

We developed cards based on the principles of the zones to help our patients support and regulate themselves, helping them access different areas when they needed to.

Personalised activities have been developed for the individuals on the ward, making them more engaging. The number of activities available on the ward per week has increased by 33% (from October 2021 to April 2023).

Over the same period we have seen an 80% reduction in seclusions per fortnight from our baseline and a 50% reduction in incidents in restraint per fortnight. We also achieved an 83% reduction in our PRN oral sedation use.

Feedback: Feedback from our focus group with patients and families was really positive, saying that the ward feels inviting and calming, much quieter and not so bright, meaning it meets their sensory needs better. They also liked having more, different activities.

If you'd like to know more about the project scan the QR code.

SCAN FOR DETAILS

" We created different zones where people could be guided to depending on their state of arousal."

ASU Blue Zone

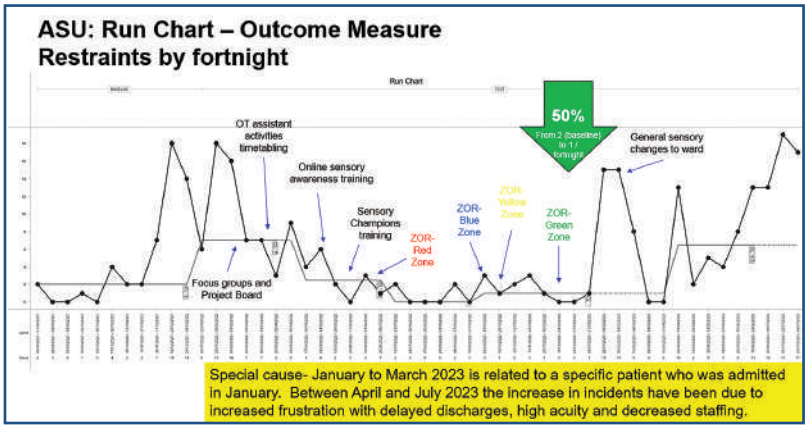
ASU Red Zone

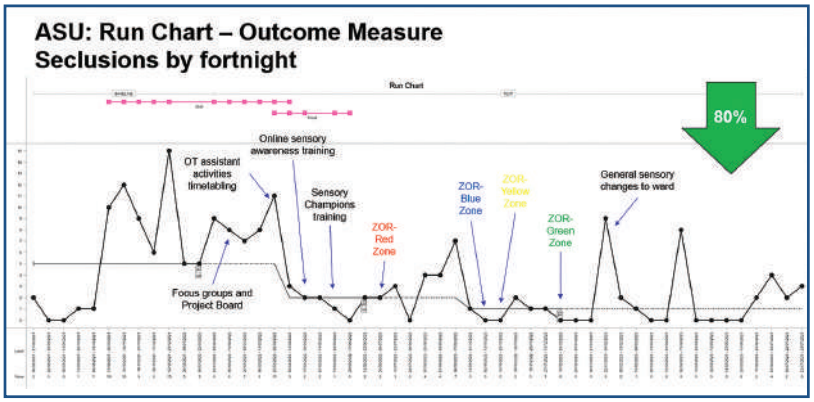
ASU Yellow Zone

ASU Sensory Garden

ZONES OF REGULATION

The Zones of Regulation, A Curriculum Designed to Foster Self-regulation and Emotional Control, by Leah M. Kuypers (2011).





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LeadingMinds

QI initiative – carers support for those with relatives placed in out of area beds

Introduction

The National Confidential Inquiry into Suicide and Safety in Mental Health (2023) (NCISH) tells us that there were on average over 6,000 deaths each year by suicide in the UK between 2010 and 2020.

Based on their evidence from studies of mental health services, they developed a list of 10 key elements for safer care for patients. These recommendations have been shown to reduce suicide rates. This includes no out of area admissions.

NCISH recommends that very ill patients should be accommodated in a local inpatient unit. Being admitted locally means that patients stay close to home and the support of their friends and family and are less likely to feel isolated or to experience delayed recovery and are more likely to be safer. In the UK, 225 patients (9% of post-discharge deaths) died after being discharged from a non-local inpatient unit.

The value of visits in maintaining links with family and community networks is recognised as a key element in a patient's safety, care, treatment and recovery and should be actively encouraged where possible in addition to letters, text and phone calls. Every effort should be made for children to visit their parents.

Every effort is made to place all patients on a Devon Partnership Trust (DPT) ward but there are times when an out of area admission will be necessary. For example, when there are no acute beds available or for a specialist service.

Method

The Bed Capacity team agreed to allocate up to 3 days a month to a member of the team to support the carers when their loved one in placed in an out of area or privately funded bed. The project aims were in line with the Triangle of Care 6 standards.

- To improve patient safety by ensuring we are working collaboratively with family and carers during the assessment, treatment and discharge of the person using services.
- To ensure carers are receiving the support (practical and emotional) that they have statutory entitlement to.
- To ensure carers receive financial support when they need to visit the family member who is using services using a SOP and is placed out of area. This SOP applies to all Trust patients (and their family and unpaid carers) who are either informally or compulsorily detained.
- To design, develop and co-produce services.

Results and Impact

The project aims to contact carers within 72 hours of someone being admitted to hospital which provides a single point of contact and advises carers on local carers' support organisations.

To date 134 carers have been contacted. Of these 31 have been text only and a further 52 received a text and email. Others have been telephone or face to face contact – some of these as a one off and others ongoing support.

"Thank you for your very timely contact and email. It is a great relief to know that someone from the hospital will be in touch with me. Thank you for your help"

Patient quote.

If you'd like to know more about the project scan the QR code.

SCAN FOR DETAILS

Andrea Fairclough
George Adams
Devon Partnership NHS Trust

Implementation of a new Ligature Anchor Point and Blind Spot Risk Assessment 'toolkit'

www.cygnethealth.co.uk

Cygnet recognised the risks posed by all potential ligature anchor points, irrespective of their height from the floor. We know that lower lying ligature anchor points pose risks to patients and have been implicated in deaths from ligatures. Cygnet identified that using a scoring system based upon the height from the floor could potentially lead staff to mistakenly believe that lower lying anchor points attracting a lower score equates to a lower risk.

" We have to balance creating a safe environment with the need to provide an environment that is comfortable enough to support and promote recovery."

Cygnet acknowledge that we cannot rely entirely on the environment alone to reduce ligature risks; even when we fit the latest reduced risk (anti-ligature) fixtures and fittings, there may still be a residual risk. If a patient is sufficiently determined, creative and innovative enough, they can circumvent the safety features of many such fixtures and fittings. In addition, we have to balance creating a safe environment with the need to provide an environment that is comfortable enough to support and promote recovery.

Cygnet data demonstrates that the majority of ligature incidents do not involve the use of any anchor point. Staff need to understand the influence the environment exerts on an individual's risk(s). The patient's risks will change dependent upon where they are within that environment.

Cygnet created a dynamic risk assessment process that stratifies the risk within each room/area of the care environment, and prompts staff teams to set out any environmental actions required to reduce the risk, and any clinical actions required to reduce the risk.

A training package was devised and delivered to all services implementing the new approach and ongoing support has been provided by the policy lead. Training is delivered virtually and comprises a short PPT, an overview of the policy and an overview of the risk assessment process and associated recording document. Attendees at the training are sent all the resources following the training to enable them to cascade the training to their staff in their service.

Governance and monitoring of the implementation and evaluation is supported via the various governance forums within the organisation. The initial pilot of the policy was at one large hospital site and was supported with a detailed implementation plan.

Once they had fully implemented the new policy, feedback was obtained via an agenda item at regional operational governance meetings, and any required amendments to the policy and/or 'toolkit' were made in response.

