National Mental Health Nurse Directors Forum
Influencing and advancing care in mental health and learning disabilities

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Leading Minds

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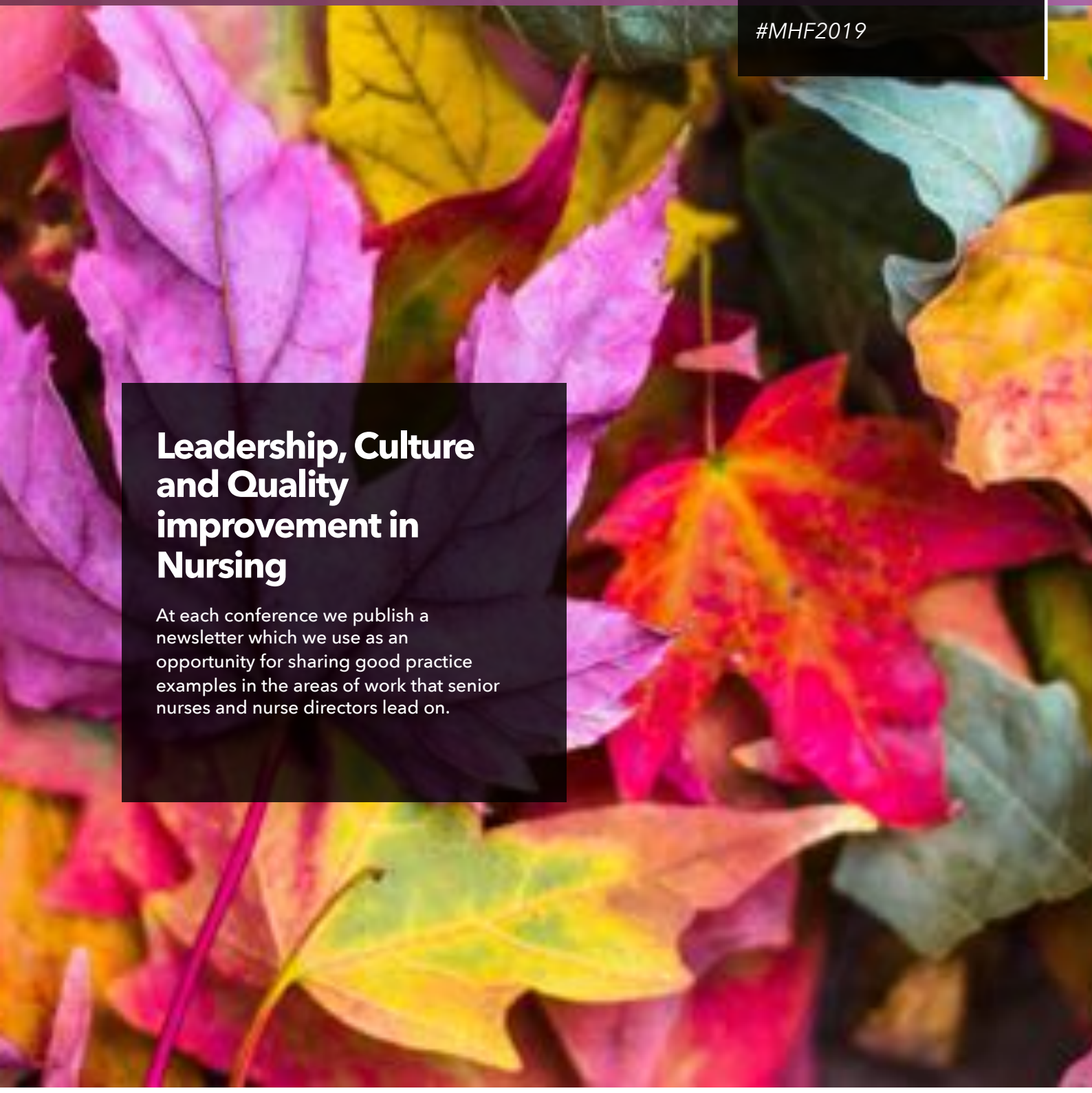

Leadership, Culture and Quality improvement in Nursing

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.

National Mental Health Nurse Directors Forum

Influencing and advancing care in mental health and learning disabilities

Maria Nelligan, Executive Director of Nursing and Quality & Leading Minds Editor

Lancashire and South Cumbria NHS Foundation Trust

Leadership, Culture and Quality improvement in Nursing

IT'S THE TIME OF YEAR AGAIN, OUR ANNUAL CONFERENCE, WHERE WE COME TOGETHER TO CELEBRATE PRACTICE IN MENTAL HEALTH AND LEARNING DISABILITY NURSING.

This conference is focusing on quality improvement and leadership, which is essential in helping us deliver the Long Term Plan. There has never been a more challenging time to focus on equipping leaders with the tools to lead teams with the stamina and compassion that is required; in particular, with the level of Registered Nurse vacancies. Additionally, it is essential the forum continues to influence and work with Health Education England (HEE) in the future of learning disability nursing and we welcome the summary provided by Peter and Tim. We need to continue to embed initiatives to enhance retention, developing people beyond registration; particularly CPD and research, the work that TEWV is doing with the NIHR – this is really helpful in informing our locally strategies.

Those of you that know me, know I am a passionate supporter of Consultant roles and I am looking forward to hearing from Fiona on the work she has done. However, I am particularly heartened to see the contribution we have this time from our consultant nurses to both today's programme and the newsletter - well done and keep going.

I am looking forward to hearing John West's presentation on Compassionate Leadership for High Quality Care and Helen Bevan's presentation on leadership and culture and taking away some top tips and key reflections. On a similar vein, Catherine Gamble's article on Harnessing BAME Nursing Talent leadership programme is well received and we can take a lot away for our own organisations.

Finally, thank you to all our contributors to the newsletter and enjoy the Conference.

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Improving mental health wellbeing

Collaborative Working Initiative

The Juniper Centre is a 54 bed acute inpatient psychiatric assessment unit for older adults that specialises in dementia and frailty.

