The JPUH Research, Evaluation and Quality Improvement Scholarships, funded by NICHE (2023/2024)

Poster brochure

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Title	Scholar role	Organisation	Impact and outcome
Factors that influence child conveyance decisions made by prehospital clinicians – A mixed methods study.	Newly Qualified Paramedic	East of England Ambulance Service.	Poster Conference presentation
MAPLE Project: Supporting staff to be mindful, to feel assisted and provided for, to have learning opportunities and to help them feel empowered to give the best end of life care.	Healthcare Assistant,	James Paget University Hospitals NHS Foundation Trust	Poster Local presentations (Trust-wide)
Identifying barriers to mobilisation of patients in the Queen Elizabeth Hospital Kings Lynn	Specialist Physiotherapist and Joint Team Lead for the Medical Therapy Team	Queen Elizabeth Hospital Kings Lynn	Poster Conference presentation Presentation to cohort 3 scholars Blog on NICHE website Successful application for ARC fellowship
Implementation of an arts-based therapy group in an acute neurosciences setting	Occupational Therapist	Norfolk and Norwich University Hospitals	Poster
Mentorship programme for health care assistants in social care setting service improvement evaluation	Home Manager	Kingsley Care	Poster
Palliative rehabilitation: Exploring service provision from the community therapists perspective in NCHC south place	Community Physiotherapist	Norfolk Community Health and Care	Poster
Recognising, reviewing and responding – The 3 Rs which contribute to the reduction in Massive Obstetric Haemorrhages	Lead Midwife for Intrapartum services	The Queen Elizabath Hospital, Kings Lynn	Poster Conference presentation
Transforming practice and empowering staff in the use of qualitative ‘friends and family test’ (FTT) data to enhance the patient experience	Patient Experience Assistant	The James Paget University Hospitals NHS Foundation Trust	Poster Conference presentation Clinical Leaders Presentation Blog on NICHE website
Determining the acceptability of using VR headsets for individuals with a Learning Disability in healthcare settings.	Registered Nurse, Learning Disabilities	Norfolk Community Health and Care Trust	Poster
Community voices: An evaluation of the InHIP bowel cancer screening pilot	Physician Associate	Norfolk and Waveney Integrated Care Board	Poster Conference presentation New role in a new Trust
Respiratory traffic light document; To improve management of children with long term and complex conditions	Paediatric and Respiratory Physiotherapist	The James Paget University Hospitals NHS Foundation Trust	Poster Conference presentation Clinical academic career pathway
Research champion programme: Managers evaluation	Research Facilitator	Cambridgeshire Community Services NHS Trust	Poster Conference presentation: RDForum
Bringing services together to provide wrap-around support: An evaluation of stroke reach	Health and Wellbeing Partnership Officer	Public Health	Poster
Relieving anxiety in patients undergoing cataract surgery	Operating Department Practitioner	The James Paget University Hospitals NHS Foundation Trust	Poster Applied for a job as a research practitioner working in R&D
Research champions’ programme: evaluating the impacts on participants	Research and Evaluation Officer	Norfolk and Waveney Integrated Care Board	Poster Conference presentation
Exploring the wellbeing and sustainability of IC24 staff working from home	NHS 111 Health Advisor	IC24	Poster

Factors that influence child conveyance decisions made by prehospital clinicians
– A mixed method study.

Alex Blake-Barnard alex.blake-barnard@eastamb.nhs.uk

Background

As the first responders to cases of paediatric trauma or acute illness, qualified ambulance crews must have an appropriate base of knowledge skills and confidence to provide effective and appropriate assistance (Fowler, et al., 2017). The Royal College of Paediatrics and Child's Health (2018) states how paediatric patients account for 25% of ED attendances, whilst an unpublished NWAS (2018) internal paper illustrates that between 5-10% of total ambulance calls were to patients under 18. Previous studies surmise that: 'management of the prehospital paediatric patient is inherently stressful', with the pre-arrival preparation for such individuals causing 'extreme anxiety and discomfort for ambulance personnel' (Fowler, et al., 2017; Houston & Pearson, 2010). Despite a small proportion of paediatric patients experiencing life threatening situations and subsequently requiring emergency interventions, children's anatomical, physiological, and developmental differences present unique and often complex challenges (Houston & Pearson, 2010).

Major reforms in the NHS, primary care, and GP's workloads in 2004, saw a reduction in access to GPs in and out of hours, resulting in the increasing inappropriate usage of hospital emergency services (Ruzangi, et al., 2020). The resulting inevitability is for the growth of pre-hospital and the Paramedics' scope of practice. Numerous policies (DoH, 2005; NAO, 2011; AACE, 2011) have led to this development and transformation, however, seldom mention specific paediatric care. Strict conveyance protocols, contradict both the Paramedics growing autonomous ability and the current discourse of hospital avoidance, and often results in the unnecessary and avoidable transportation of paediatrics. A cohort study discovered that a significant 19-83% of children visiting A&E departments between 2007 and 2017, presented with conditions that were not only appropriate for primary care but also were discharged with no treatment given (Ruzangi, et al., 2020). Of these patients a high percentage of attendances were due to ambulance conveyance. O'Cathain et al (2018) however, recognised that discharging patients at scene is a complex one for paramedics and one of which is seldom used (O'Hara et al, 2014).

This was an area of preestablished interest and therefore the subsequent publication of the rapid evidence review entitled "*Factors that influence child conveyance decisions made by hospital clinicians*" within the Journal of Paramedic Practice. The original research study was initially undertaken as part of an undergraduate academic qualification.

The analysis of previously published research identified barriers and factors along with areas of disparity in practice and procedure which effect and influence the contemporary paramedic in the conveyance decision of paediatric patient. However, reviewed studies were limited with few taking place within a UK based ambulance trust, nor any post covid and with any University cohort of clinicians. Due to this lack of transferability of previous studies, inadequate representation of the wider paramedic profession, lack of UK studies and the inability to transcribe evidence from other clinical areas, this research is well justified.

Research

Factors that influence child conveyance decisions made by prehospital clinicians

Abstract

STUDY OBJECTIVES AND PURPOSE

PURPOSE
The results of this study may be used to develop an educational intervention which may be implemented into clinical practice. This study may also inform the development of further research.

PRIMARY OBJECTIVE
The aim of this study is to identify the factors, barriers and facilitators in the successful assessment of children in the prehospital setting – resulting in appropriate conveyance decision.

SECONDARY OBJECTIVE
To identify supportive training, pathways and professionals to further support ambulance personnel in the appropriate care of patients.

OUTCOME MEASURES/ENDPOINTS

PRIMARY OUTCOME MEASURE/ENDPOINT
Producing a support pathway or additional resource / training.

SECONDARY ENDPOINTS/OUTCOMES
Reviewing hospital statistics of appropriately conveyed children both pre study and post application of additional training/support/pathways related to the identified barriers.

Method

The aim of this study was to understand the approach of clinicians to non-time critical paediatric patients within the prehospital setting. To achieve this, a phenomenological approach was employed to remove the risk of bias or preconceptions experienced by the researcher because of her own paramedic background.

A mixed method survey – created on Microsoft Forms, was disseminated to the West Norfolk locality of East of England staff to explore their experiences of decision making while managing paediatric emergencies. Themes for likert chart were taken from the previously completed rapid evidence review, with the aim of participants to established their level of importance. The survey was advertised to staff via an email and by word of mouth for incoming crews to the Emergency department at Queen Elizabeth Hospital Kings Lynn, a QR code was used to facilitate easy access. Clear information was provided to participants highlighting the aims and necessity of the survey combined with opportunity to ask questions and provide consent. Clear inclusion and exclusion criteria were established (Table 1) and shared to participants prior to their involvement. Anonymity was maintained, with the exception of those willing to be contacted for possible follow up interviews.

A total of 60 participants completed the survey. From those recruited a variety of age, experience, qualifications and paediatric exposure was demonstrated. These can be seen in the surrounding charts.

Factors influencing conveyance decisions of child patients from the Pre-hospital setting

Those who have regular contact with children under 14 in their personal life? e.g. either own, siblings, nieces/nephews etc.

Clinical years of experience within the NHS

What age group do you fit into?

Study Title	What factors influence paediatric conveyance decisions made by prehospital clinicians in the prehospital setting.
Study Design	Mixed method study
Study Participants	Qualified Ambulance service clinicians – East of England Ambulance Service Norfolk West
Inclusion Criteria	Ambulance Service Clinicians (paramedics / emergency medical technicians / emergency care practitioners) Working on active front line duties during the last 12 months Clinicians able to discharge on scene
Exclusion Criteria	Ambulance service clinicians who have not undertaken clinical shifts in the last 12 months Clinicians (apprentices) unable to discharge on scene

Table 1: Inclusion and Exclusion Criteria

Data collection

The surveys had no set time limit and on average took 10 minutes 28 seconds to complete, this allowed participants to talk freely about their experiences. Specific questions ensured participants maintained course of the subject matter, whilst text boxes allowed for responses to be expanded. Time restraints and lack of resources did not allow for follow up interviews.

Analysis and findings
Coding was exclusively conducted by the researcher. Data was coded and analysed using thematic analysis. Specifically, the Braun and Clarke (2006) model was employed to search across the dataset to identify patterns. This six-phase approach to analysis (Table 2) is not a linear process progressing through each phase chronologically. Rather, it is recursive, allowing the researcher to move back and forth through the phases as required.
Identification of patterns and grouping together commonalities of these codes formed the first basis of themes (Saldana, 2016) which were then reviewed and refined. Discarding of codes due to a lack of repetition contributed to providing a definitive dataset into which themes could then be named. Themes were further assembled into sub-themes, identified by Braun and Wilkinson (2003) as being useful for structure and hierarchy. The only software employed in the coding of the data was form Microsoft Forms. The lived experiences of participants presented as a descriptive analysis, supported by anonymised verbatim quotations from the reflective experience, form the final production of the report.

Table 2. Braun and Clarke's six phases of thematic analysis.

Familiarising yourself with the data
Generating initial codes
Searching for themes
Reviewing themes
Defining and naming themes
Producing the report

Likert chart showing the importance participants rate factors that may influence child conveyance decisions for a non-time critical patient.

Results

75% of participants recommended the benefits of a paediatric specialty phone line.

Participants rated "safeguarding concerns" as the most important factor influencing conveyance.

98% of participants said generic paediatric education should be part of their mandatory training.

73% of participants stated that training for their most recent role did not cover enough paediatric minor illnesses or injuries.

More training, Contact for paed specialist

Knowing they would be able to get a face to face appointment the next day.

Access to a paediatric clinician similar to the frailty team - this would see a lot less 'go get them checked' conveyances.

A paeds line (like the frailty line)

Availability of specialist practitioners particularly out of hours, and dispatching SPUCs to paeds first for primary assessment as most could either be discharged by the right clinician or make own way to hospital with parents.