" Staff need to understand the influence the environment exerts on an individual's risk(s). "

Following the successful initial pilot, the policy was rolled out further to other hospitals within that region, with the same oversight process, detailed implementation plan, training, ongoing support and monitoring via governance meetings. In addition, Cygnet have an overarching corporate implementation plan for the advancement of our safer environment work, which has executive board oversight. Cygnet are now rolling the policy out in a staged manner across all Cygnet healthcare services. We anticipate that we will have fully implemented the new policy and moved away from our hybrid version of the Manchester Ligature tool by the end of January 2024.

Caroline Mackay
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LeadingMinds

Elevating patient safety – the role of improved supervision recording in Mental Health Trusts through digital innovation

Introduction

Supervision plays a crucial role in the mental health sector, providing a structured framework for ongoing professional development, support and accountability. Within mental health trusts, this practice is paramount in the demanding landscape of elevating patient safety. Supervision emerges as a powerful tool in this endeavour and plays a pivotal role in enhancing patient safety in ensuring the wellbeing of both patients and clinicians. This article highlights how supervision elevates patient safety, spotlighting the improvement journey within Midland Partnership University NHS Foundation Trust (MPFT) on supervision recording and sharing our journey of continuous improvement.

" Supervision plays a pivotal role in enhancing patient safety in ensuring the wellbeing of both patients and clinicians. "

Supervision and Patient Safety

1. Risk Prevention and Mitigation: Clinical supervision acts as a proactive measure to identify and address potential risks.

2. Ensuring Compliance with Best Practices: Supervisors play a crucial role in upholding adherence to best practices and evidence-based interventions.

3. Guidance in Complex Cases: Mental health trusts often deal with complex and sensitive cases. Having a supervisory structure in place means that clinicians have a dedicated forum to seek guidance and expertise when faced with challenging situations.

4. Facilitating Open Communication: A culture of open communication is fundamental to patient safety. Clinical supervision creates a safe space for clinicians to express concerns, share insights and discuss potential improvements without fear of retribution.

5. Continuous Quality Improvement: Through supervision, mental health trusts can establish a culture of continuous quality improvement.

6. Monitoring Clinician Wellbeing: A well supported and emotionally resilient workforce is essential for patient safety. Supervision provides a platform for clinicians to discuss any personal or professional challenges they may be facing.

MPFT identifies the function of supervision as having three key components: normative (management), formative (professional development) and restorative (clinical support).

MPFT Improvement Journey

Following MPFTs CQCs well-led inspection during 2019, action for the trust was to create a central system for reporting and recording supervision to enable oversight at all levels within the organisation.

The Nursing Directorate in collaboration with IM&T created the e-form supervision recording system through Microsoft SharePoint app developers.

The system allows all staff members to input supervision and upload supervision centrally, through an easy to use app accessible from all digital devices including mobile phones. The system produces monthly reports and generates a survey on the quality of supervision delivered.

The new system was first introduced in mental health Inpatient wards and following a suite of engagement and training delivered by our clinical education team the system went live across the whole trust in April 2020.

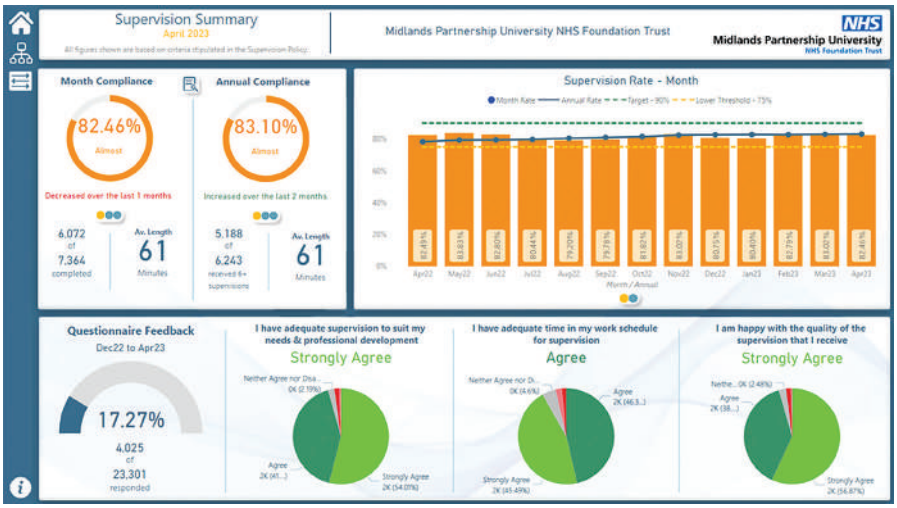
Outcomes

In comparison of April 2020 (supervision rate 67.43%) clinical care delivery incidents have reduced in direct comparison with data from April 2023 (supervision rate 99.34%). We have seen a reduction of around 40% of clinical care delivery incidents and an overall reduction in incidents of 6% across our adult acute mental health wards, supporting the direct correlation between increased supervision levels and improved patient safety. A supervision assurance group has been set up across the trust to monitor ongoing supervision rates alongside the continued deployment and rollout of Professional Nurse Advocates to support all nurses, particularly focused on our preceptorship nurses.

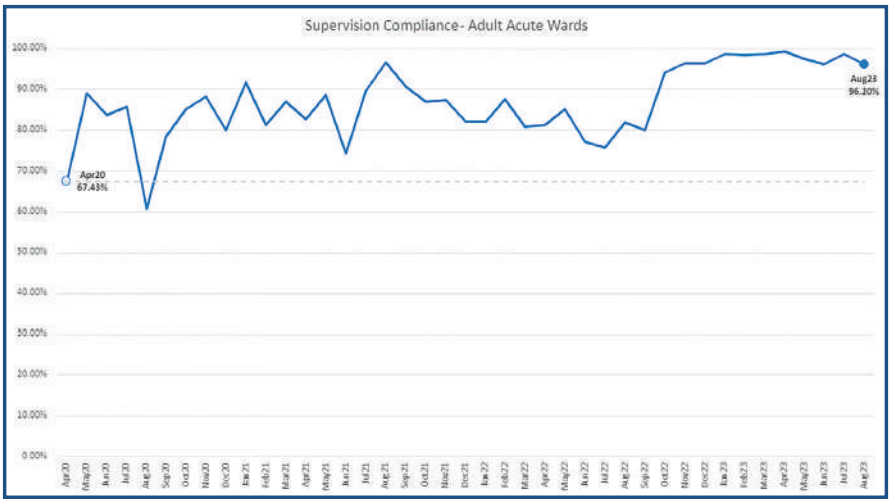
This further continues to elevate patient safety across the organisation through the PNA roles.

Steve Martin, RMHN DipHE, MSc
Deputy Director of Nursing & Chief Nursing information Officer (CNIO)
Midlands Partnership NHS Foundation Trust

Example Supervision dashboard report.



Below charts the increase in supervision recording on the Trust's adult acute mental health wards since April 2020 until August 2023.



Our PNA successes highlighted below.

Embedding relational security See Think Act – Oxleas journey so far...

Violence and aggression is a significant problem in adult acute psychiatric wards. It has adverse impact on patients' recovery as well as a detrimental effect on staffs' physical and psychological wellbeing.

The frontline ward staff need a framework that brings coherence to safety and a risk management strategy that balances the potential harm caused by the healthcare setting to patients and the harm a patient may cause in that setting. Without that balance the result is a culture in inpatient mental health settings in which restrictive practices are often seen as the first response creating additional risks, including feelings of distress and dehumanisation for patients and of cognitive dissonance for nurses.

The work being presented by Oxleas NHS Foundation Trust has evolved as part of the South London Patient Safety Collaboratives and Cavendish Square Group SIMHS project during the period 2020 to 2023.

As a result of 13 staff participating in a training and development programme to become Relational Security See Think Act facilitators within the acute and crisis directorate in 2022, they have been supporting clinical teams in adopting the See Think Act framework for relational security. They have facilitated multi-disciplinary team development workshops across 8 of our inpatient teams resulting in 150 staff receiving initial training on relational security.

The wards who completed their See Think Act training generated multiple change ideas linked to the four domains of relational security and have adopted a cross ward collaborative quality improvement approach to implementing the change ideas.