Patients are frequently admitted with multiple co-morbidities which increase their risk of deterioration in their physical health, particularly when compounded with the complexities of a decline in their mental health. Historically when this has happened patients have been transferred to a large treatment centre for assessment. However, the Juniper Centre shares its site with a sub-acute hospital which is well placed in terms of location and expertise to offer patients medical, nursing and therapy treatment for a range of clinical presentations including: UTI, URTI, Managing exacerbations of a long term condition, infected leg ulcers, Cellulitis, Constipation and Dehydration.

BRAUN ET AL 2006

It is well understood experientially and from the literature (Braun et al 2006) that patients who are admitted to secondary care are at substantial risk from developing hospital acquired infections, becoming deconditioned and, for people with dementia, the risk of increased confusion and subsequent distress is significant. Although an admission to a sub-acute hospital can not prevent these risks it is envisaged that by providing the right care at the right time with the right staff, patients will not only have an improved experience but also a positive impact on their clinical outcomes.

RIGHT SKILLS

A collaborative working group was convened to examine why patients are not routinely sent to/accepted by the sub-acute hospital. This involved multiple stakeholders from both sites and it was agreed that the reluctance was derived from concerns about not having the right skills to support patients with an acute psychiatric presentation. This provided a foundation to develop strategies to address and mitigate the uncertainties and fears.

ASSURANCE

All staff needed to feel assured in the process and confident when following the pathway. Teams were given additional support and guidance to increase their competence and confidence when assisting each other to care for patients with presentations that are different to those they are familiar with treating within their own specialty. It has been important to highlight and address challenges and obstacles as they occurred so that we could formulate solutions and action plans. Tenacity has been essential whilst establishing new practices and allowing time to consolidate and anchor the changes.

This project has promoted collaborative working, it is cost and time effective, and it facilitates safe and timely discharge and smooth transfer of care. It offers the chance to learn from each other, with the possibility of rotational placements for nurses from both sites to develop new knowledge and skills and shared training for junior Drs/ACPs/trust grade doctors.

The future aspiration is to provide an admission unit that is a Centre of Excellence for the assessment of patients who are admitted with both a physical and mental health presentation. It is envisaged that this would be a specialist unit with timely access to a Psychiatrist and Geriatrician and a team that is experienced in both mental and physical health working truly collaboratively with one focus in mind-the patient, regardless of their diagnosis.

Reference

Braun BI, Kritchevsky SB, Kusek L, et al. (2006). *Comparing bloodstream infection rates: the effect of indicator specifications in the evaluation of processes and indicators in infection control (EPIC) study.* Infect Control Hosp Epidemiol. Jan;27(1):14–22

Submit a short case study covering a leadership intervention, a clinical governance/quality improvement project, or a service development – forum.admin@mhforum.org.uk

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Choosing learning disability nursing – a new recruitment guide for learning disability nursing

There have been significant concerns about recruitment and retention of learning disability nurses for over a decade, and the last three years has shown a dramatic and worrying reduction in entrants to preregistration undergraduate courses.

Health Education England (HEE) reported a 30% fall in entrants in 2018 and a risk of some universities discontinuing learning disability nursing programmes due to viability concerns. For learning disability service providers there is a national 16% vacancy rate, the highest for any nursing field. HEE predicts this could rise to 30% without intervention. In this context, the Mental Health Forum held a national conference themed on learning disability nursing in November 2018. As well as many presentations demonstrating the valued contribution of learning disability nurses to improving health and care outcomes, there was a lively debate about the future of the profession.

Subsequent to the conference, the Mental Health Forum engaged with HEE, and two projects were commissioned. Firstly, a project to develop and publish a recruitment guide for learning disability nursing and secondly a project to develop and establish an undergraduate degree level apprenticeship programme for learning disability nursing. The recruitment guide has now been published on the HEE health careers website and is available for service providers, commissioners, higher education, and anyone thinking about a career in learning disability nursing. The guide came about with support from a range of learning disability nursing networks including the nurse consultant network, the Foundation of Nursing Studies, the Royal College of Nursing, LIDNAN, nursing students and many individual learning disability nurses. The guide sets out the role and contribution of the learning disability nurse in a multi-professional context, and contains a selection of personal stories of nurses working in a wide range of roles and settings. It also covers the different routes in to becoming a learning disability nurse, and highlights the experiences of trainees and of people using learning disability services. The guide is intended to support people thinking of training to become a learning disability nurse, but also to illustrate the future potential career options in this field of nursing. We hope that this will prove a useful resource to support recruitment activities around the country.

The second project to develop a learning disability nursing degree apprenticeship programme is also progressing well. The London mental health and learning disability trusts are working under the auspices of the Capital Nurse Programme as a collaborative and are working with the University of Hertfordshire to establish a new innovative work-based apprenticeship programme starting in February 2020. There has been invaluable learning from existing nursing apprenticeship programmes in West London and in the North East region. HEE agreed the enhanced support grant for learning disability nursing apprenticeships and this has made an important contribution to enabling these programmes to succeed.

https://www.healthcareers.nhs.uk/career-planning/resources/choosing-learning-disability-nursing

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Ward Stars – a development opportunity for HCA's and other support workers.

In his book "The Heartland" Nathan Filer says "I was nineteen years old and was beginning in my career in mental health as a health care assistant, providing short-term cover for wards with staff shortages. HCA's are often highly skilled and well-trained members of the hospital workforce. I was not."

I was equally clueless at twenty-one and the HCA role was also my first step into qualified nursing. But many people stay in the role and become highly skilled. They become invaluable and you find them in all services. Marion Janner, who founded Star Wards along with her support dog Buddy, found one:

"During my admission, I got a lot of support from one HCA, who was wonderfully responsive, kind, bright – and very, very patient. After a fraught day, she told me she'd come and say goodbye before the end of her shift … At 9PM she hadn't come into my room, but at 9.10 there she was, apologising for being a bit late and checking on how I was feeling. It was a big deal for me as I'm really reliant on a trusting relationship with staff in order to stabilise, stop the self-destructive stuff – and get back home to Buddy."

Five years ago, Star Wards set up its own unique programme for HCA's. We called it "Ward Stars" because it is an apt description of what HCA's can be. Ward Stars is designed to

- Be motivating and energising for HCAs
- Make explicit those aspects of HCAs' work particularly valued by patients
- Contribute to meeting HCAs' appetite and need for professional development
- Provide a helpful structure for professional development (if needed)
- Publicly validate good practice
- Enhance the status and reputation of the HCA role

'[Ward Stars] has already lifted our confidence and made us feel recognised and appreciated for the hard work we all do." - Heath Care Assistant in Grimsby.