Access to paediatric consultants. Similar to the frailty team.

More training, more exposure, paediatric primary care placements during training

"Access to paeds specialist/a/e advice. Knowing what will be done with the child at a/e assists in decision making regarding conveyance. For example, in adults with chest pain, we know they need troponin testing. A paediatric sepsis screening tool based on age. In at least one other trust, PEWS cards are available. Linking to traffic light system for sick child would be helpful (for each age, not a collective age group)"

advice leaflets for parents/guardians to help with worsening advice just for ease and clear guidance

Direct access to a paediatrician similar to the Frailty line pathway.

Next Steps and Recommendations

Critical factors in decision making and confidence levels, education and training should be developed to broaden the depth of paediatric education. The 2021 HCPC requirement of a full honours' degree has offered an opportunity for implementation of an in-depth paediatric module. This implementation, however, does not benefit those who are already registered therefore it could be suggested to increase the paediatric module on the yearly mandatory training to encompass a larger range of primary care conditions and highlighting alternative resources. To complement this expanding education, development of national protocols and guidelines for paediatrics with lower acuity complaints, combined with an extensive list of available alternative resources should be made readily available.

The increased scope of practice should be made widely known developing both prehospital clinicians and public confidence in the role. Further research should be developed to investigate the prospect and benefit of Prehospital paediatric specialist on appropriate and effective patient care. The creation of such a role, responding primarily to the 5-10% of call volume, would negate concerns of confidence, exposure, and experience. Whilst accepted that their presence may not be possible for all ambulance attendances, support from their specialist skill set could be accessed through alternative methods, empowering other clinicians. The research should utilise a mix-method approach, identifying successful and appropriate decision making through a synthesis of Patient Report Forms (PRFs), while also conducting interviews or collating qualitative feedback from the specialist, patient, and family to review confidence and patient centred care.

The additional creation of a 24 hour paediatric phone line direct to a paediatric specialist would also provide a specialist expert pathway and knowledge, negating the need to take children in "just for a check-up". The Queen Elizabeth hospital Kings Lynn successfully run a "frailty line" throughout the week, as such conveyance rates for elderly patients have significantly reduced, numerous participants have suggested the equivalent for paediatrics.

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Nursing Midwifery Allied Health Professionals
James Paget University Hospitals NHS Foundation Trust
NICHE Anchor Institute

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Anchor Institute

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MAPLE Project:

NHS
James Paget
University Hospitals
NHS Foundation Trust

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Supporting staff to be **Mindful**, to feel **Assisted** and **Provided** for, to have **Learning** opportunities and to help them feel **Empowered** to give the best end of life care.

Victoria Humphrey Healthcare Assistant, JPUH Research, Evaluation and QI Scholar 2023/2024
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Introduction:

Death is a subject that needs to be discussed openly and honestly.

When it comes to death the statistics are correct that 100% of us will die. We can not escape this, but we can change how we think and talk about death. As providers of care, we need to think about how we care and support not only the dying and those close to them, but also the staff and colleagues that provide the care too.

In 2022 there were 577,160 recorded deaths in England and Wales, 1170 of those deaths occurred at the James Paget University Hospital(JPUH).

When it comes to dying, we aim for this process to be peaceful, calm and dignified. However, the death of a patient can be traumatic to their loved ones, but many times, and often unseen, this can also be upsetting to staff too.

Aim:

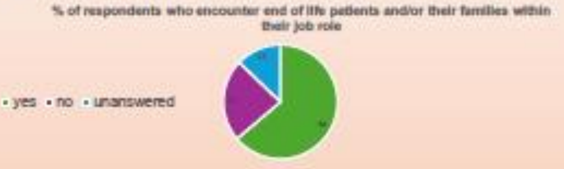
- To find a baseline understanding of healthcare workers perceptions on end-of-life care within the JPUH. This is specifically related to the Gold Standard Framework red (last few days, hours of life).
- To also gain an understanding in what HealthCare workers would need or want.
- To enable staff to give the best care within various roles.
- To give an insight in to how staff feel about end-of-life care.

Methodology:

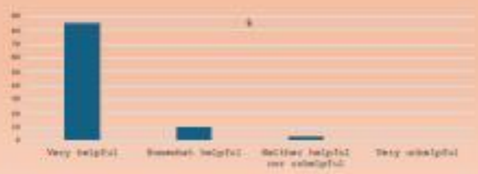
- Informal interviews were had with Nurses, Dr's and healthcare assistants on the emergency admissions unit in the early stages to gain information to base the foundations of the project. (March to June 2023)
- Key stakeholder discussions were had with the Palliative team, Mortuary, Butterfly volunteers and the Chaplain team (throughout the scholarship program)
- Staff were invited to take part in a survey that was open to the whole of the JPUH including temporary staff. (29/11/23 to 18/12/23)

Results:

A Staff survey was open for 19 days and received 163 responses; these were from: 21 Doctors, 59 Nurse/Nursing Associates, 36 Healthcare assistants, 10 AHP's, 13 Other clinical, 23 Other Non-Clinical, 0 temporary Staff RN/NA and 1 Temporary staff HCA



- 64% of those that answered encounter end of life patients within their job role.
- 72% that responded said that the Gold Standard Framework is applicable to their area of work.
- 9% that responded said they often/ always feel anxious looking after an end-of-life patient, while 20% of those said they sometimes feel anxious.
- 36% of those that answered the survey are extremely familiar with recognising the dying phase.
- 85% of those that answered said that information correlated in one place would be very helpful.



% of respondents who said that all palliative information consolidated would be a good idea.

"Allowing people to see the positives of EOLC, Passion on caring"

"Palliative link Nurse/Champion"

"Having a person, I know is there to specifically support us if we need them"

"More support"

"I don't feel we do enough for EOL patients and their family's, it is so busy the families don't get the support they need"

"Someone to contact who has answers I need or even to help with care after death"

"Being aware of who we can contact out of hour's if needed"

"To have all new `Doctors and Nurses trained more in delivering anticipatory medicine as this is the last thing we can do, we need to get this right"

"Training"

"I think it would be beneficial to have an end of life family support worker who can come and support and help staff"

"Booklet as mentioned"

Conclusion:

This project suggests staff believe that the palliative team provide high quality care at the JPUH. However, more support is needed for staff members who interact with dying patients and their loved ones. The support should focus on helping staff adapt to the physical and social needs of patients and their loved ones. Additionally, there is a need to enhance the skills and knowledge of staff regarding end-of-life care. This could involve providing easily accessible resources in one space as suggested and training to help staff better understand the unique needs of patients and their families. By strengthening skills and knowledge , staff will be better equipped to provide the necessary compassion and dignity for patients and their loved ones as well as creating a supportive environment for end-of-life care

Overall, the project identified that there is a need for additional support and resources, by implementing these changes staff would be better equipped to provide high quality care and create a more dignified environment for our patients and their loved ones during their final journey.

Next Steps:

To collaborate with The Palliative Care team, to implement the MAPLE booklet for all departments. This would contain significant information needed in relation to end of life care, all in one place. In the future, my ambition is to create a role that will provide support to all staff, enabling them to deliver best in class end of life care to patients and their loved ones. This could be facilitating last requests from the dying, to assisting healthcare professionals with care after death, resulting in dignified care for end-of-life patients and loved ones, with compassionate and confident staff.

Acknowledgments:
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ii)https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2022

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Hospital King's Lynn
NHS Foundation Trust

Identifying Barriers to Mobilisation of Patients in the Queen Elizabeth Hospital King's Lynn

Codrin Buleu - Specialist Physiotherapist and Joint Team Lead for the Medical Therapy Team

> 'Increasing mobilisation of patients in my care will be more work…'

Introduction

Thanks to research, medicine is advancing fast and now, more than ever, people live longer with more comorbidities. Years are added to life, but with hospital deconditioning becoming a growing problem, the quality of life is not always closely considered during those extra years. The frail elderly are more likely to have recurrent admissions to hospital and due to prolonged bed rest many experience the detrimental effects of deconditioning[1, 2, 3]. Their physical and mental health can be affected[3] and often they require increased health or social care support on discharge from hospital. Research suggests that 3 in 5 inpatients don't have a medical reason to stay in bed[4].

By encouraging the people we care for to get out of bed and mobilise, we can fight the negative effects of deconditioning, reduce the length of their hospital stay[1, 5] but, most importantly, we help them maintain their quality of life[1, 4, 5].

But if this is such an important thing to do, why is it not fully embedded in our day-to-day QEH ward culture? Why is it so variable from ward to ward and from shift to shift? Why is this not 'business as usual'? What's stopping us to get our patients out of bed?

Methodology

A literature search revealed a validated and widely used survey[6] specifically designed to find barriers to mobilisation of inpatients in an acute medical setting. The PMABS[6] (Patient Mobilisation Attitudes and Beliefs Survey – QR code below)) was designed in 2015 by Hoyer et al.[7] at the John Hopkins University, Baltimore, USA, and was based on a 1999 paper by Cabana et al.[8], which concludes that the reasons for clinicians not following guidelines fall into three categories: Attitudes, Behaviours and Knowledge.

The Likert scale survey was adapted to use British and local terminology. It was piloted twice: 7 questions were rephrased for clarity and one open-ended question was added. The survey was rolled out to all the patient facing staff and was opened from the 15th of Nov 2023 till the 31st of December 2023.

The answers to each question were given a score from 1 to 5, the higher the score the bigger the barrier to mobilisation of patients, with some of the questions reverse coded to reflect this. All the scores for each question were added up and average scores were used to compare the results and sort the questions in descending order, starting with the biggest barrier.

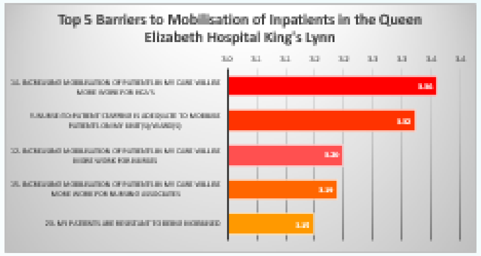
The adapted PMABS survey

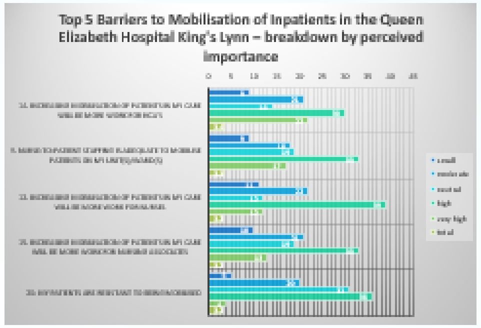
The original PMABS survey

Results and Discussion

The 96 responses were from nurses n=33, healthcare assistants n=28, therapy assistants and assistant practitioners n=11, physiotherapists n=9, occupational therapists n=6, trainee nursing associates n=3, student nurses n=3, clinical coordinators n=2 and patient support workers n=1.