The data indicates a 20% reduction in incidents of patient to staff physical aggression over a 12 month period and a significant decrease in the use of restrictive interventions (prone restraint and rapid tranquilisation in particular) as a result of the safety improvement programme.

Naidoo Armoordon
Head of Nursing, Oxleas Acute and Crisis Directorate and Programme Lead for Safety and Equality in Mental Health Inpatient setting, Cavendish Square Group.

Emma Hopkins
Practice Development Nurse, Acute & Crisis Directorate, Multi-Professional Approved/ Responsible Clinician (MPAC) in training.

Additional Attendee:

Gillian Idle
Quality Improvement Advisor, Oxleas Acute and Crisis directorate.

" We also have therapeutic conversations around smoking, alcohol, diet and exercise, substance misuse, unprescribed medication and disability. "

Older Adult Physical Health Team

Our physical health is a sub-team based within an older adult crisis and home treatment team based in Sheffield. We work with those over the age of 65 who are experiencing a psychiatric crisis or difficulty that requires intense community support from psychiatric professionals, with the aim of avoiding psychiatric hospital admission. Our service supports patients with functional mental illness and dementia. What we know is that those with mental health issues have poorer health outcomes, and when you take into consideration the psychological, emotional, physical and social changes associated with the aging process, this makes our population the most disadvantaged, with relatively poor health outcomes.

We offer an initial physical health assessment to all clients that come under our team, regardless of psychiatric disorder, presentation or disability, within a 7 day window, in their own home. This involves conducting baseline observations, including BMI, BP, pulse, temperature, respiration rate, o2 saturation and waist circumference. We do utilise NEWS2 as a guideline, however, we appreciate that this is designed for ward-based assessments.

We also have therapeutic conversations around smoking, alcohol, diet and exercise, substance misuse, unprescribed medication and disability. We provide signposting to those clients and their families.

" We have had additional training to identify the deteriorating patient, sepsis identification and early identification of physical health crisis."

We also provide home-based ECG and venepuncture, which has been found to be very beneficial for those patients who have a disability, social phobias and those with dementia. It has also been found to expedite safer prescribing, with the availability to commence psychotropic medication quickly, and monitor lithium. We have had additional training to identify the deteriorating patient, sepsis identification and early identification of physical health crisis and have an escalation pathway in place. We work closely with primary healthcare staff and GPs to create a holistic approach to healthcare and advocate physical health management.

Not only this, but we advise regarding ongoing monitoring of physical health parameters and provide education and drop-in sessions for all staff within the team, including students. At present we are developing a supportive pathway to work more closely with the next generation of support workers, nurses and nursing associates.

All the interventions we have implemented have led to;

- Improvement in care and increased physical health and psychiatric safety within the community.
- Easier access to healthcare provision.
- Reduced dependency upon primary care.
- Therapeutic conversations and empowering patients to adopt healthier lifestyles.
- Early identification and critical intervention with physical health crisis.
- Patient advocacy.
- Expediated prescribing decisions with both physical and psychiatric medications.
- Safer prescribing.

The success of this initiative can be evidenced with our acceptance of physical health reviews by patients. We have risen from 0% of patients in 2019 who have a physical health review (in adherence to recommendations by NICE and RcPsych) to 94% in 2023, with all those who have not had a physical health review having a justification.

Sherrie Richardson
Advanced Clinical Practitioner (ACP)
Non-Medical Prescriber
Professional Nurse Advocate
Registered Mental Health Nurse
Sheffield Health & Social Care NHS FT

Patient Safety Peer Review Tool

In Priory Healthcare we currently have a suite of quality walk round (QWR) tools for monthly use by hospital colleagues to audit their practice and documentation. However, this is not a patient led audit tool for use on a regular basis. Therefore, I proposed to co-produce a patient led QWR tool which has evolved into a Patient Safety Peer Review tool. This involves patients being supported to have patient to patient conversations about their care and environment to inform teams of good practice and where improvements could be made to improve quality and safety from their lived experience and perspective. This can take place on a patient's own ward or a different ward within the hospital if appropriate.

A small group of inpatients and experts by experience worked with myself and other staff through our Patient Reference Group to consider the areas valuable to include, taking time to carefully construct questions that all patients could engage with.

Areas covered within the Patient Safety Peer Review tool include; a service users first impressions, service user engagement and information, service user experience and perspective, staff experience, knowledge and understanding and culture and safety. Within these areas questions explore patients awareness and understanding of their rights, safeguarding, access to advocates, their experiences of co-produced care plans, patient involvement in debriefs, engagement in patient safety, learning lessons and much more.

Patient Safety

Initially the tool was piloted on a small scale and has since been piloted across all hospitals in England, Scotland and Wales. The implementation approach has been flexible for the patient lead to determine; individual conversations, community meeting discussions or in some instances a cup of tea, cake and a chat in a group setting.

The impact and learning from this pilot has been very pleasing at both a local hospital level as well as divisionally. Patients voice / perspective has enabled small and large changes at hospitals and has informed areas of further focus for consistent themes / areas requiring exploration and improvement undertaken within our Patient Safety Programme, which all hospital sites engage and participate.

The longer term plan is for this patient -led QWR to be refined and included within the suite of QWR tools that hospitals utilise on a regular basis to audit their practice and service quality and safety.

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The Priory Trust

" Suicide is a serious public health concern. There are over 5,000 deaths by suicide in England each year."

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Stronger Together –

improving patient safety and preventing suicide through carer and family involvement and collaboration

Suicide is a serious public health concern. There are over 5,000 deaths by suicide in England each year; it is the leading cause of death in men and women under 35, and rates in young people are increasing. Yet it is seen as a preventable phenomenon, and as such, the WHO has called on mental health services to prioritise suicide prevention.

Research suggests that family/carer involvement is an important factor in achieving better outcomes for service users, including suicide and relapse prevention, improved patient safety and reduced hospital admissions. With cuts to services and the shift towards community-based mental health care, carers are carrying more and more responsibility for supporting those in significant mental distress.

Yet, despite an abundance of government legislation, policy and strategies, research and empirical evidence consistently highlights inadequate and inconsistent levels of family/carer collaboration and integration within mental health care. It also points to patient confidentiality and information sharing policies and practice as being the primary barrier to family involvement.

Methods

Stronger Together is a co-produced, co-delivered quality improvement training initiative, which aims to reduce the incidence of suicide, improve long term patient safety and avert serious incidents through carer involvement, empowerment and collaborative working with clinicians. It is based on research and evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health 2022 which identified carer involvement as one of 10 key elements for improved patient safety and suicide reduction.

It also aims to more effectively support patients' family, carers and friends to reduce caregiver burden and burnout. It utilises a co-learning model to bring carers and clinicians together to develop a shared understanding of the needs and challenges on both sides in order to address barriers to involvement.

Results

Co-production with experts by experience was key to ensuring Stronger Together's authenticity and effectiveness for both carers and clinicians. A delivery model utilising the knowledge and expertise of both has been essential in providing both clinically appropriate information balanced with a relatable, reassuring peer for carers. It has provided clinicians with an opportunity to gain first-hand understanding of the challenges carers face and to develop perspectives on the importance of carer involvement.

From a six-month pilot (January -June 2023) there is evidence indicating that the workshop

has had a notable impact on the knowledge and confidence of both caregivers and clinicians. Having them learn from each other, listen and share experiences has been an important element.

Discussion

Stronger Together is attempting to bridge the knowledge-action gap by putting suicide prevention research findings into practice, in terms of providing training to empower carers, and in targeting clinicians to address the barriers to carer involvement, improve both individual and system-level responses to suicide. It is a model that lets go of service providers needing to be the sole expert and gives space and voice to lived experience knowledge and expertise, and to the values of mutual respect, empathy, equality and support that are required to work collaboratively to improve patient safety.