Structured around IMAGINE- seven qualities valued by patients (Imagination, Mindfulness, Activities, Generosity, Involvement, Neighbours, Empathy), the programme allows HCA's to develop and showcase their talent. Some organisations set up Ward Star programmes to recognise the work of HCA's. This is typical feedback.

We would love more HCA's to benefit from Ward Stars and, thanks to a grant from the fantastic Burdett Trust for Nursing, we are to work with 3 members of the Forum to do just that. So, why not get in contact if you have:

- A dedicated HCA support person in your organisation to help lead the Ward Stars programme with Star Wards help.
- A desire to support your HCA's.

And do check out https://www.starwards.org.uk/ward-stars/. Who knows – you might be helping the next Nathan Filer!

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A pyramid of involvement to support nurse participation in research

IN MAY 2019, THE NATIONAL INSTITUTE OF HEALTH RESEARCH (NIHR) LAUNCHED AN INNOVATIVE PROGRAMME AIMED AT STRENGTHENING THE RESEARCH VOICE OF NURSES AND MIDWIVES.

Funded by the Department of Health and Social Care, and working with NHS England, the programme recruited 70 nurses across England. The programme represents a significant opportunity for successful 70@70 nurses working in mental health and learning disability services to raise the profile of MH&LD research at a national and local level. The remit is to improve involvement, engagement and visibility of nurses and midwives in research activity within their own NHS organisations and local and national NIHR networks. A key outcome is to use and develop leadership skills to influence and improve the care of patients through research endeavour.

Supporting nurses, and the teams in which they work, to be involved in research (research delivery or as researchers) is vital.

All registered nurses (and associates) are required to base their practice on evidence (NMC, 2018). In addition, studies demonstrate a link between research active teams and improved patient outcomes (Downing et al., 2017; Jonker, Fisher, & Dagnan, 2019; Krzyzanowska, Kaplan, & Sullivan, 2011; Nijjar et al., 2017). Patients also have a right to be asked if they would like to participate in research studies (Department of Health, 2012), and the Patient Research Experience Survey reports that patients want to be involved (NIHR, 2019).

The NIHR awarded one of these 70 posts to a Nurse Consultant working in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

Early work undertaken within TEWV as part of the 70@70 programme, has included a baseline exercise to determine the number of nurses involved participating in research and to understand the culture of nurse involvement with research. This showed that although there is a willingness to be involved, many nurses and managers were not certain *how* nurses could be involved. To remedy this, the TEWV 70@70 Nurse, in collaboration with the local Clinical Research Network Lead Nurse and TEWV Clinical Professor of Health Research & Nursing has developed a 'nurse research involvement pyramid'. The pyramid which acts as an involvement guide also forms the basis for a number of activities planned to increase nurse involvement over the next three years. The base layer of the pyramid relates to all nurses, advocating that this level of research involvement should form part of standard nursing practice. The next three layers indicate the possible progression that nurses might make towards being leaders in healthcare research. Used within a recent nursing conference workshop, attendees reported that the pyramid was highly useful in guiding considerations of personal research involvement and possible progressions. The pyramid which will be evaluated forms only one part of a wider strategy to increase the nursing voice in health research within TEWV.

Valentina Short is a National Institute for Health Research (NIHR) 70@70 Senior Nurse and Midwife Research Leader. The views expressed in this article are those of the author and not necessarily those of the NIHR, or the Department of Health and Social Care.

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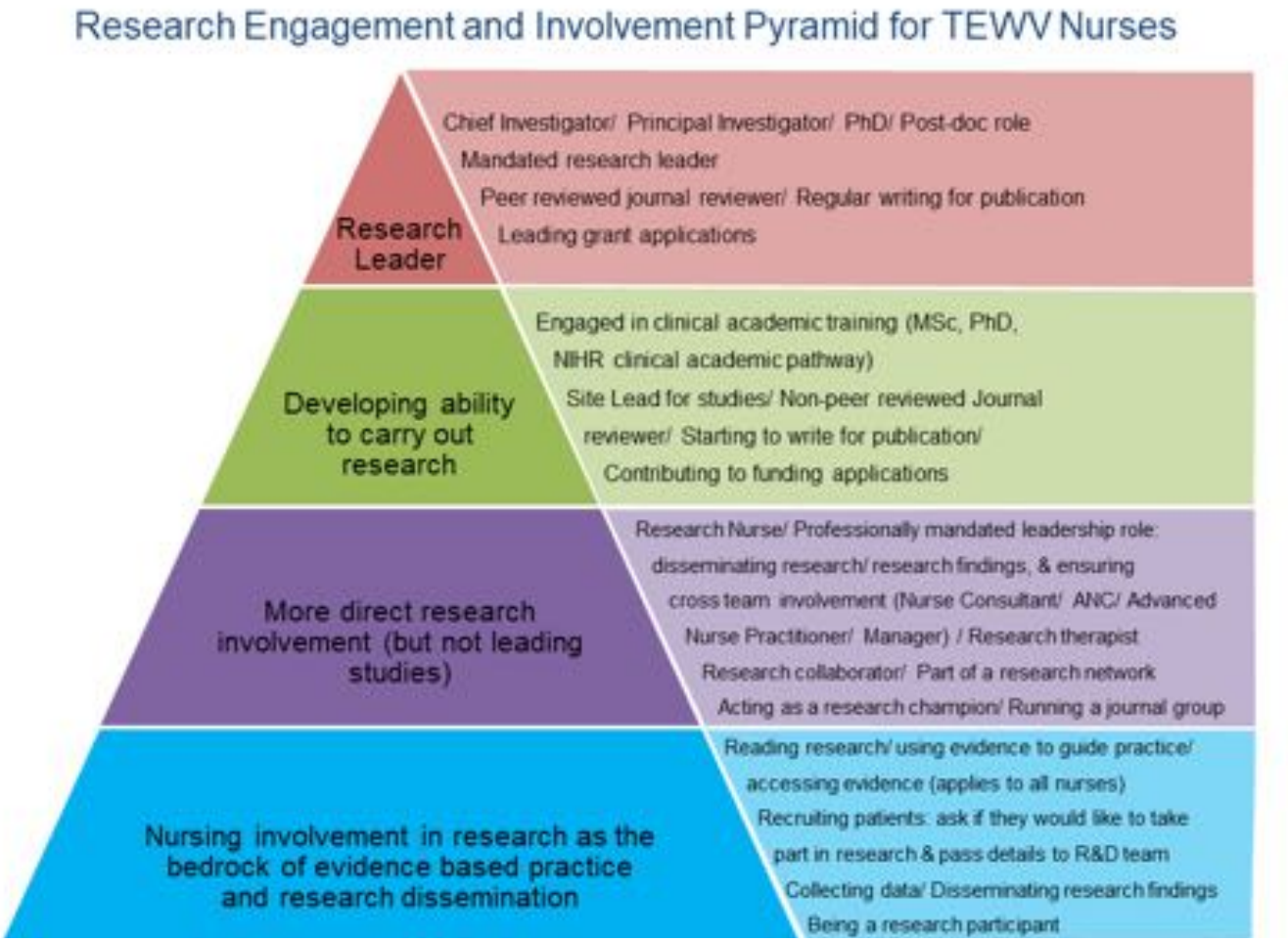

