project plan was developed. This included a six monthly rollout plan over three years. A pivotal part of the preparatory work was the selection of “showcase wards”. These were wards where staff were willing to participate in the project, share their knowledge and experiences, and provide opportunities for others to see the practical application of PMHWs and their potential impact.

The wards needed to satisfy a selection criteria set by the project team, which included such factors as having a ward leader in post and having fewer than 10% of posts vacant.

All 65 ward leaders were invited to apply. Following the shortlisting process, six wards were selected to be showcase wards. These represented different clinical services, such as acute adult psychiatry, older people, forensic and rehabilitation, and a national behavioural disorders unit; these were based at five different sites. Ward leaders included an occupational therapist, which demonstrated that the initiative was relevant not only to nurses.

A project bid was submitted to NHS London and the trust was awarded funding to support starting PMHWs on six wards for the first nine months, after which funding was provided by the trust board. The funding enabled the project team to employ two full time improvement facilitators, purchase resources required and set aside money for anticipated minor works when it came to reorganising the ward environments.

Once the showcase wards had been selected, the project team held briefing meetings where staff could discuss their roles and responsibilities and the team could try to alleviate any anxieties. During these meetings, the ward teams were informed about the support that would be available to them, as well as the benefits to them.

A page was set up on the trust intranet with information and resources relating to the project. Information leaflets for service users, carers and staff were developed. The NHS Institute initially provided training and support for ward leaders, improvement facilitators and the project lead. The training covered the foundation modules and one process module. Subsequent training to support rollout has since been developed and is delivered by the project team.

IMPLEMENTING THE MODULES
Our trust’s experience has been that it takes between three and four months to complete the foundation modules. The time it takes to complete a process depends on the unique features of each team but has ranged from between two and six months.

Ward teams are supported by improvement facilitators until they complete all the foundation modules and the first process modules.

The first action for each ward team, with input from carers, services users and its facilitator, was to develop a shared vision of what they wanted their ward to look and feel like. A variety of methods were used to capture all the views to ensure inclusivity.

This agreed vision was then displayed in prominent places on the ward and reviewed periodically. It showed there were common themes shared by service users, carers and staff that had never been discussed before.

Knowing How We are Doing
This module focused on identifying and selecting ward based measures to help teams’ understanding of their performance on key objectives and to set actions for improvements. Table 1 shows the measures used to address the objectives.

Staff found the process of selecting and monitoring measures at ward level empowering. The performance data was displayed in a communal area that anyone visiting the ward could see.

The information displayed on the board formed the basis for discussions and reviews at PMHWs weekly meetings and, where possible, involved service users. These discussions encouraged openness and an acknowledgement of weaknesses, and highlighted what the team was doing to address any problems. It helped give a sense of shared responsibility between the service users and staff members to ensure improvements were made.

A key feature of this module was the “activity follows”. This involved a ward staff member following another member of staff at a similar grade with a similar professional background, noting what they were doing at a similar grade with a similar professional background, and addressing the situation. This was then shared with the team to highlight what the team was doing to address any problems. It helped give a sense of shared responsibility between the service users and staff members to ensure improvements were made.

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TABLE 1. KNOWING HOW WE ARE DOING

<table>
<thead>
<tr>
<th>Improvement objectives</th>
<th>Examples of measures used in the trust</th>
</tr>
</thead>
</table>
| Safety and reliability of care | - Slips, trips and falls  
- Missed medication doses  
- Substance misuse detection  
- Security breaches  
- Violence and aggression  
- Abscondion  
- Self harm episodes |
| Staff wellbeing | - Unplanned absence (sickness)  
- Clinical supervision  
- Appraisals |
| Patients’ experience | - Patient satisfaction survey  
- Carers’ satisfaction surveys |
| Efficiency of care | - Expected date of discharge  
- Percentage of direct care time  
- Bank and agency usage  
- Length of stay |

This article has been double-blind peer-reviewed.