Despite good self reported knowledge from all staff that responded to the survey, three out of the top 5 barriers to mobilising the people we care for here at the Queen Elizabeth Hospital King's Lynn appear to be the perception of extra work involved. Unsurprisingly, 'insufficient staffing' also makes it in top 5 barriers to mobilisation of inpatients.

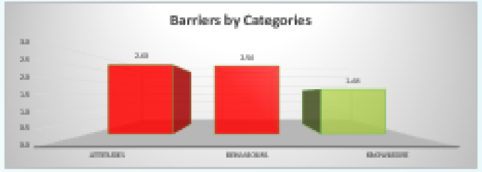




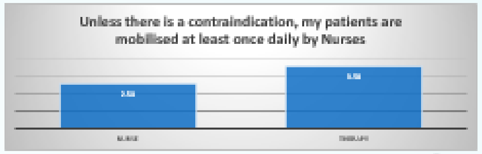
A novel barrier that this survey uncovered comes from the patients: their resistance to mobilisation. Could this indicate a gap between expectation and reality in patients' perceptions of their involvement in their hospital care? It could also be interpreted as an opportunity to propose a change in the way we encourage our patients to get out of bed and mobilise or in the way we facilitate true informed consent.

When grouped by category, the responses suggest that the biggest barriers lie in the Attitudes and Behaviours sections. This is unsurprising knowing how challenging it can be to change culture in the NHS.

The Knowledge section scored the lowest suggesting that it is not a barrier to mobilisation, or it is a lower one. But wouldn't most Attitudes and Behaviours stem from Knowledge (or a need for it)?



The data may be analysed in several other ways, which could lead to more potential routes that could be explored. For example: what about those questions that returned a high score discrepancy between therapists and nurses/healthcare assistants? Is there a difference of perception due to the different job role? Is there a need for further audit or training? For example, below is question 11 and the results have shown the highest discrepancy in answers (1.04 points). While nurses and HCA's think that patients often get mobilised at least once daily, therapists feel this is not the case.



The post op surgical patient has a plan made at pre-assessment but with medical and emergency patients this is not the case, and this is where the focus on mobility should be discussed where possible on admission. - **Nurse**

As a therapist, I'm often told by the nursing staff and the HCAs on the ward they have been told to not mobilise a patient until OT/PT have seen the patient… - **OT**

In ED we make the pts immobile by putting them on trolleys and raising the sides… - **Nurse**

HCAs not understanding that we can also assess a patient's mobility. - **HCA**

I feel that the culture in which staff are used to working means that fewer patients are mobilised during a shift. The nature of the workplace seems to be very task orientated and staff seem to be "too busy" and see mobilising as an extra task to be done. I feel that it's also seen as "not my problem" by some staff when actually it's the responsibility of all staff to help the patients. There also seems to be a culture of risk adversity and that reduces the number of patients who are mobilised as staff feel they need permission from a doctor / nurse / OT / PT to be able to mobilise a patient… - **Nurse**

Conclusion and Next Steps

In the last years we have seen a steady increase in pressures at the 'front door'. With limited community resources to support safe discharges of patients with more and more care and health needs and with historic staff recruitment challenges, we need to look at doing things differently to prevent hospital deconditioning in our inpatient population. To change behaviours and attitudes, we may need to address the knowledge first, despite it being perceived as a lower barrier to patient mobilisation in hospital. Is there a need for training and for raising awareness of the negative effects of deconditioning?

While the patients' willingness to mobilise is also brought into discussion by the results of this survey, there may be scope for further research or for a pilot to trial an educational programme for the patients or even for the public on what is expected of them when receiving care in hospital?

These are just two of the many avenues that could be explored in the one-year ARC Implementation Fellowship that was awarded for following up on the findings of this survey and for designing and implementing an intervention to fight deconditioning in the QEHKL. We need to make the task of patient mobilisation everyone's job.

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- Clinical Leads and the Medical Therapy Team at the QEHKL for the support
- Staff at the QEHKL for taking part in the survey

Implementation of an arts-based therapy group in an acute neurosciences setting

By Rebecca Winter- Occupational Therapist at NNUH

Research, Evaluation and Quality Improvement NICHE Scholarship

Background

The relationship between occupation as purposeful, meaningful and goal-directed doing, and health and wellbeing has been well established in Occupational Therapy (OT) literature (Wilcock 2006, Hocking, 2009). Engaging in creative and meaningful occupation can impact positively on health and wellbeing (Ellis-Hill, 2019). Participating in social and leisure activities are also legitimate goals of intermediate care, as outlined by the NICE guidelines (NICE, 2017).

Creative arts-based therapies have been recommended for stroke survivors, and have no adverse side-effects (Lo, 2018). Craft materials can often be sourced for low-cost or from recycled materials, which is essential given NHS budget restraints.

Creative arts therapies can be used to help reduce anxiety, depression and isolation with stroke patients by helping them express internal feelings through artwork (Kongkasuwan, 2015). Stroke survivors who have received art interventions have been shown to improve their spatial processing, attention, planning/sequencing, social expression and increased use of affected limb (Reynolds, 2012). Improved spatial improvement in brain connectivity may also be associated with increased psychological resilience in adults, which is beneficial following such a life-changing event such as stroke (Bolwerk, 2014).

Art-based therapies can be a useful supplement to existing stroke rehabilitation programs that have a primary focus on functional recovery. This comprehensive rehabilitation provides holistic care and enhances the post-stroke quality of life for survivors (Lo, 2018).

Introduction

Approximately two-thirds of stroke survivors in the UK are left with some form of disability. Therapy is key to recovery and quality of life, and evidence shows that intensity is key. Therefore the Stroke Sentinel National Audit Programme (SSNAP) recommend 45 minutes of therapy daily. However, this is rarely achieved and therapy is often infrequent. Staffing levels are a contributing factor, along with the severity of the stroke (Gittins 2020). Providing a group with activities for different skill levels and allowing therapists to see multiple patients at once may improve patient outcomes and the SSNAP targets for the department.

An 'art' based group was chosen by the OT team following communication with other trusts about the groups they were running. The resources were easy to obtain via community social pages, meaning there would be no costs to the ward. Many patients highlighted creative pursuits when asked about their hobbies by the OT team.

The project aimed to increase the overall SSNAP rating score for OT within Neurosciences, and to review the patient experience of being a group participant to see if there were any additional benefits to offering groups in an inpatient setting.

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Methodology

Quantitative Data:

A survey was developed which tracked:
- The banding and amount of staff to run each session
- Patient attendance/drop-out rate
- Patients support needs

This data was then analysed using Excel to identify trends and connections.

Graph 1 shows that the mean total of staff to run the group over the four months was 12 per month. The mean amount of attendance was 19.25 patients. This data is slightly affected by some months being longer than others, so more sessions were run.

Qualitative data:

Patients were surveyed during their session to gain feedback on their experience joining the groups. Questions included:

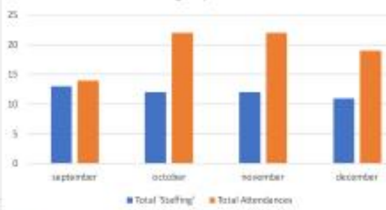
1. Do you feel that the group therapy session is of benefit to you? If so, how?
2. Are there any particular aspects of the group sessions that you enjoy?
3. Are there any particular aspects of the group session that you dislike?
4. Do you feel your function has improved? If so, how?
5. Are there any changes you would make to the group?

Not all patients were able to respond to the feedback request, due to reasons such as aphasia or cognitive difficulties.

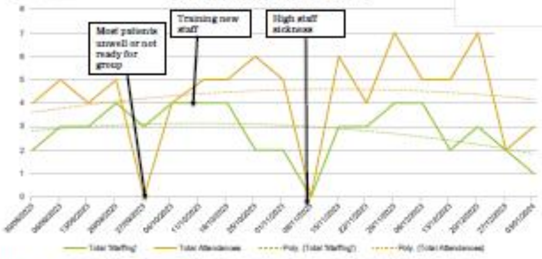
5 Commonly Asked questions

Occupational Therapy Group

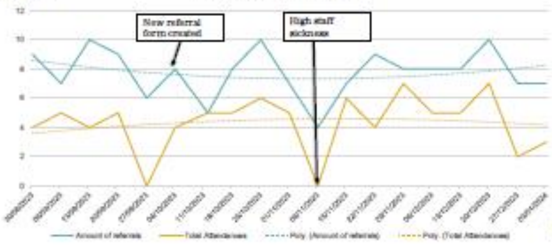
Graph 1



Graph 2



Graph 3



Occupational Therapy 'ART' Group

Results

Patient Feedback:

Quantitative data analysis showed mostly positive feedback, such as enjoying the opportunity for social connection, enjoying the diversity of activities and the opportunity to have a change of environment. Patients also reported self-rated improvement in hand function, however as the sessions are short and often patients move on from the acute environment to onward rehabilitation it is difficult to formally measure functional change.

While comments were mostly positive patients also mentioned finding creativity challenging, especially if it is not a usual occupation for them. Also comparing themselves to others can lead to personal frustration about how their abilities have changed post-stroke.

Staffing Impact:

Graph 2 shows the amount of staff vs. the total attendance of patients during the session. Qualitative data analysis showed that occasionally high staff numbers were running the group. As per the annotations on the graph this was often due to a multitude of factors, such as new students joining the team and training up new or returning staff. However, this would have meant the group was less effective from a SSNAP perspective. The group takes 2 hours to run, including prep time and collecting patients. As it's taking 12 staff on average to run the group monthly there needs to be a minimum of 24 attendances to make it an effective use of time. However, the general trend is that it is taking fewer staffing hours to run the group now that it has become more established, hopefully this trend will continue.

Graph 3 shows that there was only one week with no patient dropouts. This is a consistent issue and contributes to the group being less effective from a SSNAP perspective as fewer patients attend than anticipated. It was felt some of this was due to staff referring patients without having the chance to fully explain the group. A leaflet and poster (pictured left and below) were created for the patients to read in their own time, as this took some time to get approval it is not yet known if this will have an impact on patient drop-out rates.

PDSA Developments:

Multiple PDSA cycles were completed, mostly due to staff feedback that the group could be difficult to run if the usual OT staff were absent. This lead to the creation of a flowchart, altered referral form and 'easy pickup' activities to try and facilitate smoother running of the group, and ensure sustainability as the group could then be continued if the leading OT's were absent.

Conclusion

Implementing a therapy group in an acute setting can be a lengthy process to embed in a busy environment. Fluctuations in patient motivation, attendance, support requirements and staffing numbers can all have an impact on the effectiveness of group therapy.