Research Engagement & Involvement Pyramid for TEWV Nurses

Joint DoNs and MDs QI conference

There is thinking around what people might want if there were to be further joint events. Some of the initial ideas were events based on the new Community Framework and interface with PCNs and ICSs and how we can use Digital technology as enablers.

The other area we thought might be of interest to both groups is how we operationalise the Liberty Protection Safeguards when they come into force.

A link to this survey will be emailed to get people's views on what they would like to focus on if we were to have a joint event.

https://www.surveymonkey.co.uk/r/HHHYNHM

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EFFECTIVE AND SAFE PRACTICE

NHS Trusts across the country are governed and scrutinised both internally and externally in relation to providing effective and safe practice of a high quality to the population they serve.

CNTW NHS Foundation Trust's vision, values and priorities have been developed through wide involvement and consultation with patients, carers, staff and partners. Our vision as an organisation is to:

"Improve the well-being of everyone we serve through delivering services that match the best in the world"

This includes ongoing evaluation of services and process including celebrating and sharing of good practice.

Every day, more than one million people are treated safely within the National Health Service (NHS); however, the advances in technology and knowledge in recent decades have created an immensely complex healthcare system. This complexity brings risks and evidence shows that things will and do go wrong within the NHS; service users are sometimes harmed no matter how dedicated and professional the staff. In order for an organisation to learn, it has to have embedded into it an effective and timely incident reporting, investigation and learning system. The Trust will embed within its safety culture, a systematic process to aid the organisation to learn from incidents, concerns or complaints that occur, and promote effective risk management processes to help provide solutions to reduce errors and prevent further harm to service users, staff and visitors. (NTW Operational Policy 05)

In November 2018 the Central Locality Care Group introduced a new post, Clinical Manager-Quality.

The main aim of this post at the time was to oversee effective support and monitoring to ensure the timely completion of action plans that had been developed, following any complaint or serious incident that had been addressed by the Group. The practice of developing action plans to effectively address identified gaps in service and/or lessons learnt has always been in place, however the Group were requesting extra assurance that these plans were being addressed in a timely, evidence based manner and that the outcomes of these actions were then embedded into practice and shared with other areas for learning, where appropriate.

At the time, many actions were outstanding, having passed the target date set and evidence provided to confirm that the point had been addressed to an acceptable standard were not scrutinised clinically at the point of completion.

1 YEAR LATER

A year later and the Clinical Manager-Quality has developed excellent working relationships with services, Clinical Business Unit Leaders and Managers, providing advice, support and training, when required, which has resulted in a more effective assurance system in place to feed into the Organisation the safe and effective management of these issues.

Alongside the primary aim of the role, other elements of "clinical quality" issues have been identified and included within the sphere of responsibility for the role:

- Investigating complex complaints where an investigation, independent from within the service, is felt to be in the best interest for the complainant and the service.
- Undertaking clinical audits for the Group, as required, linking in to local, regional and national programmes. Producing and presenting findings to relevant committees/teams, working with the service areas to develop any action plans from findings, especially in relation to lessons learnt from incidents/ complaints, to confirm if systems put in place following an investigation are robust and firmly embedded into practice, identifying any further gaps and actions to address these effectively.
- To offer support to others undertaking clinical audit, when required
- Delivering bespoke training to Multidisciplinary teams in relation to the Complaints/ Serious Incident process and investigations to ensure that they are up to date with policy and aware of their role within the various processes
- Undertaking thematic reviews at the request of the CBUs, identifying and linking any potential group wide and service specific themes, issues and help develop plans to address these either locally or as a Group
- Monitoring of Mental Health Act CQC visit action plans, using the same process as for complaints/SIs to ensure effective learning has taken place.

This is an exciting and expanding role which is felt to have shown a clear and measurable beneficial impact of the work undertaken.

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CHIME to Care – Improving Collaborative Care Planning in Practice using Improvement

INTRODUCTION

A twelvemonth project was established initially using a quality improvement approach through to both get a deeper understanding and address concerns about the quality gaps in recovery orientated practice within adult and older peoples mental health services. It was identified that we needed to improve how we meaningfully collaborated with our service users and carers to improve our care planning with them. Service users and carers voices were evidenced as being absent within plans and there was little evidence of recovery language. The improvement project set out to find ways of changing practice using a participatory method 'World Café' (Brown & Isaacs, 2008) to create a learning space where collaborative conversations could lead to improving the construction of recovery orientated collaborative care plans.

METHOD

The Recovery and Collaborative Care Planning programme was initially co-produced by a small team of mental health nurses who had knowledge and experience in delivering recovery orientated services. Within the approach collaborative academic advisory oversight was provided by a leader in the field of recovery and social inclusion throughout the programme of work. The 10 key challenges of organisational change by ImROC have been used as a framework to develop the recovery approach within the café focusing on changing the nature of day to day interactions and quality of experience of our services. The real strength to this project has been the involvement of service users and carers with lived experience and their growing leadership input. The lynchpin of the project is a monthly café space which is a learning and improvement group using the strengths based collaborative World Café methodology. It is a space where service users, carers and clinicians and talking about what matters to them through collaborative conversations. This has developed over the year into a community of practice, co-produced with service users and carers with lived experience of conditions and using services within the trust.