LeadingMinds

An innovative digital solution for improving patient safety through the development of a NEWS2 Alert Dashboard

Objectives

- Address the outcomes of a thematic review that identified the poor recognition and escalation of the deteriorating patient as a contributor to serious incidents.
- Recognise the critical challenges faced by paper-based monitoring physical health observations.
- Explore the technological solutions implemented and their effect on quality and safety.
- Gain insights into fostering a culture of technological innovation in healthcare to improve efficiency and patient outcomes.

Background

St Andrew's Healthcare (STAH) is a large mental health charity with approximately 600 beds across three inpatient hospital sites in Northampton, Birmingham and Essex.

Patients with serious mental illness, learning disabilities and cognitive impairment often struggle to access physical healthcare services which plays its role in the high level of comorbidity and poor physical health outcomes seen in this large population.

The patient population at STAH is complex and the timely identification and escalation of physically deteriorating patients presents significant challenges as identified in a thematic review that investigated the serious incidents linked to physical health over a 12 month period.

Project

The primary aim of this work was to significantly enhance patient safety and the quality of care at STAH by introducing a transformative digital solution for monitoring patients' physical health. This initiative aimed to tackle the prevalent issues within the paper-based manual system, including errors in calculating NEWS2 scores, delayed escalations and incomplete recording.

"Patients with serious mental illness, learning disabilities and cognitive impairment often struggle to access physical healthcare services."

The theory of change underlying this work revolved around leveraging technology to streamline and enhance the monitoring process. By introducing mobile devices that could record health observations, automatically calculate NEWS2 scores and provide real-time oversight via a NEWS2 alert dashboard, the hospital aimed to create an efficient, error-free, and patient-centric healthcare environment. This would allow the hospital to proactively allocate resources where they were most needed.

The methodology involved a comprehensive analysis of the existing healthcare observation process, identifying pain points such as transcription errors, delayed escalations and inefficient paper-based records. A proposal was subsequently developed to introduce mobile devices equipped with features like automated NEWS2 score calculation and real-time monitoring capabilities.

Outcomes

After implementing the mobile device solution and linking to a dashboard the results demonstrated several positive outcomes over time:

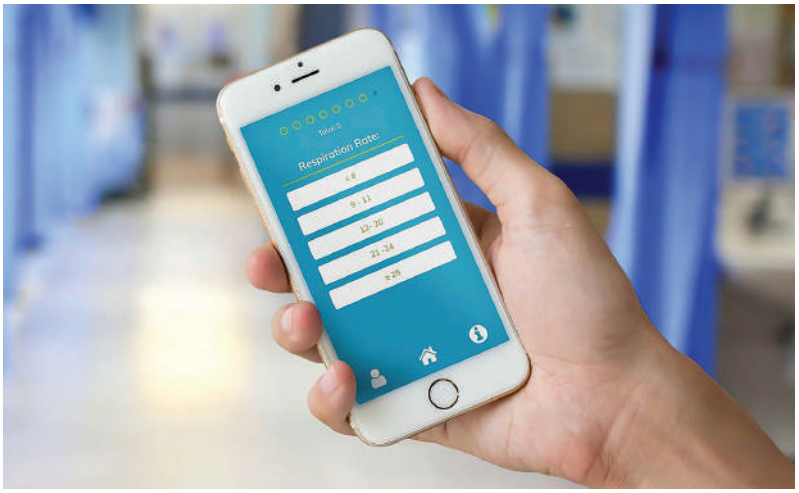
1. Increased Compliance with Physical Health Monitoring: The new system significantly improved compliance with physical health monitoring protocols. Clinicians found it easier to record observations, reducing the likelihood of missed assessments.

2. Reduction of Errors of Calculation: Calculation errors in NEWS2 scores were virtually eliminated due to the automated scoring feature of the mobile devices.

3. Real-Time Overview of Physical Health Observations: The system provided a real-time overview of all physical health observations in the hospital, allowing for efficient resource allocation and timely interventions.

These results underscored the success of the initiative in enhancing patient safety, improving care quality and achieving sustainable positive change within the hospital's healthcare processes.

St Andrew's HEALTHCARE



"The theory of change underlying this work revolved around leveraging technology to streamline and enhance the monitoring process."

Example of the STAH NEWS2 Alert Dashboard

National Early Warning Score (NEWS2)

Current NEWS2 Status

Seriously Unwell (= 7)	Non Contact Concern	Unwell (3 In A Single Parameter)	Unwell (5-6)	At Threat (1-4)	Well (0)
0	0	1	0	127	481

Rio Number	Division	Ward	Date	Resp	SpO2	Sys BP	Pulse	Temp	Consciousness	NEWS Score	Variant
[redacted]				16	97	92	111	37.7	Alert	4	
				16	96	104	120	35.8	Alert	4	
				15	97	97	94	36.0	Alert	4	
				13	97	105	114	36.3	Alert	3	
				16	98	110	111	36.8	Alert	3	
				20	96	92	64	35.9	Alert	3	
				17	97	96	92	36.8	Alert	3	
				16	95	126	92	36.5	Alert	2	
				16	97	108	80	35.6	Alert	2	
				19	98	111	116	37.1	Alert	2	!
				18	94	107	85	36.1	Alert	2	
				17	95	129	107	36.3	Alert	2	

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Putting patient safety at the heart of mental health and learning disabilities

Positive culture, person-centred approach and quality improvement – a recipe for success

Scarisbrick Unit comprises a mixed sex adult mental health ward and a male Psychiatric Intensive Care Unit (PICU). As a unit we have always prioritised patient safety and engaged in a number of focused quality improvement initiatives to enhance patient care - some of the best examples are briefly outlined below.

Recovery Riders was established initially on the PICU, designed with patients and staff to support reduction in restrictive practice. The project allowed for police to donate bicycles to the unit, Halfords to service them and then by upskilling our staff who led on bike rides around the Lancashire countryside. The Recovery Riders had massive success in supporting both the mental and physical health of service users and saw a reduction of seclusion by 90%. The project was recognised on a national level, winning three prestigious national awards in 2022. Since then the Recovery Riders has been replicated across the Trust and implemented onto other wards. Furthermore, we have been able to support other Trusts who are keen to implement and are currently working with community teams to enable continuity through services. This work has now been published in a national journal with support for others to adapt and utilise to improve patient safety in their own organisations.

More recently the service established a nurse-led project, with psychology and occupational therapy, underpinned by training and support. This initiative saw the establishment of 'The Bus Stop', an area to stop, reflect and engage in activities to reduce the stress when entering identified flash points on the ward; bedrooms (increased risk of self-harm) and the communal areas (increased risk of violence and aggression).

"Due to the nature of innovation and the successful results, the project has been shortlisted for four national awards this year."

This initiative has been a vehicle to promoting therapeutic engagement between staff and patients. The delivery of activities and interventions such as mindfulness, relaxation and guided interviews, all of which has supported service users in feeling more able to cope. Since being established in October 2022, there has been a 35% reduction in harm incidents and a 30% reduction in restrictive practices. Due to the nature of innovation and the successful results, the project has been shortlisted for four national awards this year.

There is an example of work completed by the teams within the Scarisbrick Unit in order to deliver person-centred care to a patient with a profound learning disability and autism. This included working closely with his main carer, his learning disability team and his placement to create a bespoke care package on the ward underpinned by staff training. In addition, environmental changes were made to create the low stimulus setting required to best support this individual. Throughout the adaptations patient safety was at the heart and the learning achieved has been adapted so that the team can continue to support those with a Learning disability and/or autism in the best way possible when admitted to an inpatient mental health setting.

The teams within the Scarisbrick Unit have been engaged in some focused work to ensure effective patient flow. This again has been supported by quality improvement methodology to implement safety huddles and the use of a Recovery and Discharge Planning Tool. The philosophy is to ensure meaningful admissions for all, making each day count and reducing barriers to discharge. Through the implementation of this work we have seen a reduction in length of stays and managed to move forward stranded patients with positive outcomes. The focus is shifting to community-based treatment from the outset of the hospital admission.