Despite this the group received mostly positive feedback from a patient experience perspective, indicating that patients receive many social, mental and physical benefits from having the opportunity to attend a group therapy session.

Further study would benefit to establish the effectiveness of the new leaflet on patient drop-out rates, also to compare data from other settings such as inpatient rehabilitation units where patients may be more independent with less demands on staffing numbers- which may show greater effectiveness from a SSNAP perspective.

Acknowledgements: I would like to thank my mentors Rene Gray and Jordy Yazbek for all of their guidance and support with the scholarship.

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Mentorship Program for Health Care Assistants in Social Care Setting
Service Improvement Evaluation

Author: Helen Jackson RN (Adult)

Introduction

This service evaluation was undertaken whilst working as a care manager. One of the service improvement projects identified was the quality of current induction.
Despite the introduction of the care certificate there remains significant difference in the support and development offered to healthcare assistants.
A 9 month mentorship program was commenced. Evaluation of literature was utilised to aid identification of skills for effective mentors and aspects of effective mentorship programmes in practice.

Objectives

- Aid high quality care by developing an effective mentorship program
- Aid staff retention by creating a supportive and challenging environment.
- Develop an active learning culture with staff members from induction

Methodology

Evaluation of the project utilised a mixed method design incorporating quantitative and qualitative data collection.

- Structured Interviews
- Knowledge and Skills Questionnaire

Mentees who had been through the mentorship programme and previous new starters were included, mentors were included.

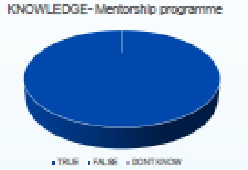
Data Analysis

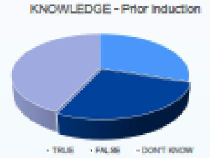
The project had a data sample of 6 staff consisting of 2 mentors and 4 health care assistants. 2 of the healthcare assistants had been through the mentorship program and 2 had commenced employment prior to the mentorship program.
Quantitative data was collated to evaluate the effectiveness of the mentorship program in preparation of the mentors to undertake their role and preparation of new starters to fulfil their role.
Qualitative data was evaluated for trends regarding successful aspects of the program and areas of improvement.

Limitations of the evaluation include small data sample and limited diversity in data sample which could Impact on the learning needs of the mentee.

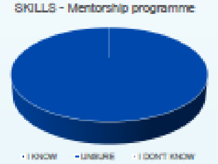
Results

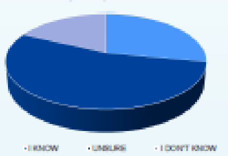
New starters who had not participated in the mentorship program recorded obtaining only 30% of the knowledge needed to fulfil their role compared to 100% those of who had completed it.





New starters who had not participated in the mentorship program also recorded obtaining 30% of the skills to fulfil their role compared to 100% of those who had completed it.





Trends Identified

- Mentor was person centered and learnt from them
- Felt prepared after supernumerary period
- Felt supported during induction
- Proud to be a mentor, the satisfaction of seeing new starters strengths become the strengths of the team

Conclusion

A structured mentorship program and creation of a leaning culture aided the knowledge and skills of new starters which positively aided the quality of care provided.
Selecting the correct individuals to be effective mentors and preparing them for the role was vital to the success.

Acknowledgements

With thanks to James Paget University Hospital, NICHE Anchor Institute, NMAHP, Kelly Ferrigue, Jonathan Thompson, Antonia Anderson, Jorny James, Carol McGuinness and Helen Fort

Further Reading

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Palliative Rehabilitation: Exploring Service provision from the Community Therapist's Perspective in NCHC South Place

Exploring 'generalist' Community Physio and Occupational Therapist's lived experience of the service they deliver to patients identified on the Gold Standard Framework (GSF) in South Norfolk (South Place)

Tracy Whyte, Community Physiotherapist, BSc (Hons) NCHC South Place tracy.whyte@nchc.nhs.uk

Background

Definition: Rehabilitation within palliative care empowers people with incurable health conditions to **actively manage their condition, reduces symptoms and enables individuals to stay independent and socially active**. This allows them to enjoy the best possible quality of life, right up to the end of their life'

Increasingly Ageing Population particularly East of England

It is projected that between 25% and 47% more people will require palliative Care by 2040

Potential Barriers to Palliative Rehab (WHO)
- Lack of recognition for rehab needs/awareness of benefits
- Inadequate training and skills
- Delays in/ lack of resources
- Failure to prioritise Services

Admission Risk
Average probability of In-patient admission for a GSF patient in South Norfolk in the next 6 months
= 36.2%
Of an extended admission in next 12 months
= 12.4%

NHS England recognise generalist therapists and their skills as part of the core workforce *'Regard should be given to supporting general clinicians to build knowledge, skills and confidence to deliver high quality, personalised Palliative and End of Life Care'*

Objectives

- To determine rate and reason for referral
- To explore therapist experience triaging and managing this patient group
- Gain insights into how therapists communicate/interact with other relevant teams and colleagues
- To identify potential learning and development opportunities

Methodology

Staff Survey conducted Oct-Nov 23

Database Review/Realtime referral audit Sep 23-Nov 23

ICB Data Hub, BI Insight and Analytics were sought for further insight Sep'22-Sep'23

Semi-structured follow up interviews (n=2)

Results

ICB Health Analytics
Data reviewed Sep'22 – Sep'23 across South Norfolk PCN's
- 864 patients registered on GSF
- 9% referred to Physiotherapy
- 27% referred to OT

Norfolk and Waveney ICB Data Hub, BI Insight and Analytics. Data not validated at GP practice level.

SURVEY sent to 26 therapists
70% response rate OT:PT
52:47%

What areas are you interested in learning more about?

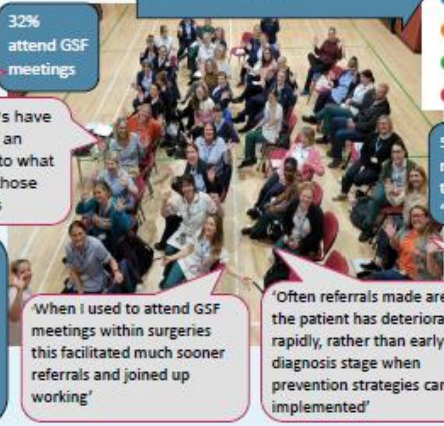
● Role of Exercise in Palliative Stage	14
● Advancing frailty	11
● Palliative Care Emergencies	13
● Bone Health and metastases	13
● Management of Lymphedema	12
● Pain management	8
● Breathlessness management	8
● Fatigue Management	8
● Advanced communication / Hav...	10
● Knowledge of local voluntary, h...	12
● Different Cancer types and their...	12
● Oxygen prescription/arrangeme...	11
● Communication aids/pathway	6
● Nutrition and dietetics	10

32% attend GSF meetings

I think we don't necessarily talk about goals at GSF

different areas work in different ways

think that the GPs have much more of an understanding as to what my role is from those discussions



53% Perceived referrals received later than what they would consider 'timely'

Reported benefits of GSF meetings
- Having up to date patient information
- Being able to discuss patients of concern
- Identifying patients to be added
- Enabling appropriate referrals
- Discussing patient's needs

Discussing patient's goals was only identified by one respondent as a benefit

'When I used to attend GSF meetings within surgeries this facilitated much sooner referrals and joined up working'

'Often referrals made are when the patient has deteriorated rapidly, rather than early in the diagnosis stage when prevention strategies can be implemented'

it's always good, isn't it, to get involved earlier and start having discussions and that would make the patients themselves feel more in control and empowered more

Confidence, Knowledge and skills

Understanding each other's role's

Do they get more involved once it's hit the crisis point or are they more involved earlier just that would just be interesting information

Conclusion and Recommendations

- Community therapists and assistant practitioners routinely assess and provide care and rehabilitation to GSF patients. Physio's receive fewer referrals and few for exercise intervention/symptom management.
- Therapists are eager to increase knowledge and skills across all areas of palliative care and rehabilitation
- There is an inconsistent approach to MDT working across South Place
- Those that attend GSF meetings report a range of benefits
- Referrals are predominantly reactive in nature
- Therapists rate their confidence lowest in prioritising referrals and referring onto specialist services from triage.

- Continue to develop links with specialist therapists re: training needs and collaborative working
- Feedback to Trust Education Team
- Feedback evaluation findings to NCHC to inform service review/specification
- Include training/competencies in triage induction process
- Review patient pathway – could our therapy services be promoted earlier? Are there opportunities for joint working and information sharing with specialist services?

Acknowledgements

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Recognising, Reviewing and Responding – The 3 Rs which contribute to the reduction in Massive Obstetric Haemorrhages.

Sarah Bedford Lead Midwife for Intrapartum Services, The Queen Elizabeth Hospital, Kings Lynn, Norfolk, supported by NICHE Anchor Institute Scholarship

Introduction

Severe bleeding after childbirth- postpartum haemorrhage (PPH) is the leading cause of maternal mortality world-wide. MBRRACE-UK reports a non-significant decrease in maternal deaths from direct causes between 2014-2016 to 2017-2019 with Thrombosis and Thromboembolism being the leading cause of direct death with Obstetric Haemorrhage being the next commonest cause of maternal death.

The Queen Elizabeth Hospital (QEHKL) identified an increase in the rate of massive obstetric haemorrhage (MOH) in 2023 and a thermatic review was commissioned.

The thermatic review analysed the quantitive data that was held on 17 outstanding MOHs awaiting review. The outcome of the review highlighted a lot of learning, and how improvements could be made.

The objective of this QI project was to contribute to the reduction in the rate of MOHS by identifying improvements in care that can be made in the clinical setting.

Quality Improvement Initiative

The biggest highlight of this review is how the current review process of MOHs was not robust, nor identifying and disseminating learning to the wider teams. This brought about the quality improvement project undertook as part of NICHE scholarship to redesign and embed a robust review process of any MOHs occurring within QEHKL to maximise learning and help to support change in practice to contribute to the reduction in the overall MoH rate.

The process of reviewing MOHs prior to this QI project involved a "Datix" being completed, a datix is a form to recognize events which pose a threat patient safety, and the datix being reviewed by the midwife in charge of the shift when the MOH occurred. There was no consistency, systematic process to reviewing the MOHs, or documentation tool to support the review, and the learning wasn't consistently distributed.
To overcome this approach a 3 point initiative was designed and implemented shared on the next bubble

Methodology

To design an electronic proforma, accessible to all which would allow a systematic, consistent, in depth approach to reviewing, analysing and learning from all blood losses outside of the normal parameters.

To build a multi-discplinary review panel to review all blood losses over 1000mls.

To reduce the threshold of reporting blood losses from the current 1500ml MOH threshold to 500mls, with 500mls and above being considered a PPH.

Impact

Since launching the new approach to acknowledging a PPH through the Datix system 128 PPHs have been recorded.