RESULTS

Through the café, we have collectively built in CHIME (Leamy et al, 2011) into co producing a recovery orientated narrative to changing conversations in services to become more collaborative and recovery focused. Developing a shared understanding about recovery has been informed and underpinned by the delivery of masterclasses which has utilised the CHIME conceptual framework. The community of practice has contributed to the development of guidance on recovery, having collaborative conversations leading to collaborative care planning which is co-produced with service users and carers. We have designed and launched a practice-based recovery focused collaborative conversation module utilising Motivational Interviewing with De Montfort University. 75 places have already been offered to qualified healthcare professionals with a 78.9% completion rate. Further modules are in place for year 2.

DISCUSSION

Session evaluations have evidenced the value of the project. We have learned how important it is to service users and carer's in having strengths based collaborative conversations with professionals. There is further exploration underway of the potential for applicability within physical health services. An evidence base learned through applying established research into practice has been needed to design this work. Particularly in engaging with staff to think differently about collaborative care planning supported by skilful strengths based conversations (Simpson 2011 & Lovell, 2017). Collaborative care planning quality improvement work is well underway within mental health community and inpatient services as a result and has been informed by the learning from the café conversations. This programme has delivered to date and continues to do so.

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CHIME to Care– Improving Collaborative Care Planning in Practice using Quality Improvement Methodology and World Cafe.

NHS Leicestershire Partnership

Aims:

A 12 month quality improvement project using a PDSA systematic approach was established with the aims of achieving the following:

- Find ways of improving our collaborative conversations with service users and carers when writing and constructing collaborative care planning and doing this routinely.
- To gain a better understanding as to how we ensure that needs & concerns from service users and carers and needs are met through a collaborative care plan-

What have we learnt?

- How important having positive collaborative conversations are to service users & carers to improve their experience of being partners in their care.
- A different way of writing of collaborative care plans is needed whilst ensuring professional care interventions are clear
- Experts by Experience are pivotal with lived experience of conditions & are central to making sure that we are co-producing the café and quality improvements in LPT as partners.

Azar Richardson, Claire Armitage Dr Lyn Williams , Dr Theo Stickley

Outcomes and Impact:

- Using ***Connectedness, Hope, Identity, Meaning and Empowerment*** **(CHIME)** as a conceptual framework is enabling us to become more recovery focused.
- **Masterclasses & conversations** between practitioners and carers
- **CHIME Recovery college course**– A five week course constructed on each of the concept areas has been tested & successful.
- **CHIME to Care** –Recovery concepts have informed the development of CHIME collaborative Care Planning guidance.
- **EQUIP Patient Rated Outcome Measure (PROM)** has been tested by Experts by Experience & partners as a measure of service users experience in care plan-

Bringing EQUIP into CHIME to Care

- We are working with Manchester University to transfer learning from EQUIP (Enhancing the Quality of User Involvement in Planning of Care) study into our collaborative care planning approach
- A PROM is enabling measurement of change and improvement which can be used alongside other improvements in the quality of care planning.
- A 'Recovery in Practice' newsletter has been developed with EQUIP updates on masterclasses, service user & carer voices in improvements

Enhancing Recovery Through Collaborative Conversations (ERCC):

- De Montfort University (DMU) in partnership with Leicestershire Partnership Trust (LPT), have co produced a course focused on practitioners in ERCC.
- 79.8% of participants have completed the course in year 1 of 3 cohorts.
- The course has been more successful than accredited CBT and PSI courses which have shown no or late take up in 2018.

Future Outlook:

- Core care planning quality standards are being informed by a Quality Improvement approach through a learning methodology & in combination with learning from PROM.
- LPT's switch from RiO to SystmOne patient record system is providing an opportunity to refocus and change towards collaboration in care planning.
- Combined LPT and EQUIP approach will ensure improvement in practice is co-produced by involving Experts by Experience

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Service Development Project – Development of an intensive, structured sleep pathway for children with moderate to severe learning disabilities in a Children's Community Learning Disability Team.

BACKGROUND AND THE PROBLEM...

The Children's Community Learning Disability team is a small multi-disciplinary team supporting children with moderate to severe LD and/or autism.

There are the equivalent of 3 full time RNLD nurses and additional support on two days per week from the Consultant Nurse in learning disability. Average caseload numbers are 33 per full time nurse. The majority of the referrals for nursing support are related to either sleep difficulties, continence issues or behavioural concerns. There were no clearly defined clinical pathways to enable a consistent and evidence based approach to supporting children and their families. Furthermore the waiting lists for the team were high and lengthy with 63 children waiting for complex assessment and intervention. Of these, 6 children were identified as requiring support with sleep and a further 12 had needs in relation to sleep and behavioural distress. Sleep deprivation can have a significant impact on a child's mental health and physical wellbeing and a detrimental effect on family relationships (Simola et al, 2014, Teitze et al, 2014).

The project was inspired by the Sheffield Children and Young People Sleeping Well Project (Sheffield Children's Hospital, Sheffield City Council, The Children's Sleep Charity, 2018).

What did the team do! The Solution!

Following the securement of some funding the nursing team attended bespoke training on sleep assessment and intervention for children. Two of the nurses and the consultant nurse developed a clinical pathway to support timely assessment and intervention for children with sleep difficulties via a sleep clinic. The pathway clearly defines what families and children could expect from the nurse and also the tasks that the family would need to complete to support the pathway. The pathway is planned to be 12-15 weeks and comprise of up to five contacts. In summary, the process commences with an initial appointment letter being sent out to parents, including blank copies of two weeks of sleep diaries, which they are asked to complete and return to the team prior to the appointment. The second contact is in the home and the team assess the bedroom environment and complete a comprehensive sleep assessment. A third appointment is offered where a diagnosis is made in relation to the nature of the sleep problem and the family and young person are offered a choice of interventions in the form of discussion and a care plan. A further three follow up appointments are offered to track progress and offer guidance and support if needed. The young person is then discharged.