These examples really demonstrate how, with the right culture, a person-centred approach and supported by the framework of quality improvement methodology, teams can really improve the care of people within mental health and learning disability services, improve patient outcomes and really keep patient safety at the heart of all we do.

" The philosophy is to ensure meaningful admissions for all, making each day count and reducing barriers to discharge."

" The Recovery Riders had massive success in supporting both the mental and physical health of service users and saw a reduction of seclusion by 90%."

Rebekah Nwaka: Matron **Lisa Smith:** Consultant Nurse
Rebekah Roshan: Director of Nursing & Quality (Central & West)
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LeadingMinds

Psychosocial interventions in mental health nursing – a renewed frontier for the profession

Introduction

NHS England has commissioned the Royal College of Nursing (RCN) to develop a nationally recognised programme for mental health nurses across England. The programme will focus on psychosocial interventions (PSI) and will be a revamped version of a highly successful programme previously offered by the RCN Institute in the early 2000s. We aim to bring about sustainable cultural change and improve care quality within and beyond mental health services.

Background

In March 2022, Health Education England (HEE) published a mental health nursing review, Commitment and Growth: advancing mental health nursing now and for the future, led by Baroness Mary Watkins of Tavistock. The report made eight recommendations for advancing the role of mental health nursing in England.

"We aim to bring about sustainable cultural change and improve care quality within and beyond mental health services."

Recommendations two and three of the report are most relevant to the need for PSI in mental health nursing, which emphasises that mental health nurses should prioritise enhancing therapeutic relationships, valuing experiential knowledge, and identifying core skills across all practice settings and age groups, responding to local needs.

From a recent survey of mental health nurses, the RCN has found that developing psychosocial intervention education for post-registered mental health nurses is a priority for practice-based nurses, students, educators and researchers. There is currently no nationally recognised offer to specifically develop the skills and knowledge of mental health nurses to advance the therapeutic relationship within the context of psychosocial interventions.

Annex A of the NMC's Future Nurse Standards highlights the importance of nurses practising evidence-based communication skills and therapeutic interventions. If we want to establish and embed this approach in pre-registration education, it is crucial that our post-registration mental health nurses feel confident and knowledgeable enough to incorporate these practices into mental health services.

Module 1	• **Applied PSI in mental health nursing** • **The model of stress and vulnerability** • **Critical reflective practice**
Module 2	• **Co-production with patients, service users and carers** • **Enhanced psychosocial care planning** • **Culturally sensitive care**
Module 3	• **Therapeutic environment** • **Safe workplace, safe practice** • **Setting the culture for sustainable change**

"Each module builds on the previous one, improving care quality and promoting sustainable practices."

The Programme

The programme is conceptual but will undergo rapid development in the coming months. Our programme will take learners approximately 9-12 months to complete. Successful completion will lead to membership of the RCN Community of Psychosocial Nursing Practice.

The high level content of the modules can be seen in the table above but are subject to refinement as the programme is reviewed and developed.

Each module builds on the previous one, improving care quality and promoting sustainable practices.

The Bespoke Offer

The programme is open to all post-preceptorship nurses and aims to help learners integrate newly acquired skills and knowledge into their current roles or advance to new ones. The programme addresses the lack of enhanced-level education and clinical development opportunities for mental health nurses to grow clinically in their careers.

The RCN acknowledges the challenges of releasing nursing staff for CPD due to workforce shortages. The RCN PSI programme is designed to be accessible and practical, with customised delivery available to organisations booking whole cohorts.

Get Involved

If you would like to express an interest or learn more about the programme, please contact the RCN mental health programme's team at **mhprogrammes@rcn.org.uk**

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UK Professional Lead for Mental Health
Royal College of Nursing

Ellie Gordon RN (MH)
Senior Nurse; Learning Disability and Mental Health
NHS England

LeadingMinds

Schwartz Rounds – leadership intervention on staff wellbeing and patient safety

S	**Self-care: Practice self-care by being kind to yourself; take a break, stay healthy and stay safe.**
O	**Open up: Talk, share your experiences and feelings; we are here to listen.**
O	**Others: You are not alone; others are here for you and there is lots of support if you need it.**
T	**Teamwork: We are all in this together. Stay connected, look out for each other and keep huddling.**
H	**Help: It's okay to need some extra help. Ask and take the support you need for what you are facing.**
E	**Enjoy: Find ways to take time out and do things that make you happy.**

MPFT is an integrated mental health, learning disabilities and community NHS provider recognised through national forums, literature review and by understanding the intrinsic links between the wellbeing of staff and patient safety. Staff wellbeing and patient safety are Board priorities supported by a framework developed by the Trust called SOOTHE.

SOOTHE was developed to provide a strategic approach to wellbeing and wellbeing interventions. It is an acronym built around key aspects of wellbeing: Self-care, Open Up, Others, Team, Help and Enjoy. These six areas were informed through research and British Psychological Society (2020) national guidance.

As a leadership intervention to enhance staff wellbeing and strengthen the recognised intrinsic links between staff wellbeing and patient safety (NIHR 2018), we introduced **'Schwartz Rounds'** as one of the resources within SOOTHE. We learned, **'people needed to talk about things'** to share the emotional, social and ethical challenges of their work in a safe, supportive and confidential space outside of quality safety and governance arrangements.

How we implemented we started with the formation of a Schwartz Round Steering Group made up of a Clinical Lead (RN/Clinical Psychologist), Facilitators Clinical Psychologists. Core members are lived experience colleagues, RMN/RN and Health Visitors, AHPs, Administration, Estates and Chaplaincy colleagues. The Group vision is – **'We care for you, so you can safely care for them'.**

Opting for a sustainable implementation model through the steering group with a supportive communication and engagement plan and associated initiatives such as 'bring a buddy' scheme helped to organically spread the value of the rounds across the diversity and breadth of services. Virtual rounds delivered via Microsoft Teams were optimised and continue to teach us the value of the digital revolution where the geographical footprint is complex and far reaching. Rounds are open to all and panellists share pre-prepared stories to trigger reflection in audience members to generate insights and collective discussions (Maben, 2018).

"We care for you, so you can safely care for them."

SOOTHE

Examples of rounds delivered/due to be delivered related to patient safety:

- **The boundaries within which we manage**
- **No health without mental health**
- **Being inclusive – in inclusion**
- **The importance of taking a break**
- **Raising the flag**
- **We are human too: making mistakes and the impact**
- **Mental Health: without walls**
- **Safety is the golden thread**
- **To err is human**
- **Feeling free to speak up**

"SOOTHE was developed to provide a strategic approach to wellbeing and wellbeing interventions."

How we determine round themes related to staff wellbeing and patient safety:

- Organisational or Care Group priorities.
- NHS staff survey feedback.
- Patient safety incidents and associated themed learning outcomes.
- Confidential Freedom to Speak themes.

How the Steering Group evaluate the link between staff wellbeing and patient safety:

Specific category-based evaluation question asked is 'I gained insights that will help me meet the needs of the service users/patients and improve patient safety, quality and experience. **Evaluation so far** - 84.3% of staff agreed rounds attended will help them meet service user needs and improve patient safety.

Overall themed qualitative feedback is:

- Helpful by giving space to share and process experiences in a safe place.
- Encouraging a culture of openness by supporting staff to deliver safe care.
- Learn from each other when things don't go as planned.
- A different way to tackle cultural change.
- Opportunity to share thoughts, feelings and emotions to connect to improve services.
- Improve multi-disciplinary team communication and teamworking.
- Good to be my real self and not the professional.

Keywords shared from participants: Powerful, thought provoking, reflective, time to think, learn from others, human, humbling, impactful, feeling understood, listened to, meaningful, practice safely, not alone, insight, reduce errors and mistakes, valued, feeling less guilt, emotional.