A MDT team has been established and has weekly attendance with review of 30 PPHs >1L being collaboratively reviewed.

Version 1 of the electronic review tool was implemented in September, and after feedback was converted to a Microsoft Form containing the PPH management proforma and launched in December.

The electronic form has been completed 54 times since the launch in December and has had good user feedback.

Themes identified from these reviews have been highlighted, and actions taken to improve education, skills, and recognition of a PPH whilst addition equipment has been sort to support the clinicians respond and manage PPHs.

Results and Conclusion

The impact of these changes have changed practice and management of PPHS at QEHKL.

Since launching the initiatives in September a fall in PPHs has been seen consistently over September, October and November, with November having the lowest rate of MoHs for 12 months (1.49%).

From the review panel themes have been identified which contributed towards a spike in December and January and therefore action plans have been put into place to address these issues.

The initiatives put into place as part of the NICHE Scholarship have support clinicians to recognize a PPH before it becomes a MoH, enabled a robust, consistent review process which allows early identification of themes and barriers which prevent optimum PPH management, which in turn allows for swift action plans to be drawn up and put into place.

Transforming Practice and Empowering Staff in the Use of Qualitative 'Friends and Family Test' (FFT) Data to Enhance the Patient Experience (2024)

By **Jamie Kirkham**, Patient Experience Assistant at James Paget University Hospital

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Summary

Over the past decade, the NHS has collected patient feedback, but qualitative insights were often overlooked.

This project focused on using staff-driven changes through a quality improvement approach. Staff identified implementation barriers. The gathered data shaped the quality improvement model.

Ward staff rated their engagement using a Likert scale, and ward audits assessed FFT implementation standards. 'You Said, We Did' implementation increased by14%

Issues highlighted the need for standardised hospital practice, improved communication, and clarified responsibilities.

Introduction

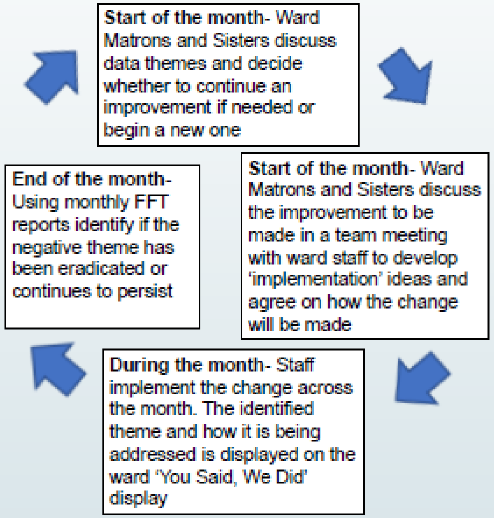
The 'Friends and Family Test' (FFT) is a national survey designed to gather patient feedback. Yet often there is a pre-occupation on gathering statistics, rather than looking at the qualitative themes and how patient suggested changes can be implemented.

Aims

- To involve staff in developing strategies and resources that inspire them to utilise FFT qualitative data for enhancing the patient experience, aiming to establish a cultural shift within a quality improvement framework.
- To understand the barriers staff have with the use of FFT qualitative data to improve the patient experience
- To increase the percentage of wards displaying 'You Said, We Did'

Methodology

- A qualitative survey was conducted with Ward Matrons and Sisters to identify the barriers they face when implementing patient suggested changes. This data informed the **quality improvement model** which was implemented in two wards monthly.



Start of the month- Ward Matrons and Sisters discuss data themes and decide whether to continue an improvement if needed or begin a new one

Start of the month- Ward Matrons and Sisters discuss the improvement to be made in a team meeting with ward staff to develop 'implementation' ideas and agree on how the change will be made

During the month- Staff implement the change across the month. The identified theme and how it is being addressed is displayed on the ward 'You Said, We Did' display

End of the month- Using monthly FFT reports identify if the negative theme has been eradicated or continues to persist

- To gauge staff motivation and engagement, and assess the impact of the quality improvement approach, a survey was conducted among all ward staff in two wards. The survey, administered at the project's start and end, used a Likert scale for responses and included open questions
- Additionally, observational ward audits were conducted to establish baseline standards for FFT implementation. Comparison between the initial and final audit was conducted to reveal improvements and areas for development

Results

- Identified barriers and solutions put in place

Identified Barrier	Solution
Staff resistance to change	The QI model built in the need to have meetings with staff for generating ideas
Quality and clarity of data	Bespoke reports were created for wards that were simple to understand
Implementation of improvements	One simple change was implemented each month and 'You Said, We Did' display was simplified
Training	PowerPoint presentation in QI approaches and guidance sheets on data analysis

- Final impact based on Likert scale improvement

Question	Initial	End	Progress
The ward works as a team to implement changes	3.8	4	+0.2
There is a culture of implementing changes	3.7	4.6	+0.9
FFT improves patient care	3.6	4	+0.4
There is regular FFT feedback	3	4.5	+1.5
FFT improves staff experience	3	3.5	+0.5
There is a clear hospital strategy	3	3.5	+0.5

- Qualitative Findings

-Time was an issue and staff felt there needed to be a better platform to share ideas

-Staff from the top down needed to be more 'proactive' with feedback themes, including who should take the lead in wards

- **Increase of 14%** (9% rising to 23% of wards) in terms of implementation of 'You Said, We Did'

Conclusions

- Staff felt there was a culture of implementing changes and that they worked as a team. They were more aware of FFT feedback
- There was an increase in 'You Said, We Did' display across the hospital
- Staff felt FFT improves patient care, but felt it improves the staff experience to a lesser degree
- The need for clearer hospital policy and practice for implementing changes was raised along with better communication and clarity of roles

Recommendations inform the next cycle of quality improvement:

- Develop and deliver a strategic approach to the use of a QI model for responding to patient feedback (You Said, We Did)
- Develop a robust cascade system, ensuring responsibilities and staff communication methods are clear
- Develop and deliver FFT 'cultural change management' QI training
- Explore the impact FFT can have on the 'staff experience' through positive case studies that can be shared widely with staff
- Create 'FFT champions' who can act as change agents to move the FFT agenda forward within wards, especially with regard to 'You Said, We Did'

Acknowledgements

I would like to thank Ward 2 and Charnwood Ward staff for piloting the quality improvement approach and taking part in evaluation surveys. I also thank wider hospital staff for their support in developing the QI model. Finally, I thank NICHE and the research scholarship staff for the opportunity and their invaluable support, including Alice Webster, CEO at Queen Elizabeth Hospital, King's Lynn

Determining the acceptability of using VR headsets for individuals with a Learning Disability in healthcare settings”

Mr Matthew Perryman RNLD – JPUH QI, research and service evaluation scholar 23/24 &
Community Learning disability Nurse – NCH&C NHS trust community learning disability team East Norfolk
Matt.Perryman@nchc.nhs.uk

Background

A public health England (PHE) **report** (2017), ‘Blood tests for people with learning disabilities: making reasonable adjustments’, highlights that ‘many people with Learning disabilities are afraid of needles for good reason’ including ‘forced use of needles’ and use of restraint used to complete procedures. The report also highlights that there is ‘little research and policy’ in this area to understand the wider issues related to this topic although there is a wide range of good practice recommendations available to practitioners to enable successful blood tests.

Literature searches indicate that including a Virtual reality intervention for Childrens blood tests has had positive outcomes in reducing anxiety, stress and noted pain reduction aspects with improved patient experience.

Aims

- To develop a safe and user-friendly Virtual reality session for people with a learning disability.
- To gather the views of participants to inform whether using virtual reality as a reasonable adjustment is a viable option for use in healthcare settings..

Methodology

- Quality Improvement project which would look at finding out the views of people with a learning disability about virtual reality.
- Research and acquire appropriate virtual reality equipment
- Seek advice, feedback and guidance from people with a learning disability, family/carers and colleagues about developing a safe and effective Virtual reality ‘taster desensitization’ session and effective results questionnaire.

Results

- 15 potential participants were identified from current Community Learning Disability Team East Norfolk caseloads.
- 7 females and 8 males.
- Of those 15, 3 participants decided they didn’t want to take part in the VR session questionnaire following demonstration of the equipment
- 12 participants took part in a VR session and completed an accompanying questionnaire.

91% of participants said that virtual reality might be helpful during healthcare appointments

100% of participants said they enjoyed the virtual reality session

100% of participants said they would try virtual reality again

Scan QR code for full results

Recommendations

- Further development of co-produced content which is learning disability friendly.
- Further development of content that would support people with a learning disability to access de-sensitization of healthcare settings and procedures prior to appointments and/or procedures
- Further research with people with a learning disability into the potential of Virtual reality in improving access to healthcare and improving patient experience.
- Continue to link with wider local and national Learning disability networks who are implementing similar virtual reality projects and support continued data collection.

Discussion

Results and feedback from the virtual reality sessions suggest that a virtual reality experience can be an enjoyable one for people with a learning disability and have added positive benefits that could aid a healthcare professional in providing interactions and interventions that are ‘calming, fun, safe and relaxing’.

The relatively high number of participants who had never tried Virtual reality before (83%) suggests that a ‘taster desensitization session’, such as that used in this project, can enable positive outcomes and a positive attitude about virtual reality.

Exciting testimony from colleagues at Leeds University hospital suggest VR is already being used to **good** effect to improve blood test experiences for people with a learning disability

Acknowledgements

Study supported with thanks to Marcus Hayward,, colleagues in the CLDT East and Lynne Fanning (NCH&C).

NICHE
Anchor Institute

Health Innovation East

Community Voices: An Evaluation Of The InHIP Bowel Cancer Screening Pilot.

Matthew Whelband, PhD– Norfolk and Waveney ICB

Community Voices
Using your feedback to improve care

Improving lives **together**
Norfolk and Waveney Integrated Care System

1) Introduction

The Community Voices (CV) Programme has been delivering community engagement initiatives as part of the ICS's approach to tacking health inequalities. The initiative trains 'Trusted Communicators' (TCs) from Voluntary, Charity, and Social Enterprise (VCSE) organizations to discuss healthcare topics with Core20PLUS community members. These discussions are then documented in an 'Insight Bank' to analyse themes.
This pilot study, funded by Innovation for Healthcare Inequalities Programme (InHIP) NHS Accelerated Access Collaborative in 2023, explored connections between deprivation, reduced awareness of bowel cancer signs and symptoms, and uptake of screening tests in CORE20+5 communities of Norfolk and Waveney.

2) Methodology

Objectives were to describe the

1) Themes from CV conversations logged in the insight bank.
2) Perceived impact of the CV inHIP pilot on raising awareness about bowel cancer screening and other cancer screening programs.
3) Barriers and facilitators of this CV initiative.