Outcome/Results.

The focus was initially on the 6 children waiting for sleep assessments only. A sleep outcome measure was used pre and post intervention. Two children were supported to sleep in their own bed and three of the children were supported to remain asleep all night. The overall outcome was that sleep improved in five of the cases and they were successfully discharged within the agreed timeframe. The sixth person required psychological support before sleep intervention could be agreed.

Support is now being offered to the remaining children where sleep difficulties have been identified.

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Harnessing BAME Nursing Talent: Development of a Customized Leadership Programme Methodology

In partnership with South West London & St George's Mental Health NHS Trust and Kingston University

INTRODUCTION

A key Trust strategic/clinical objective is to 'improve leadership and talent' within the nursing workforce. To support achievement of this objective, a customized leadership programme for Black, Asian Minority Ethnic (BAME) workforce across the trust was developed. This will not only support professional development and foster excellence but promote future leaders from BAME backgrounds. Why is there a need for this programme?

•Our workforce is not sufficiently represented at senior nurse level by the diverse community it serves.

•In line with Lord Hunt's observations (Campbell 2016) we recognise:

"There are too few women and non-white faces in positions of authority in NHS services. Lack of representation in senior management in the NHS is linked to the persistence of severe service failure and inequality of provision."

•To address this SWLStG is making a strategic investment into the retention of our BAME nursing workforce, as historically there has been an investment gap and a lack of promotion and progression of this group highlighted by the Workforce Race Equality Standard data.

Figure 1: Word cloud from participants' 100-word statements

•We want to ensure our nurses represent the community they serve, have the right leadership and development opportunities to benefit them and also deliver high-quality care to our service users and carers.

Aim of Project

The overall aim of this project was to co-produce and deliver a customized advanced skills based BAME leadership programme, through an intensive 4 day programme in conjunction with Kingston University and Springfield Consultancy. From this, the project intends to promote development opportunities for BAME nursing workforce who are committed in providing the best quality care, reinvigorating our existing workforce and improve our retention rates. Furthermore, this project aims to bring awareness of how the development of BAME nursing workforce can impact patients and staff. This project will provide participants with the tools to identify their strengths and support their work on improving areas which they believe issue barriers to their success.

Objectives

•Evaluate the programme's impact on BAME nurse retention

•Seek accreditation of the bespoke programme with Kingston University

•Develop a dissemination framework which will be used with SWLStG and shared with our South London Trust partners, and nationally via the Royal College of nursing BME advisory group.

METHOD

Three parts of the project were identified:

Part One

•Literature review to identify programme evaluation tools.

•Setting up a steering committee and consulting with stakeholders.

•Conducting focus groups with BME staff, service users and carers (drawn from local BME partnership organisations) to generate and map out programme content.

Part Two

•Blended-learning approach to develop and implement a skills based leadership programme run in conjunction with Kingston University with service users and carers' inputs and sessions featuring invited BAME inspirational speakers to share their journey of professional and career development.

•To tailor-make developmental activities depending on specialties or career intention eg.shadowing senior nurses.

•Work based learning academic opportunities offered.

Part Three:

•BAME Mentor/Coach support – a range of clinical experts matched on participants clinical area of work, career intention (e.g. matching a nurse-educator with a BAME

nurse who wants to become a clinical-academic), and geographical proximity.

•Evaluation of the programme.

"I've really enjoyed my time on the course and it has most definitely given me the confidence required to achieve my long term goals. I have met a lot of great people and wonderful role models. After starting the course and finishing my preceptorship, I applied for a band 6 role - which I would have never considered if I had not started this course."

Quote from participant one

LEARNING SO FAR

Outcome of Part one

A thematic analysis (Braun & Clarke, 2006) was conducted in order to identify, analyse and report patterns (themes) within the focus groups. Two analyses of the 100-word statements (n=32) were conducted:

a) A 'word cloud' (Figure 1) was generated from the text in the collection of 100-word submissions. The word cloud visually depicts the relative prominence of word-frequency in the source text

b)Thematic analysis of the statements. The qualitative perceptions and experiences of prospective candidates for this bespoke skills-based BAME leadership programme are consistent with the quantitative equality gaps highlighted nationally by WRES indicator 1,4 and 7.

"I've really enjoyed my time on the course and it has most definitely given me the confidence required to achieve my long term goals. I have met a lot of great people and wonderful role models. After starting the course and finishing my preceptorship, I applied for a band 6 role - which I would have never considered if I had not started this course."

Quote from participant two

Outcome of Part Two

•37 recruited on to development programme – four workshops conducted

•External advisors from CNO BAME national group and RCN BAME diversity lead recruited.

•Funding provides opportunity to use Factor 8 self-reflective tool with all participants.

Outcome of Part Three

•Coaches recruited for all participants.

•Evaluation of initial focus groups reveals the need to investing more attention and time to focus group and one to one interviews with the line managers and senior staff of programme participants. This will cover questions related to:

- BAME role models.
- The role of relationships in advancement.
- Giving positive and negative feedback and coaching to BAME staff / interview support.
- Managing staff access to non-mandatory training and secondment/ development opportunities.

•Experience of interviews and panels.

"My time so far on the programme has given me insight into key areas of my own development. This includes: coming out of my comfort zone; building my confidence to communicate more despite my accent; always putting myself in other people's shoes; becoming a reflective practitioner; promoting self-independence in myself and others."

Quote from participant three

Learning derived to date

This programme has helped to identify the need for a more consistent approach to how BAME staff development is supported within the Trust. There is a need to provide the managers and clinicians with more guidance and support. The next step will be to determine whether services are incorporating change and if not what tools might be used to better understand the situation, and what action should be taken as a result.

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'Today We Talked' – promoting sexual safety for in-patient mental health services

Introduction

Undesirable and unsolicited sexual attention from others is not uncommon and everyone in society is at risk of sexual violence in one or more of its forms. However, some are more at risk than others. Of serious concern is the finding that admission to the presumed safety of a mental health ward is not shown to reduce the risk and, it is reported that sexual violence is commonplace on such wards (Care Quality Commission, 2018). If sexual safety on NHS in-patient wards cannot be assured then a proactive approach is required. In North Wales a partnership to address this was established between Mental Health Services and CANIAD, an independent third sector organisation that supports people affected by mental health problems.