Conclusion:

We are in the early stages of our journey and learning every step of the way. Our next steps are to focus on data to fully maximise and evaluate the intrinsic links and people with lived experiences to join us to optimise our learning as partners. Our aim is to have a growing body of evidence to further link wellbeing to the safety of our patients within MPFT.

We deliver monthly rounds and continue to understand the impact and benefits for our patients' safety and staff wellbeing and experience.

If you would like to share your experiences, join us on a round or ask any questions please contact **SchwartzRounds@mpft.nhs.uk**

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Search training

Introduction

Searching patients, their property and the ward environment is a clinical task that's conducted on a daily basis by inpatient wards, and is recommended in the Mental Health Act Guidance. NICE guidelines further state that the removal of means to self-harm should be considered and lethal means of suicide removed or restricted. However, despite this recognition, there is a dearth of research pertaining to how this task should be undertaken and its effectiveness in increasing patient safety. Consequentially, there is variation from ward to ward in how this is conducted, with staff often not feeling confident in undertaking this task.

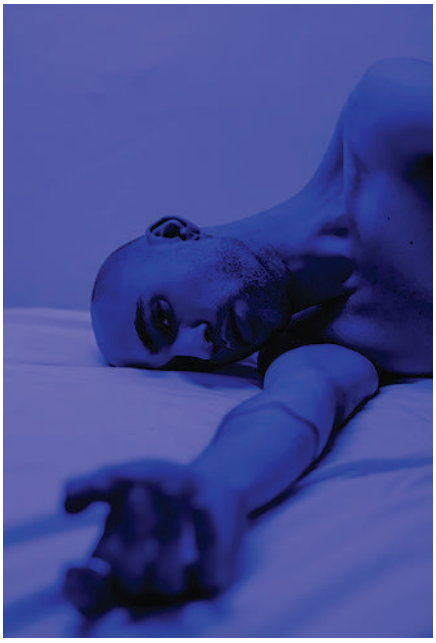
To address these issues it was felt that simulation training would offer realistic environment and scenarios base on real ward experience to enable staff to practice, acquire and hone the skills required for clinical practice of search.

Method

A one day training course was developed, and based on an already offered course on Secure Wards, guidance on reducing self-harm from NICE and NCISH in accordance with the Mental Health Act, as well as the application of trauma informed practice.

Further experiential knowledge was sought from a range of stakeholders, including a patient, peer support workers, a range of clinical staff, trainers and specialists from the Safe from Suicide Team.

The training was trialled on Moorland View, an adult acute ward. In total, 31 staff all working on this ward attended training. The training was delivered by two to three staff with each training event hosting up to six people. The training comprised both a simulation component and a classroom component. Key areas of the course content included different types of search; what a search kit should contain and how



to use the search kit; obtaining consent; identifying restricted and banned items; risk assessment and formulation and trauma-informed practice.

Results

Staff confidence levels obtained pre and post feedback across a range of searches showed a significant increase in staff confidence. A knowledge evaluation questionnaire applied pre and post training identified a significant increase in knowledge across all areas. Qualitative feedback obtained on the ward post training also highlighted the learning value and practical value, with suggestions for the future of the course.

Discussion

The results highlighted that this course was very effective in teaching staff the required search skills and thus in supporting the reduction in harm to any. Staff and trainers who developed and delivered the course believe this was likely due to the training approach used. Whilst it is acknowledged that an online training package could reduce cost, it is believed that this would not be as effective as a simulation approach. The course evaluators would also like to identify further how well the knowledge is retained over a longer period of time and how the knowledge continues to be applied in practice.

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An evaluation of a nurse-led learning disability and autism drop-in clinic for adult mental health services

Abstract

Background

People with a learning disability and autistic people (LDA) experience significantly higher rates of mental illness than the wider population (NHS Long Term Plan 2019). This population is also more likely to experience restrictive practices when using mental health services (CQC 2020). Most clinicians do not receive any training about LDA (BMA 2014) raising important questions about patient safety, quality of care and workforce capability (Health and Social Care Act 2022). To address this need, a nurse-led LDA drop-in clinic for adult mental health services (the drop-in clinic) was developed. The drop-in clinic provides mental health clinicians with timely access to specialist advice, consultation and support about LDA.

Aims

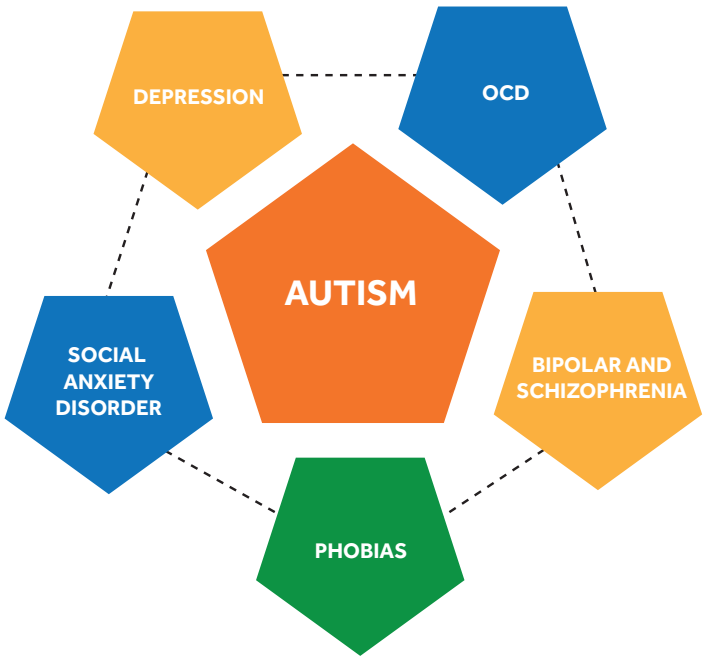
To evaluate the drop-in clinic's impact on clinical care and acceptability to clinicians.

Method

Data was collected about those attending the clinic and the nature of their queries (n=43). Semi-structured interviews were held with staff. Descriptive statistics and Thematic Analysis (Braun & Clarke 2006) were employed for data analysis.

Results

Between 11 March 2021 and 8 September 2022, 54 drop-in clinics were held. 15 drop-in clinics were not attended. Of the 38 drop-in clinics that took place, 23 (61.5%) were about autism and 15 (39.4%) were about learning disability. Clinical Psychologists were the professionals that most frequently attended (n 10). Clinicians were most likely to be part of a community team (34/38 drop-in clinics). The most common queries were related to signposting such as diagnostic pathways and access to specialist resources (14/43 queries), followed by improving knowledge and understanding of LDA in relation to patient care or case formulation (9/43 queries). Thematic Analysis of interviews started in May 2023. Full results and findings will be presented alongside a discussion of the benefits and limitations of the drop-in clinic and implications for further development.



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LeadingMinds

Putting patient safety at the heart of mental health and learning disabilities

An in-person event dedicated to promoting and ensuring the wellbeing of patients

STOMP (Stopping the over medication of people with a learning disability, autism or both) aims to reduce inappropriate prescribing of psychotropic medication for people with learning disability and/or autism, in the absence of a diagnosis of serious mental illness (NHSE, 2017). As part of actions to embed STOMP, a joint clinic, utilising a specialist pharmacist and consultant nurse, introduced an independent prescribing model in a community learning disability team in Lancashire.

What did we do?

A review of the current outpatient caseload based on the following criteria;

- Validated learning disability
- Adults aged 18 years and over
- Prescribed a psychotropic medication for managing behavioural distress.

Clinic Structure

The clinic offered extended appointments focusing on;

- Reasonable adjustments
- Consultation
- STOMP principles
- Reservations by staff, carers and patients
- Physical investigations
- Formal side effect monitoring (GASS)
- Review of incident data and engagement levels
- Home visits also facilitated.

This supported a structured and varied job plan reflective of the Consultant Nurse and Lead Pharmacist job roles.

Medications that were reduced included benzodiazepines and antipsychotics.