Data Collection Methods:

1) Measuring the number of insights logged per VCSE organisation.
2) Qualitative analysis of the Insights Bank
3) Analysis of Focus Groups with project design stakeholders and TC's.

3) Key Findings

24 Trained TCs, 10 VCSE organisations → September – November 2023 → 322 conversations

VCSE Organisation	Core20+5 Group	Number of Insights
Access	Migrant/refugee	17
DIAL	CORE20	51
St Martins	Homeless	4
ShoeBox	CORE20	131
GYROS	Migrant/refugee	33
Hear for Norfolk	CORE20	64
New Routes Integration	Migrant/refugee	7
Woman Like Me	CORE20	12
Shrublands	CORE20	1
GYBC	CORE20	2

Analysis of the Insight Bank revealed a general understanding of bowel cancer screening and symptoms among Core20PLUS5 communities, improved by some following conversations.

Stakeholders expressed positivity towards the project's impact on community engagement, trust-building, and perceived behaviour change in Core20PLUS5 communities, showcasing effectiveness of Community Voices model in healthcare discussions.

Challenges arose in engaging external teams and processes (e.g., screening data/RIDAC, DPIA) and people's difficulties in ordering a test, led to difficulties in measuring impact of ordering FIT tests following conversations with trusted communicators.

Trusted communicators in focus groups highlighted the importance of TCs to overcome difficulties in discussing bowel cancer screening with their communities, with group discussions and broader health discussions shown to overcome barriers this topic.

4) Key Focus Group Quotes:

VCSE partnerships:

"you actually respect the work that we're doing in communities, and we probably are the best people to bridge between what you need done and what people need to be doing for themselves."

Conversations with communities:

"I'll start the conversation about it with one and then by the end of it, they're all talking about it."

"I felt when I went into the kill, by the way, how are your bowels? People sort of shut me down."

5) Key Insight Bank Quotes:

Screening test Insights:

"Gets the bowel cancer screening kit and does it every time. … it's much simpler now."

"had it for a while and kept putting it off…the results came back really quick, everything was all clear. I know what to look for, I did find it very messy trying to catch the poo."

Barriers:

"this person would not seek help for health care issues due to being homeless and no address."

"Client received Kit and done it, after that she was invited for further testing, but she refused to go. She has lost trust in service here."

6) Moving Forward: Considerations For Community Voices

- Importance of Community Voices in building trust between the ICB and VCSE organisations and building trust with community members by discussing health topics.
- TCs and project leads discussed a preference for a continuous working plan with the ICB team over reactive, short-term projects.
- Need to address community members from more isolated groups, alongside more targeted population health approaches to engagement.

Acknowledgements: Health Inequalities team, Cancer transformation and Research and Innovation teams, N&W ICB, JPUH Research Scholarship team, Health Innovation East, Hazel Smith (Associate Professor, Staffordshire University)

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Respiratory Traffic Light Document

To Improve Management of Children with Long Term and Complex Conditions

Lucy Jarvis BSc MCSP, Paediatric & Respiratory Physiotherapist JPUH

NHS
James Paget
University Hospitals
NHS Foundation Trust

Background:

- Acute respiratory failure with respiratory infection is the most common cause of emergency hospital admissions for children with neuromuscular disorders [1].
- Many healthcare professionals feel overwhelmed in the management of complex children due to the multifactorial element of their condition [2].
- We have recently implemented a respiratory traffic light document at JPUH and therefore feel it's important to evaluate the acceptability and usability of the document.
- The traffic light document aims to summarise a child's respiratory care needs and identify early signs of deterioration. If a child deteriorates, the traffic light document will provide information and advice on actions to take.
- This will enable carers and staff less familiar with the child to act quickly to prevent further deterioration and admission to hospital.

Method:

A survey was utilised to establish the usability and acceptability of the traffic light document within the acute (all paediatric and on call physio teams) and community setting (a subset of parents/guardians/carers who attended our respiratory clinic). The survey was sent out via a QR code and explores the perceived helpfulness of the traffic light document in the following three domains:

- Understanding the child's normal respiratory status
- Understanding signs that the child is becoming unwell
- Promoting confidence in the child's respiratory management

> *"It enables everyone involved in X's care to have the same understanding of her needs and know when to take action"*
> *Parent*

> *"It helps to give a clearer picture of what deterioration looks like and reduces anxiety of not knowing the child well"*
> *On Call Physiotherapist*

Results:

- The survey was sent out to 20 **physiotherapists** (14 working across the acute hospital setting and 6 working in the community setting) with a response rate of 85%, and 5 **parents/guardians** with a response rate of 60%.
- Out of the 20 respondents, 100% stated that they use/would use the traffic light document.
- Figure 1 shows the perceived helpfulness of the traffic light document.
- The surveys were analysed descriptively and two themes were identified:
  1) The majority of respondents said the traffic light was useful to help understand the child's "normal" presentation. Physiotherapists found background information helpful to reduce anxiety and to help avoid over treating. The parents/carers views were that it's helpful for professionals less familiar with the child's care needs and helps identify when extra help is needed.
  2) 75% of respondents commented that they liked the format of the document. They liked that it was clear and concise and also easy to follow in an event of any deterioration.

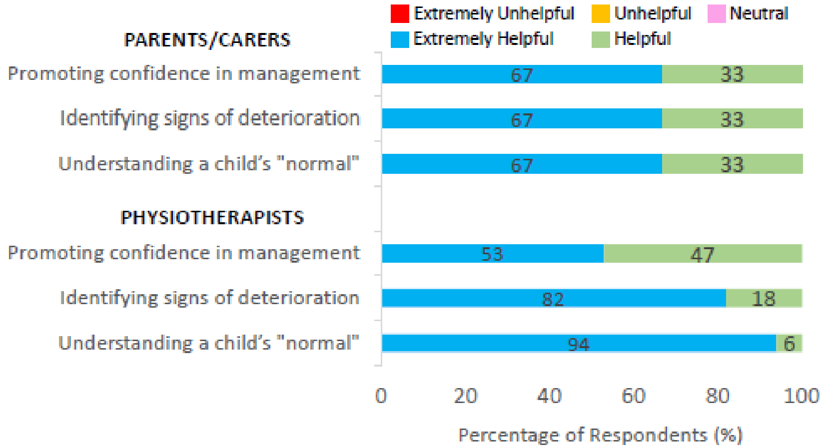

Figure 1: A graph to show the perceived helpfulness of the traffic light document

Conclusion:

- The traffic light document was helpful in the respiratory management of children with long term and complex conditions.
- It has been accepted and used within multiple different settings (acute and community) and by multiple stakeholders (paediatric/on call physio teams and parents/guardian/carers).
- We will continue to use the traffic light document at JPUH with plans of liaising with other trusts (e.g. NNUH) to share findings and encourage its use.
- Further research or evaluation should be considered to inform additional improvements to the document.

Acknowledgements:

All of the children, parents and carers involved in this project.
Michael Twigg, Jonathan Yazbek, Helen Hall, Rene Gray, Roberta Wakeley, Andrea Mccombe, Rachel Matthews, Rowenna Durrant and Adrian Sweeney.

#JPUH QI

References

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NMAHP
Research and Evaluation Service

CCS NHST Research Champion Programme: Manager's evaluation

Samantha Nunn, Research Facilitator,
Cambridgeshire Community Services NHS Trust (CCS NHST)

Introduction

Informed by our 2019 pilot and with consideration to recent national research strategies, we launched the Research Champions Programme (RCP) in 2023 for Trust staff. The RCP aims to create a vibrant, multi-professional community of Research Champion Practitioners, support evidence-based practice, build staff awareness and confidence with research, and enhance the Trust's research culture. Informed by the literature, and a logic model, an evaluation was conducted with service leaders, who facilitated staff participation. Ease of access, Perceptions of the RCP, and Systematic Organizational Support were the key themes identified for the evaluation.

Methodology

A mixed methods design was used comprising a quantitative survey and a qualitative focus group. The Three themes informed design. A convenience sampling method was adopted.

Survey:

- Created on iQVIA and distributed by email to 23 managers across 4 trust services.
- The survey contained 7 questions, each mapping onto one of the identified themes (see example below). Multiple answers were allowed for each question.

S — Please indicate any activities you do to support the RCP

E — Have any of the following made it easier for you or your staff to engage with the RCP?

P — Have you observed any positive impacts from the RCP for your service?

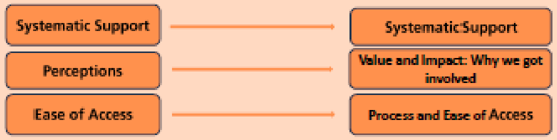
Diagram 1: S = Systematic organisational support; E = Ease of Access; P = Perception

Focus Group:

- The same managers were invited to take part in a focus group on MS Teams to allow further exploration of emerging themes.
- The group was facilitated by Samantha Nunn and Jack Hallworth as a silent facilitator, using a topic guide that was informed by the survey themes.
- The focus group was recorded, verbatim, with consent to aid analysis.

Analysis

- **Survey** results were analysed within the iQVIA platform.
- The **Focus Group** transcript was anonymised and analysed thematically. Key themes identified in the literature informed the deductive approach and during analysis the framework was refined as shown below:

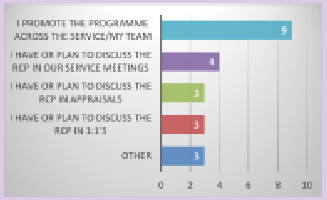


Results

Survey

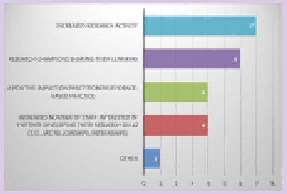
Eleven respondents completed the Survey comprising: 3 Clinical Leads, 3 Team/Locality Leads; 2 Operational Leads, 2 Heads of Service, 1 Service Manager. Response examples from 2 themes are given below.

Systematic Support



Type of activities undertaken to support the RCP within services

Perceptions



Number of managers reporting positive impacts of the RCP for their service

Focus Group:

Four Managers, from four separate services joined the focus group: 1 head of service, 2 clinical leads and 1 service manager. Refined theme example results are shown below.

Process and Ease of Access

- Managers utilized routine service processes to implement the RCP.
- Protected time to undertake the RCP activities was expected from the managers.

Value and Impact: Why we got involved

- Managers experiences of the RCP were very positive.
- The value of the RCP was seen as a way of building research culture *within* the service.
- Managers would 'highly recommend' the RCP to other staff and services.

Systematic Support

- Managers reported and provided wide systematic support,
- The value of 'buy-in' at all levels of leadership was recognised.