Approach

Somewhat like the peloton of professional cycling leadership was shared between users and providers of services with each taking the lead dependent on the phase of the project and the skills and experience to be shared for the benefit of the whole. Overall the project gave primacy of leadership to survivors of sexual violence with experience of using mental health services to assure that their often neglected voices were heard and acted upon.

The 'TODAYICAN' approach towards change was used to focus attention on the contribution that each person could make by taking ownership of their time and how they chose to use it to develop and improve services (Dolan and Holt, 2017). In recognising that well-intentioned individuals coming together and, talking to each other, could be transformational, one of the authors (SF) redefined 'TODAYICAN' as 'TODAYWECAN' and ultimately to 'Today We Talked'. By doing so the possibility for change was enhanced and a new sense of solidarity and equality introduced.

Outcomes

The project researched the meanings of sexual safety and the barriers placed in the way of achieving it. Sexual safety was seen as both a right and a duty. As a right the focus was placed on acceptance that sexuality and sexual needs are an aspect of universal human needs and, that one has liberty to express ones sexuality whilst, being free from unsolicited sexual attention or violence. As a duty this was seen beyond that of the professional's duty of care but encompassed the duty to oneself and innovatively the duty of one service user to another.

Identified barriers were threefold. First, there was inadequate training, knowledge and skills. Second, it was a topic that for a number of reasons (primarily embarrassment, social taboo and ignorance) no-one was talking about. Third, physical and social environments within mental health care were unsafe.

Following this people using services and staff worked together within an Appreciative Inquiry project to identify how to overcome those barriers. From that has come co-produced advisory guidelines for preventing or responding to allegations of sexual violence; a training module for both service users and staff to attend together and, service user published peer information about sexual safety.

The culture of 'Today We Talked' is firmly rooted within all parts of the Mental Health and Learning Disability Division and is seeing exciting new opportunities to meaningfully develop new relationships rooted in trust and respect.

The project described here is discussed in more depth in a co-produced academic paper (see – Page et al. 2019).

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Co-existing Mental Health and Substance Misuse need: Improving communication and growing confidence within and between services.

The poorer outcomes and the difficulties faced by service users with co-existing substance misuse and mental health needs are well documented. The tragic consequences of which are highlighted on an annual basis within the National Confidential Inquiry into Suicide and Safety in Mental Health. Commentary identifies service users falling between services, with mental health services expecting sobriety before help can commence, and substance misuse services suggesting treatment will only be effective once an individual's mental health improves. However good practice guidance demands services should communicate robustly with each other and a simultaneous and integrated approach to care should be sought for those with co-existing need.

In October 2018, North Staffordshire Combined Healthcare Trust board and local Commissioners set an objective to provide joint care reviews of care for service users between mental health and substance misuse services, and was subsequently written into the work plan of the Trust's Consultant Nurse in co-existing need and that of the Quality Leads associated with the substance misuse services. Despite universal agreement of the need for such joint review processes, the mechanism for delivering such an objective was unclear. The urgency of the need and the expectation to deliver a joint review process demanded the wielding of Occam's razor; a problem-solving principle that states "Entities should not be multiplied without necessity." Hence in order to identify a plan, some simplifying questions were posed and answers constructed in order to drive the project forward in a timely fashion, see table 1 below:

Following the identification of this simple plan a regular monthly slot of ninety minutes was identified, and the attendance of the Consultant Nurse and Quality lead representing substance misuse was agreed. The opportunity for case review along with the intended outputs was advertised and organised by the clinical lead within a CMHT in early December 2018. Later in December the first joint review commenced. The intended outputs were delivered as advertised, and very quickly thereafter the usefulness of the joint review opportunity was accepted and taken up by clinicians within the CMHT. Three months later a neighbouring CMHT requested a similar review opportunity, followed 4 months later by a third and negotiations have commenced with the final CMHT within the area.

The outcomes of the project to date are multifaceted: Feedback from the CMHT's report that the reviews have led to service user gains, such as the development of more flexible access and engagement opportunities through either service, thus enhancing therapeutic relationships. Confidence and knowledge has grown in terms of therapeutic risk management strategies adopted. It has provided an awareness and acceptance of the need for, and the opportunity for inter-agency working and information sharing. It has provided a record of defendable and considered practice. Practitioner confidence in the utility of the skills they hold to deliver interventions for both aspects of need has grown, and in turn a greater willingness to work and engage has been noted. It is reported that knowledge and interest in working with co-existing need has grown, with staff seeking out further opportunities for training. Furthermore it has established a baseline position of joint reviews that can now be built upon and enhanced in the future.

Question	Answer
What is the smallest start that will make a difference?	One review with One Care Co-ordinator (or other clinician) in One Community Mental Health Team (CMHT)
What are the minimum staff required to provide a credible joint review that is useful?	One credible senior mental health clinician, One senior credible substance misuse clinician, One care co-ordinator (clinician)
What would be the minimum frequency of reviews to ensure it is seen as a regular opportunity for review?	One 90 minute session once a month at a regular time
What would be the minimum managerial / local leadership support?	One local manager/ leader, to book rooms and advertise and sell the opportunities afforded by joint review
What are the minimum outputs for the review to be useful?	An agreed formulation and plan that identifies the contribution of both substance misuse and mental health provision. Or an engagement strategy if necessary. The provision of a formulation that contains the insights and experienced views of credible clinicians from both substance misuse and mental health A review of risk and risk management strategy Information on services and substances where required A direct offer of timely senior clinical input if required

Table 1

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Developing a Clinical Assurance Framework for Mental Health Wards in Lancashire

Continuous quality improvement is essential for all healthcare organisations focussed on providing the highest quality care for patients and service users. This should also promote shared learning and improve staff satisfaction through engagement and continuous improvement.

Ruth May stated that one of her "key objectives as CNO is to support the implementation of shared governance – the harnessing of collective nursing and midwifery leadership to influence and drive change" (NHS Improvement, 2019) .