Challenges

- Reluctance and fear from family and provider.
- Previous negative experience of reducing medication.
- Reluctance to change the status quo and make the decision.
- Gaining initial medical secretary support and clarity of roles.
- Access to clinic space for face to face reviews.
- Access to physical health monitoring equipment.
- Limited access to desensitisation kits.
- Provider staff not always familiar with patient or have access to relevant information.
- Difficulties in obtaining requested information outside of the consultation e.g. falls log, physical health parameters, incidents, sleep records.
- Prolonged time lag between recommended changes and commencement by GP.
- Responsiveness to queries can be a challenge given the varied job plans of the prescribers.

Benefits

- PBS informed review by nurse based on previous experience and knowledge using a coaching and educating approach.
- Senior nurse role allowed facilitation and appropriate allocation of referrals to nursing colleagues.
- Unblocking barriers and enabling informative discussions with CLDT nursing team to gain timely engagement with support around PBS and blood desensitisation.
- Pharmacist was able to articulate in easy understood language around the pharmacokinetics and pharmacology of the drugs.
- Shared learning for both professions.
- Generated interest and shared learning around NMP students and multi-professional colleagues.
- Clear articulation of why discontinuing the medication was not appropriate.
- Holistic review of patients including drug interactions, contra-indications and review of all medication as opposed to sole focus on psychiatric medication.

STOMP

Stopping over medication of people with a learning disability, autism or both

Jacquie Shenton
Consultant Nurse/Independent Prescriber

Kieran McCormack
Lead Pharmacist Learning Disability/ Independent Prescriber

Lancashire and South Cumbria NHS Foundation Trust

Outcomes

- EDUCATION: STOMP easy read letter and literature provided prior to the first appointment.
- Principles of STOMP discussed in detail at first appointment, including risks and benefits and opportunity given to explore concerns.
- All patients have been supported to ensure Annual Health Check and physical health checks.
- Successful medicines optimisation. A significant proportion have had medication discontinued and/or reduced.

Women who need intensive care – a time to change

As a society, we are trying to better understand the needs of women, and bring about those changes that enable women to feel and be safe. When women need intensive care they are often at their most vulnerable, so it's only right that we pause and consider the therapeutic environments we offer women.

A bit of history

In the UK, PICUs were created in the 1990s, although initially predominantly for men, some were mixed-sex wards. Several studies have highlighted male admission rates to be as much as 85%. (Brown et al 2008, O'Brien et al 2013, Archer et al 2016). Men are mostly in their 20s-30s (Cullen et al 2018) with diagnoses of acute psychosis and in particular schizophrenia (O'Brien et al 2013, Brown et al 2008).

The first women only unit seems to have been built in 2008 in Bristol. In the NAPICU national survey of 2016, results found only seven women-only PICUs.

These findings demonstrated the overall greater need for male PICU beds than womens' PICUs. However, it has also meant that research conducted on PICUs, along with treatment and management approaches, were based on a majority male population and findings were generalised to women service users. This was based on the held belief at the time that women were not a 'special group', but part of the mainstream and, therefore, should be treated accordingly (Satel, 1998).

More recently

Kohen (2001) argued that psychiatric services had failed to consider that women suffer from certain gender-specific mental illnesses. Consequently, by using mainstream approaches to psychiatric care, mental health services were dismissing critical factors that could affect the care, management and outcomes of treatment for women.

" When women need intensive care, they are often at their most vulnerable, so it's only right that we pause and consider the therapeutic environments we offer women."

With the turn of the millennium, concerns started being raised that women accessing mental health services did not have the same characteristics and needs as men and, therefore, they were not receiving appropriate care (Archer et al 2016).

Archer et al (2016), conducted a literature review of the women population of PICUs and low secure units. The study reported that women had higher incidence and prevalence of Personality Disorders (namely Emotionally Unstable Personality Disorder and difficulty with emotional regulation). However, they also presented with other psychiatric illnesses such as depression, generalised anxiety disorder and panic attacks. The authors highlighted that women engaged in significantly more deliberate self-harm.

Womens' relationship with the staff was emphasised as an important factor for their recovery and the authors stressed the importance of feeling heard, understood and respected by all team members. Therefore, they advocated for gender-sensitive training for staff and that women-only wards required more resources.

The Department of Health (Department of Health, as cited in Archer et al (2016) also mentioned that aspects of safety, privacy and dignity for women were not being considered by mental health services and, therefore, psychiatric treatments were providing a disservice to this population.

Additionally, over the past decade, society has continued to become increasingly aware of the widespread issue of women being victims of both physical and sexual violence. Sexual violence against women was being recognised as a significant global issue and clear direction was set for this to be a priority for healthcare systems in terms of service delivery (WHO 2017).

Gender-specific considerations for women who require PICU admission

Women who are in an acute phase of mental illness necessitating PICU admission may present with a range of symptoms. Their presentation will be impacted by both the severity of mental illness, their trauma histories and an unfamiliar hospital environment. This combination of factors contributes to increased feelings of anxiety and fear. As a result, women may present as highly dysregulated and with behaviours that include disinhibition, irritability, agitation and severe self-harming.

Sexual Violence

In society women continue to be at risk of being the victims of sexual violence. National data shows that women are over five times more likely to have experienced sexual violence since the age of 16 than men. In 98% of incidences perpetrators are male (ONS 2021).

A significant number of women who require PICU admission will have experienced sexual violence (McLindon and Harms 2011).

"National data shows that women are over five times more likely to have experienced sexual violence since the age of 16 than men."

Evidence suggests that this is a significant factor on mediating mental health issues impacting recovery and is a factor in increasing vulnerability and re-traumatisation. (Hughes et al 2019, Tarzia et al 2018).

Women have been identified as being at particular risk of sexual assault whilst inpatients (Ashmore et al 2015, Banja 2014, Foley and Cummins 2018). When sexual assaults towards women occur in inpatient units, evidence suggests that these often happen in communal areas. Consequently, single sex sleeping arrangements may not mitigate risk or help feelings of safety (Ashmore et al 2015, CQC 2018, Foley and Cummins 2018).

Regulatory reports have also highlighted this as a concern (CQC 2018). This has led to a focus from national improvement programmes with the mental health safety improvement programme.

More severe histories of sexual violence in women link with more severe mental health presentation, including longer and more frequent admissions, longer periods in seclusion, higher amounts of medication and rapid tranquilisation and increased frequency of self-harm. (Read et al 2006).

Feelings of vulnerability are further exacerbated by the fact that women admitted to mixed sex PICU units are often in the minority amongst a majority male patient and staff population. Admission to a mixed sex PICU may therefore impact on clinical presentation, delay recovery and prolong admission.

" For many women there continues to be an expectation that they will want to be a mother, to marry and to act in accordance with other cultural standards that are applied to them."

Being a mother

Many women admitted to mental health units, including PICUs, have children. Often, they will be the primary caregiver, and will be separated from their children during the admission. This can be particularly anxiety provoking for women during their admission and may impact on their clinical presentation and recovery. Women who have children may be engaged with multiple agencies to support the welfare of them and their children.

Culture and Society

Although there has been societal change, women continue to experience the impact of societal pressures and cultural expectations related to their sex. Media portrayal of the acceptable woman continues to prevail which impacts on their beliefs about themselves and the understanding of their worth.

Women also continue to face pressures related to the cultural norms they are socialised within. For many women there continues to be an expectation that they will want to be a mother, to marry and to act in accordance with other cultural standards that are applied to them.

Recommendation

For the past year, a number of practitioners, academics and service users have been considering the needs of women who need intensive care. Following this wide discussion, it was recommended that, as a nation, we should be moving towards single sex PICUs.

This recommendation has been presented to the National Association for Psychiatric Intensive Care (NAPICU), the RCPsych PICU accreditation body and the RCPsych lead for womens' mental health.

NAPICU and the RCPsych bodies involved in this discussion have supported the recommendation that there is a national requirement for PICUs to be single sex only.