> **'we agreed as a service it would be one per locality'**

> **'We could foster, we could nurture, to then kind of allow that process to work in an informal way, if you like'**

> **..' and we wanted to have a system whereby we had research champions within the team that could feed back on the ground flow'**

Conclusion

- Managers reported and showed wide systematic support for the RCP .
- There was limited understanding in the focus group, of the degree to which Research Champions update their reams locally, so this may be an area for consideration in future iterations.
- Managers valued the RCP, perceived it very positively and had observed positive impacts, likening it to a 'ripple effect'.
- Routine processes were used to support RCP implementation.
- Limitations include potential bias of the author, and limited representation of locality leads.

Next Steps

- This evaluation and that of the research champions has been combined to inform improvements to the 2024 RCP.

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Bringing services together to provide wrap-around support:
An evaluation of Stroke Reach

Abigail.Langley@norfolk.gov.uk
Abigail Langley, Advanced Public Health Officer, Public Health

Introduction

Co-designed with a stroke survivor, Stroke Reach went live in February 2023 aiming to provide wrap-around support to improve the experience of stroke patients once discharged from clinical settings (see pathway below). 8 challenges were identified including coordination of care, support for falls, feelings of abandonment, mental wellbeing support, support for carers, accessing physical therapy, and signposting.

A strong evidence base supports the need for structured exercise programmes to enhance recovery by increasing cardiovascular health, mobility, building strength and cognitive recovery, and reducing further strokes. Providing this alongside a holistic support offer through Help Hubs and Headway could enhance recovery and reduce likelihood of returning to a clinical setting. This poster presents the evaluation of results so far according to data collected up until February 6th 2024. It addresses two questions:

1. **Is there a need for this project?**
2. **Is it effectively offering wrap-around support?**

Methods

1. Is there a need for this project?

- Survey of stroke survivors who didn't access Stroke Reach support.
- Qualitative data from discussions at Diss Stroke Support Group and the Early Supported Discharge Team (ESD).
- Data from service evaluations including Health Today scores, and EQ-5D-5L (a self-assessed, health related, Quality-of-Life questionnaire- the lower the score the better the outcome).
- Thematic analysis of Health Coach case studies.

2. Is it effectively offering wrap-around support?

- Interview with Active NoW Exercise Referral Support Officer.
- ESD team survey results and qualitative discussions.

RESULTS: Is there a need?

100% of survey responses said they would have taken up Stroke Reach support if it was offered at discharge, and answers reflected the challenges the project was designed around. Low responses to the survey (4 people) was a limitation of the research so Diss Stroke Support Group facilitated a discussion around need for a project such as this. They emphasised the abandonment and helplessness felt post discharge, confusion with services, and a sense of worry for their carers (those who had them). In addition to the support provided through this project, they emphasised need for a simple list of available support and contacts they could access post-discharge as they felt let down by lack of proactiveness from support services.

Quantitative data below supports this, demonstrating most people completing the Broadly Active programme rated their health better than before. The EQ-5D-5L results from Health Coach programme completers shows their score improving in each category.

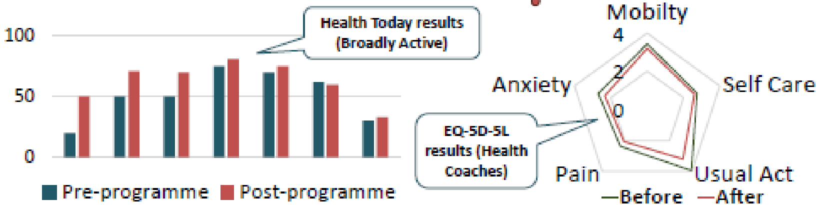
A thematic analysis of case studies about individuals completing the Health Coach programme resulted in four themes: Negative feelings and pain pre-support, Tailored support, Positive feelings and physical improvements post-support, and Continuation of support post programme. Increased confidence, hope, and energy were common codes across each case study, demonstrating the positive impact of this support.

Discussions with ESD informed of long waiting times for community physio, and emphasised more concern for patients who don't meet the ESD criteria with moderate to severe needs. These people are discharged with generic community therapy team follow-up which can involve a wait.

Stroke Reach support pathway:

Quantitative data from service evaluations

81% take-up rate



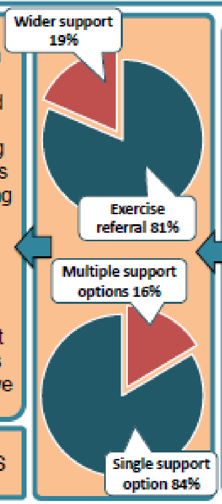
Conclusion

This evaluation has shown significant need for an array of proactive support services to meet each challenge identified by stroke survivors. Equally as important is the coordination of these support options that utilising Active NoW has enabled within the project. The Norfolk & Waveney Integrated Care System has a variety of support options in existence but needs to be increasingly joined-up with the aim of providing the most simplistic, joined-up support possible. Where provision is lacking in a locality, there is a need for this to be strengthened. To conclude whether there is a need for this project, Stroke Reach provides a step towards increasingly joined-up support through strengthening trust between clinical organisations and non-clinical support, bringing existing services together through a single referral pathway, and increasing likelihood of the right support at the right time. There may also be a higher need for this holistic support for those who don't qualify for ESD.

Addressing the second evaluation question, whilst Stroke Reach provides the option of wrap-around support, several barriers were identified explaining why take-up of multiple support options and non-exercise support is low. However, within individual services, a holistic approach to support was taken, shown through thematic analysis of Health Coach case studies. The creation of leaflets and posters detailing the Stroke Reach offer for clinicians and patients before referral would remove some barriers and increase likelihood the individual receives the range of support they require.

Acknowledgements:

With huge thanks to Peter Ellis, Diss Stroke Support Group, Helen Hall and the JPUH NMAHP RES team, Karen Watts, and NCHC ESD team for invaluable contributions.



RESULTS: Is it effectively offering wrap-around support?

Active NoW data (left) shows only 16% of individuals accepted multiple support offers. Reasons have been identified for this:

- During an interview, an Exercise Referral Support Officer explained they can only offer wider wellbeing support if the referrer writes it in their notes or if the individual brings it up themselves. This highlights the importance of how the offer is communicated to the individual pre-referral.
- Some individuals take up a wider support offer further down the line or when referred in by individual exercise providers, which isn't picked up by the data.
- This project has also highlighted lack of provision in certain localities, meaning the offer depends on where the individual lives.
- ESD makes up 59% of referrals and a survey demonstrated why referrals are predominantly for exercise support instead of wider support (81% compared with 19%):
  - 18% thought Active NoW was just exercise provision.
  - 43% refer with a specific service in mind for the patient rather than a suite of available support.
  - 55% recommend support as an optional extra instead of recommended next step.

Discussions with ESD team showed a need for a document mapping out the support available in each locality to inform how they communicate the offer to patients and how they refer in. This has been created by Active NoW referrers and shared with ESD staff.

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James Paget
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NHS Foundation Trust

Relieving Anxiety In Patients Undergoing Cataract Surgery

Research, Evaluation and Quality Improvement

Martine Foyster, Operating Department Practitioner, James Paget University Hospital

Introduction

Having Cataract Surgery under a local anaesthetic can be a daunting experience. This project aims to identify the concerns patients have and see if we could allay their fears by possibly addressing them, by improving the patient information provided. This could help relieve anxieties and possibly prevent cancellations or the need for a patient to return to theatre, to have the procedure under a general anaesthetic. As well as the distress and disruption caused to the patient and their families, this also has an impact on our waiting lists and a financial cost. It would also help us as caregivers to support patients better through their surgical journey.

NICE Guidelines state that patients should be provided with patient centred information, to help them develop their knowledge and confidence, to make informed decisions about their healthcare. This includes clear written information that outlines the individual steps of the operation , as well as pre and post operative care.

Clear explanations can allay anxiety, increase understanding and in turn secure patient co-operation and compliance.

Method

- Examine what information is provided to our patients in the Patient Leaflets, that are issued pre surgery and compare this with information that is provided at other Trusts.
- Research existing literature on patient care and cataract surgery.
- To evaluate the information provided to our patients, I designed a questionnaire which was completed by 22 patients postoperatively. It examines whether they felt that the information provided was adequate, in a format that was easy to understand and if further information would be beneficial.

References

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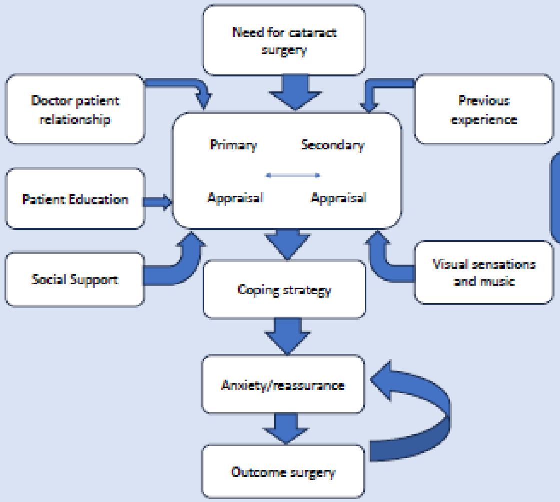
Acknowledgements

With thanks to Helen Hall, Jonty Yazbek, Senior Sister Helen Sutherland, Rebekah Girling, Shannon Carter, Sister AnnMary Jacobs and Sister Annie George.
Photograph courtesy of Newarta.

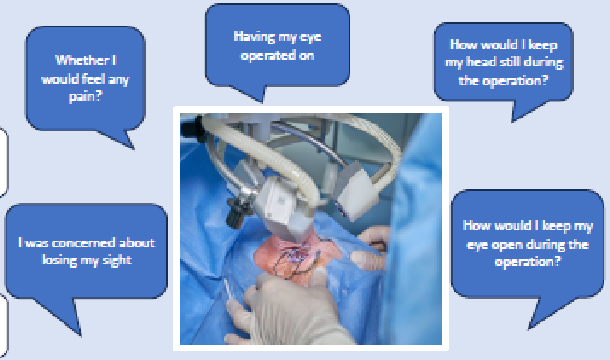


Research model of anxiety related factors is based upon Nijkamp et al

Results

8. Would you have liked more information about what happens in theatre?

9. Would it have helped to have known that there was a member of staff available to hold your hand and support you through your operation?



The results showed that the main concerns patients had, was the fear of losing their sight and having their eye operated on while they are awake. Patients said the information they were provided with was adequate and in a format that was easy to understand. It was felt that there could have been more information about what happens in theatre, not going into great detail about the operation itself, but answering concerns about how they would keep their eye open and whether they would be able to see what was happening during the procedure. Patients thought it would be helpful to know that there would be a member of staff available to hold their hand and support them throughout the operation, if required.

Conclusion

In comparison with other trusts, the information we supplied to our patients about their time in theatre was quite limited. Moorfields provide their patients with a short video in an animated format, which illustrates the patient's journey through theatre.

Most trusts informed their patients, that there would be a member of staff available to hold their hand and support them through the procedure, which when questioned our patients felt that having this prior knowledge would be reassuring.