In 2018/19 nurses from Lancashire Community Nursing and Mental Health Services came together to explore development of a Clinical Assurance Framework. Nurse leaders at ward level were concerned that they did not always have access to information on key quality indicators that would give them an overview of quality on the ward. Their main request was to have ready access to information on "Nursing Fundamentals" at ward level. Some of this information was data driven, but surprisingly, although ward staff contributed to the data collection, they found it difficult to access the information and to be able to benchmark their ward against other similar wards within the Trust. Sometimes in order to access the information they had to access multiple systems and databases.

The teams stated that this was not just about visibility and accessibility of data. They wanted more meaningful information than simplistic measurement of compliance rates. An example of this was that there was a monthly data pull for the Clinical Supervision compliance rate by ward. Using the Clinical Assurance Framework, this data could be supplemented by the monthly ward audit which provided time and space for the ward manager to engage with staff about their experience of supervision and how this could be improved.

Data from Datix (incident reporting system) was also pulled into the Clinical Assurance Framework, but then the monthly ward audit provided the opportunity to talk to service users about their experience on the ward and to capture this essential feedback.

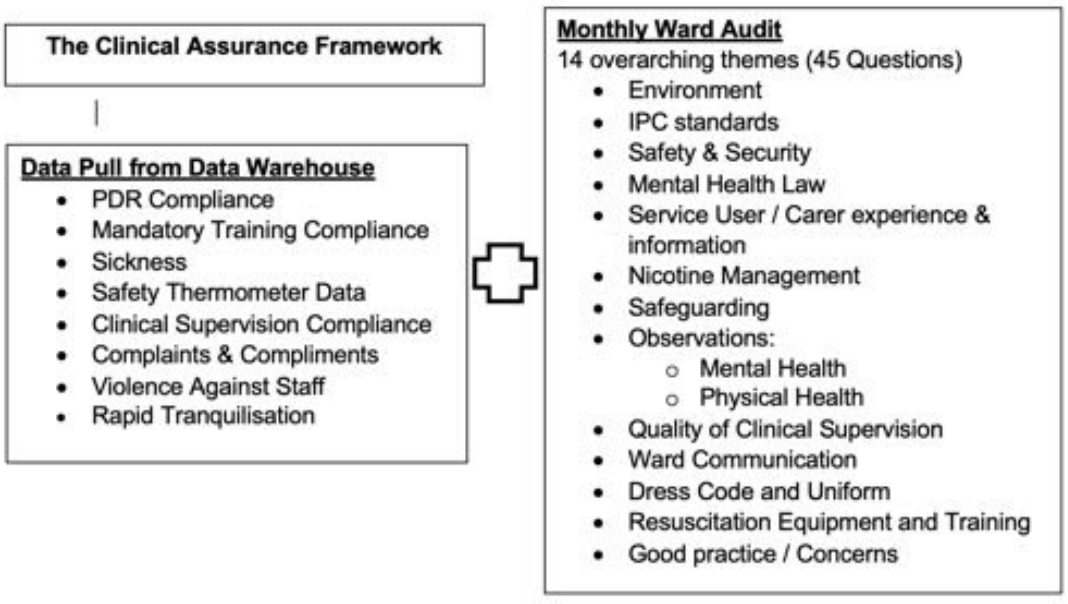
The Clinical Assurance Framework started to take shape and was piloted and revised on older adult and adult wards in Mental Health. The aim was to promote continuous quality improvements through staff engagement that would use existing data sets together with monthly ward audits to monitor key quality indicators at ward level.

Development of an automated system with support of the Business Intelligence department and Clinical Audit gradually led to development of a live dashboard. As data is often significantly out of date by the time clinicians receive it, this was seen as being an extremely positive outcome from the development of the Clinical Assurance Framework.

The data pull and ward audit questions are RAG rated when pulled across to the Clinical Assurance Framework Dashboard and this is accessible to all staff. A "no" response to any of the questions in the ward audit will lead to a RAG rating of "red" for the overarching theme. A compliance rate lower than the Trust standard will also lead to a red RAG rating. This was agreed by the teams in their desire to strive for excellence and to highlight areas for benchmarking practice with other teams.

Although the Clinical Assurance Framework has only been operational since April 2019, wards have already stated that the Framework has helped them to identify hotspots and areas for improvement and to address these in a timely manner. Many wards have demonstrated significant improvements and the next stage in this process will be to work towards ward accreditation to recognise and celebrate this success.

Reference:
NHS Improvement (2019) Guide to developing and implementing ward and unit accreditation programmes



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Peter Hasler – Development Officer

LEARNING DISABILITY NURSING

The celebration of 100 years of Learning Disability nursing has in my view been a great success, but of course time will tell whether it makes a real difference to the number of students going forward. Tim Bryson and I did two pieces of work supported by HEE earlier in the year. The first was to promote an apprenticeship model into learning disability nursing and the second was a recruitment aid that can be used by universities and providers. My learning came from interviewing a number of existing learning disability student nurses to ask them why they chose this field of nursing. The answers were interesting, a very high proportion talked about their own experiences of having a family member with a learning disability. There were also personal stories of people who had work placements at school and instantly knew that that was the job they wanted to do. The Forum will keep Learning Disability Nursing high on the agenda going forward.

ASPIRING DIRECTORS

The last year has seen the first group of 15 Aspiring Directors being supported through our joint venue between the Forum and NHS Confederation. The programme is a year of personal support and masterclasses that exposes people to the movers and shakers in health and social care. We will be shortly going out for applications for the 2020-21 intake – if you wish to discuss this then please contact me directly.

SAFER STAFFING

People will have seen the huge interest in this subject on the email exchange. We will find a way to take this forward in conjunction with NHSE. We anticipate that this will be in the form of two workshop conferences, one in the North and one in London. Please speak to me if you wish to get involved.

Have a great conference at Warwick.

Reflective Account Form

Reflective account:

WHAT WAS THE NATURE OF THE CPD ACTIVITY

WHAT DID YOU LEARN FROM THE CPD ACTIVITY

HOW WILL YOU CHANGE OR IMPROVE YOUR PRACTICE AS A RESULT?

HOW IS THIS RELEVANT TO THE CODE?
SELECT ONE OR MORE THEMES: PRIORITISE PEOPLE – PRACTISE EFFECTIVELY – PRESERVE SAFETY – PROMOTE PROFESSIONALISM AND TRUST