Implementation

The proposal recognises that currently there is a range of PICU provision in place nationally, some single sex and some mixed sex. If this recommendation is supported more broadly, implementation would need to be planned over the coming three years, with service user, national, regional and other stakeholder engagement, tailoring services to meet the needs of women who need intensive care.

"Media portrayal of the acceptable woman continues to prevail which impacts on their beliefs about themselves and the understanding of their worth."

Current Perspectives...

A Different View?

Vicki Charlesworth
Professional Lead for Clinical Quality & Clinical Leadership, Berkshire Healthcare NHS Foundation Trust

Seamus Watson
National Improvement Director, NHS England

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Seamus Watson: Seamus.watson@nhs.net

Dr Shanika Balachandra: s_balachandra@hotmail.com

We would very much like to support you with your local discussion regarding single sex PICUs.

Transition to adult services in mental health of intellectual disability – A best practice example

Introduction

The SLaM CAMHS tier 4 national and specialist service had been involved with a person for several years who had complex physical, mental health and behavioural needs and lived in a 52-week specialist residential school placement. He had profound intellectual disability, autism, ADHD and anxiety. As his transition to adult supported living approached, he presented with a significant increase in self-injurious behaviour and aggression towards others. Learning disabilities nursing took the lead role in implementing a robust multi-disciplinary care plan to ensure a safe and effective handover of care to adult services.

Summary

The intervention involved meeting with the young person's parents and the staff at school to gather an understanding of the current concerns, challenges and timeline for transition to adult services. This was led by psychiatry and LD nursing with discussion with the wider multidisciplinary team.

A care plan was agreed including:

A summary of the patient's care needs to support an application for continuing healthcare funding, which was subsequently approved.

Completion of an updated functional analysis by the LD nurse which included direct observation, data gathering and functional assessment interview with parents, education and care staff.

Speech and Language Therapy completed a language and communication assessment providing recommendations to parents and school staff.

Occupational Therapy completed a sensory needs assessment providing recommendations to parents and school staff.

Mental health of child and adolescent psychiatry reviewed patient's mental state and the role of medication.

A review of physical health needs including annual health check, blood test and appropriate specialist review.

All work was in collaboration with parents, school staff, local CAMHS and social services to formulate current concerns and develop a positive behaviour support (PBS) plan.

Handover to adult services involved:

Multiple meetings with local adult LD and health services to hand over the care plan. This included the consultant psychiatrist in adult LD services, the mental health and LD team and community LD nursing team. All relevant information was shared.

Multiple meetings with the supported living care staff to hand over the PBS plan and recommendations from each assessment.

Residential school staff supported new care staff to build relationships with the young person and develop an understanding of the PBS plan.

Advocacy support was recommended.

Parents were involved and in agreement with every step of the process.

Conclusions

A collaborative approach between service users, their families and services is key to ensuring a safe and effective hand over of care. It was essential to ensure this was completed at the pace of the young person and not expedited with the aim of discharge.

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Sarah H Bernard
Consultant Child and Adolescent Psychiatrist
National and Specialist CAMHS Mental Health of Intellectual Disability Service.
South London and Maudsley NHS Foundation Trust

Peter Hasler
Forum Development Officer

As we travel south to Winchester for our Autumn conference, It feels like our chosen subject of Patient Safety could not be more timely. We have tried to get a balance of national speakers and local initiatives and good practice.

The strength of the Forum is our ability to link up people across the country to learn from each other. Wherever we are able, we have responded to the subjects being discussed on our email group. Subjects like, blanket restrictions, safety in seclusion, ligature harm minimisation, crisis teams in CAMHS, enhanced observations. We are always looking for volunteers who are willing to lead on a discussion group on subjects of interest and have been grateful to those who have come forward in the past year.

In October 2023 we started our 5th intake of the Aspiring Director programme jointly with the NHS Confederation. 17 people commenced this year's programme of masterclasses, group and personal support. Our first speaker was Claire Murdoch who gave a fascinating insight into her career and the experiences of working at executive level. Many of you will have seen there has been a lot of movement in the chief nurses' positions nationally, so it is even more important that we do everything we can to support the next generation of chief nurses, executive directors and indeed Chief Executives.

On the 3rd November 2023 we held our 5th Future Mental Health Nurse Conference in Sheffield. This Conference was led by a group of third year students who gained valuable knowledge and experience of pulling together a significant event, with 250 attendees. Many Trusts also attended with recruitment stands and we hope they have been successful in attracting new recruits.

Peter Hasler
Forum Development Officer
Peter.hasler1@nhs.net

"The strength of the Forum is our ability to link up people across the country to learn from each other."

National Mental Health and Learning Disability Nurse Directors Forum

Influencing and advancing care in mental health and learning disabilities

Putting patient safety at the heart of mental health and learning disabilities

Friday, 10th November, 2023

08.45-09.15 **Arrival, registration and refreshments**

09.15-09.25 **Welcome by Chair**
Paula Hull, Director of Nursing & Allied Health Professionals, Southern Health.

09.25-09.55 **National overview and update on MH Nursing**
Acosia Nyanin, Deputy Chief Nursing Officer for England - Professional and System Leadership.

09.55-10.35 **National Therapeutic Observation project update**
Angie Fletcher, Associate Director of Quality Improvement & Effectiveness, Oxford Healthcare Improvement.

10.35-11.05 **Learning safely**
Rebecca Burgess-Dawson, National Clinical Lead (Mental Health).

11.05-11.35 **Break**

11.35-12.05 **Outline and interim results from a national evaluation of prevalence, governance and impact of vision-based monitoring and body worn cameras in mental health services in England**
Fiona Nolan, Clinical Professor, Chair of Mental Health Nurse Academics UK.

12.05-12.25 **Hazel Ward Safe Space**
Charlotte Dodd, Clinical Ward Manager, Southern Health NHS Foundation Trust.

12.25-12.55 **Scenario Based Education**
Caroline Harris-Birtles, Head of Nurse Education & John Hall, Regional Nurse Director, Midlands and Wales, Cygnet.

12.55-13.15 **Improving patient safety by reducing restrictive practice**
Amy Hartley, Interim Deputy Chief Nurse & Stephen Osbaldeston, Lancashire & South Cumbria Foundation NHS Trust.

13.15-14.10 **Lunch**

14.10-14.25 **Searching patients, their property and the ward environment**
Shane Summers, Health Care Assistant, Moorland View (adult acute ward). Karla Wilson-Palmer, Clinical Lead, Safe from Suicide. Samantha Blake, Senior Clinical Quality Improvement Officer, Devon Partnership NHS Trust.

14.25-14.40 **An evaluation of a nurse-led learning disability and autism drop-in clinic for adult mental health services**
Karina Marshall-Tate, Consultant Nurse & Lecturer/Practitioner (Learning Disability)
Dr Debbie Spain, Honorary Consultant Nurse (Autism) and Cognitive Behaviour Therapist
South London & Maudsley NHS Foundation Trust.

14.40-14.55 **A multi-element approach of bringing together sensory friendly environmental design, education and co-production to promote regulation, improve occupational participation and reduce restrictive practices in an adult learning disability inpatient unit**
Rachael Daniels, Clinical Lead Occupational Therapist, Specialist Directorate and Sensory Integration Lead
Danielle Morgan, Advanced Specialist Occupational Therapist, Devon Partnership NHS Trust.

14.55-15.10 **Embedding relational security See Think Act – Oxleas journey so far...**
Naidoo Armoordon, Head of Nursing Oxleas, Acute and Crisis Directorate and Programme Lead for Safety and Equality in Mental Health Inpatient setting, Cavendish Square Group.
Emma Hopkins, Practice Development Nurse, Acute & Crisis Directorate, Multi-Professional Approved/Responsible Clinician (MPAC) in Training.

15.10-15.25 **Chair of the Forum**
Mary Mumvuri, Chief Nursing Officer/Deputy CEO, Nursing, AHPs and Quality Directorate Coventry & Warwickshire Partnership Trust

15.30 **Closing comments**