My findings were that patients felt that they needed more information about what would happen to them when they went into theatre. It should not be overly descriptive about the procedure itself but provide information that would help allay their concerns. Providing good preoperative education and support will help reduce negative feelings and any anxiety. I feel that by updating and addressing these areas within the material that we provide to our patients would be beneficial.

Next Steps

- Improve the information provided in the Patient Information Leaflet.
- Develop a video about the patient's journey through theatre.

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CCS Research Champions Programme: Evaluating The Impacts On Participants

Jack Hallworth, Norfolk and Waveney ICB

NHS
Norfolk and Waveney
Integrated Care Board

Introduction

The Programme:

The Research Champions Programme (RCP) is designed to increase the research capability and capacity within Cambridgeshire Community Services (CCS) NHS Trust. The RCP programme includes three taught workshops, regular communication from the CCS Research Team, opportunities to shadow and receive mentorship, and the submission of a proposal for the Research Champion role moving forwards. The RCP is available to anyone within the trust. Research Champions are expected to be made available for the taught workshops but also to be given protected time for one day per month in which to work on the RCP.

The Evaluation:

This evaluation arose as part of the NICHE (Norfolk Initiative for Coastal and rural Health Equities) embedded scholarship programme. It aims to describe the experiences of the Research Champions taking part in the Research Champions Programme hosted by Cambridgeshire Community Services NHS Trust.

Key findings

- The Research Champions highlighted the programme's role in encouraging their enthusiasm in addition to challenging the perception that research is viewed as secondary within frontline healthcare provision.
- The interviewees emphasised the pivotal role of Research Champions within their teams, highlighting the present focus on promoting research and sharing information, while suggestions for the future include hosting journal clubs and expanding the network of Research Champions for idea-sharing.
- The Survey found that the RCP was generally well received by participants (Figure 1) and respondents generally felt they were able to incorporate the Research Champion position into their existing job roles (83.3%).

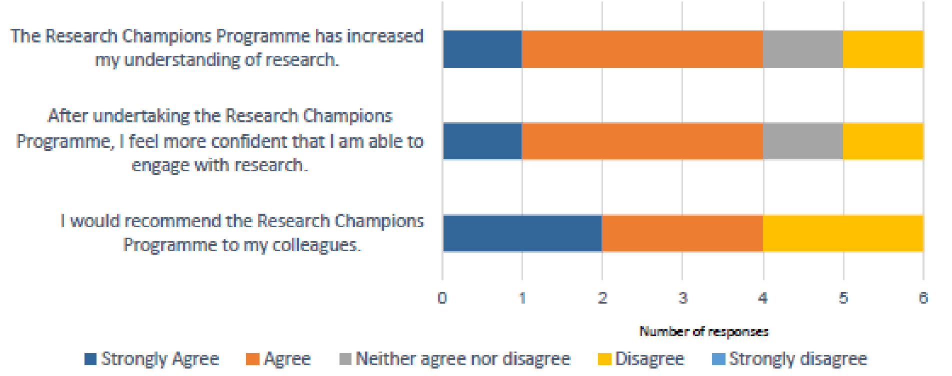

Figure 1: Stacked bar chart relating to agreement with statements regarding the RCP.

- Half of the respondents were able to allocate less than two hours per month to RCP work, 33.3% managed two to four hours, and one respondent was able to dedicate the suggested full day per month. This suggests time available to undertake RCP work was a significant barrier to participants.

Methodology

Aim:

To describe the perceived impacts of the Research Champions Programme on those undertaking it.

Objectives:

1. To describe the perceived impact on the confidence/ understanding of Champions to engage with the research culture.
2. To explore whether the role as a team's Research Champion has affected their workload within their jobs.
3. To describe any suggested improvements to the RCP that are uncovered.

Data Collection:

1. Three semi-structured interviews were conducted with Research Champions. Interviews were recorded and transcribed verbatim. Transcripts were analysed thematically using QSR NVivo.
2. A survey was designed and distributed to examine the experiences of current and previous Research Champions. Data was collated and descriptively analysed.

Key quotes

The Programme:

"I enjoyed taking part in the programme. I have learnt a lot and look forward to implementing my learning into practice."

Building on existing attitudes towards research:

"It [research] shouldn't be put on the back burner as a sideline or seen as just as an academic pathway. And you know, it's frontline and it needs to be addressed as such."

Personal Development:

"An opportunity that I got was the Research and Development Forum Conference that happens every year. I had no idea about it [...] so to have an opportunity to contribute, even though again I haven't had that much experience [...] compared to the others, but to just chip in my own experience in an oral presentation, that's a good opportunity via the Research Champions Programme."

Barriers to engaging the RCP and suggested improvements:

"You know, other priorities come up and then you think, [...] I try and slot things out in my diary to say that's the day I'm gonna do my research work or study and learning but then something else comes over that's more urgent from practice."

Conclusion

The Cambridgeshire Community Services Research Champions Programme has increased participants' confidence and understanding in research engagement, though challenges like time constraints and the programme's academic focus have been noted. To enhance the programme's value, addressing these challenges by offering flexible scheduling and practical, hands-on learning experiences could be beneficial. Despite these obstacles, the ongoing desire of Research Champions to contribute to research-related activities signals a positive cultural shift towards prioritising research in clinical settings. With improvements, the programme has the potential to build a team of Research Champions capable of advancing research capability and capacity within Cambridgeshire Community Services NHS Trust.

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Exploring the Wellbeing and Sustainability of IC24 Staff working from Home

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Introduction and Background

Wellbeing is not merely the absence of disease or illness; rather, it's a complex interplay of physical, mental , emotional and social health factors. Happiness and life satisfaction are strongly linked to wellbeing. Measuring wellbeing in a population is challenging due to its subjective interpretation.
One's perception of life influences how they feel ,as the adage goes," one person's problem is another person's challenge"

Sustainability, defined as meeting present needs without compromising the future, involves companies adopting practices that reduces the consumption of limited resources. The three pillars of sustainability – environmental, social responsibility and economic pillars are crucial to IC24 NHS 111.

As Henry Ford, succinctly puts it

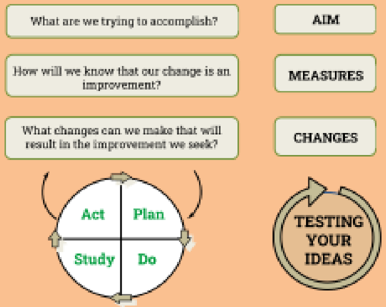
"Quality means doing it right when no one is is looking."

My interest in participating in this project stems from a desire to share the experiences of my colleagues and I , particularly for newcomers, whilst working remotely.

This endeavour aims to explore strategies to enhance our experiences and promote a more enriching work environment. Engaging in this project, which is focused on quality improvement will significantly broaden my expertise in helping address any challenges faced by remote workers, aligning with my fervent commitment to facilitating a balanced, healthy work-life equilibrium for myself and my colleagues. It is interesting to note , during my survey, approximately 96% of stakeholders mentioned that working from home provided them with a better work life balance, which was a positive impact on their wellbeing .

A happy and confident team not only enhances wellbeing but also help to increase long –term productivity.

Methodology



Langley, G., Nolan, K. and Nolan, T., 2009

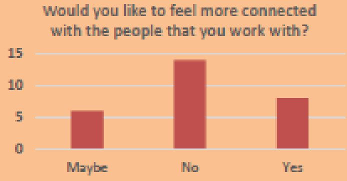
Project aim
Utilizing the model for improvement by Associates in Process improvement, a robust framework for expediting change, this theory is successful in healthcare organizations, it focuses on achieving goals by looking at the following models:

Measures
Using survey to understand more about how call handlers working from home feel. It is reassuring that IC24 reduced carbon footprint. And cost savings on fuel due to remote work were highlighted.

Change – In terms of changes some questions looked at is as follows : What is already working? Do we implement change ? etc. Despite IC24 Wellbeing comprehensive strategy which targets three areas such as personal , financial and mental factors as well as Trims, Perks platforms such as Heartbeat which have resources that staff can use ,annual B-heard survey where staff members can express how they feel about work and a lot more, from the survey conducted 18% out of 28 respondents reported experiencing feelings of Loneliness, a sense of lacking companionship as the negatives of remote working.

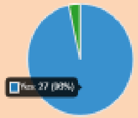
What did I do?
Designing a survey – steps involved was involving stakeholder's
Using pen questions – like 'what service are you aware of?' 'what is the positive impact of working from home? This brought to bear positive benefits of the scheme. Some colleagues even emphazing the need not worry about their appearance before starting their shift.

Results.



Examining the initial graph, it illustrates the duration of service for my colleagues and I at IC24.

- Notably, 43% have engaged in remote work for the past 1-3 years., marking a significant period representing the inception of remote working for many.
- The enrolment has contributed to staff retention, as evidenced by the 4% who have worked either hybrid or remotely for 1 to 6 years.
- This data holds importance as it facilitates an exploration into whether there is a heightened risk of isolation within specific groups.
- Turing attention to the second graph, it delves into the preferences of staff members regarding connectivity.
- Surprisingly, 50% expressed a lack of interest in any form of connection. 21% indicated a possibility(maybe) while 29% affirmed a desire for connection.
- A prevailing theme evident in this survey looking at the pie chart is the enhancement of Work –life balance, increased flexibility , reduced travel time, diminished destructions enabling improved concentration, all underscored by sustainability considerations and contributions to environmental well-being
- It is crucial to note that these findings are derived from a relatively small cohort , results obtained from only 28 respondents, a notable contrast to the 84 staff members engaged in remote work.



96 % of staff were happy working from home. Whilst only 4% said maybe.

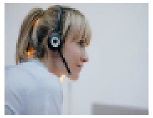
Conclusion

It is noteworthy that , according to the conducted survey, 96% of stakeholders, expressed that remote work has improved their work –life balance .The majority is cognizant of the available support tools TRIMS, Debriefs, Mindfulness journey etc; however, insufficient research has been conducted to ascertain the extent of their utilization and the efficiency of these tools.

Furthermore, 29% of stakeholders deem it crucial for their mental well-being to feel connected. Echoing the sentiment of Mind UK, " Connecting with others can help us feel close to people and valued for who we are".

Continuing this research in greater depth is imperative , as it holds the potential to not only enhance staff retention but also contribute to an improved overall patient experience. It is gratifying to share that IC24 is actively exploring this project , and my findings are anticipated to spearhead initiatives.

In summary , remote working is proving effective, and IC24 is implementing successful practices. As Mark Zuckerberg aptly stated "
" People are more productive working at home than people would have expected. Some people thought that everything was just going to fall apart , and it hasn't"



Reference

https://www.betterhealth.vic.gov.au/health/healthyliving/wellbeing
https//www.ihi.org/resources/how-to-improve

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