Skill Mix and Safer Staffing Review Inpatient and Neighbourhoods Mental Health Settings

May 2019

1. Introduction

The trust approach to safe staffing is about the ability of the organisation to provide a person centred patient pathway that has the right staff with the right skills and for those staff to be in the right place at the right time.

12 months ago, in May 2018, a dashboard approach to reviewing data and trend analysis was adopted to support monitoring of staffing trends. However, a more layered approach that included qualitative information was felt to be of benefit.

In this review of the skill mix and safer staffing issues across the adult mental health services in DHCFT, we will be looking at an update on projects from the last review in November 2018, that support that layered approach and will be exploring issues arising from our Safer Staffing dashboard data and comparing our performance against some of the key national issues identified at the recent Safe Staffing Policy and Practice in the NHS event.

2. Background

15 years ago there were 17 million contacts across the NHS in 10 days. Now that figure has risen to 17 million contacts within 7 days. There are 2.5k more registrants across the different clinical specialities than there were 12 months ago, but the demand had increased by a further 5k.

Whilst this illustrates the demands that modern health care is under and, coupled with the fact that mental health trusts nationally have double the turnover of staff of acute trusts, with some having staff vacancy rates as high as 30%, the vacancy rate of DHCFT (Derbyshire Healthcare Foundation Trust) is 8%. This is a major success and is indicative of the work that has been ongoing in terms of recruitment, retention and cultural shift.

The key push points where staff are most likely to leave the NHS are due to poor or mismatched cultural values, a lack of early year's career support, and flexibility in the work place. The bulk of leavers in NHS are those at the start of or in the early years of their careers. In the early phases of the analysis of leaving trends, the high attrition rates were initially thought to be due to the impact of MHO (Mental Health Officer) status. Further analysis has revealed that it is people new to working in mental health who struggle with adjusting to the challenges their first roles present, that are most likely to leave.

The workforce strategy has described the work that is under way to address these strategic issues and this report looks at specific actions that we need to be reporting in terms of our safer staffing work and skill mix monitoring at divisional level.

NHSI guidance identifies that boards must be assured that clinical leaders and managers have allocated sufficient rime to supervise and lead effectively. Our supervision rates overall have remained consistent but there are particular areas where supervision is low and has remained so with no upward trajectory over the last 6 quarters. Whilst the trust must also ensure that there is access to and uptake of supervision and reflective practice and check if they are facilitated and monitored, there also need to be supportive challenge to these areas of concern. The Heads of Nursing review the requirements for supervision and offer support to managers to assist with raising compliance. This will be an area of renewed focus over the next 6 months to try to increase supervision compliance in areas with consistently low rates

Requirements from NHSI have identified that trusts must ensure that the NQB (National Quality board) guidance be embedded in their safer staffing governance and that the annual governance statement describes how it complies with the guidelines from April 2019 onwards. There should also be QIA (quality impact assessments) for all workforce changes including posts held and subsequently lost to CIP(cost improvement plan) . These areas of compliance are included in the Board Workforce safeguard report.

When reviewing safer staffing requirements we must triangulate the information from the areas below to provide the safer staffing requirements.

Principles of safe staffing fig 1

Evidence based tools and data – we use our dashboard data alongside workforce metric, the CHPPD data and the safety thermometer information for wards that compete this. We do not currently use a standardised safer staffing tool such as the Hurst tool and opt for the Telford method (professional judgement method). As our dashboard is based on the recommendations from NQB and NHSI, there is assurance that we are meeting the requirements as specified.

Outcomes – again our dashboard includes outcomes and points to areas where we require additional support to improve performance

Professional judgement – it is important to use professional judgement to support the decisions that are made around safer staffing. For example ward layout and how it impacts on staffing numbers needs consideration.

We are also exploring the need for standardised approaches to care through a series of workshops aimed at developing clinical pathways for care that will impact on service provision and staff skill mix.

We are also looking at the technological support that staff require though a review of our electronic patient record (EPR)

Campus Services

Campus services continue to operate with ongoing staffing difficulties in relation to the levels of clinical acuity and availability of registered staff. At the recent Safe Staffing Policy and Practice in the NHS event the concept that a skill mix that is richer in registered nurses is associated with improved clinical outcomes. Higher levels of non-registered grades of staff are associated with more safety and care concerns. This is not about capability or experience; it is about training and knowledge. Trusts that have struggled to recruit registered staff and have substituted in non-registered staff have to be mindful of managing this risk. Some trusts have followed the option chosen by DHCFT which is to review their skill mix and employ registered staff from other professions such as pharmacy and Occupational therapy. In these instances the risk has been manged more effective than where the numbers have been made up with non-registered staff. Whatever the solution to staffing difficulties, it is imperative that the risk is assessed and managed. We have robust systems in place to review this approach.

Right Staff

Cubley skill mix – the skill mix on the Cubley wards has been re-reviewed as part of the response to the CQC actions. The review found that the position on Cubley Court female has improved and the staffing numbers have increased whilst the situation is reversed on Cubley Court male. Support will continue to be provided to the wards around the areas that challenge. The wards have employed an RGN who

will be able to support with patients who have high levels of physical health care needs and a Learning disabilities nurse will be joining the team in June.
They are also looking at how other skills may help with issues encountered on the wards such as housing worker or social worker to assist with moving people on to more appropriate placements.

Ward Based OTs (WBOTs) - the provision of ward based OTs has continued to be embedded at the Hartington and Radbourne units. In addition the Cubley wards have reviewed their provision of Occupational therapy and have employed additional staff and recreational workers. It will be interesting to review if there has been an impact on the clinical presentation of the patients through the engagement in meaningful activity.

Discharge nurse role – our older adult wards have encountered difficulties with delayed transfers of care and now have a nurse with designated responsibility to facilitate discharges. This post requires review to determine the level of quality of impact it has had both on the length of stay but mainly on the quality of patient care.

Speech and Language Therapist (SLT) on Cubley – The review of Speech and language therapy input to the Cubley wards has continued with conversations with about the type and amount of input required. Staff have had additional training on how to look for swallowing difficulties and an assessment has been added to the EPR to assist with this

Nursing associates - Nursing associates (NAs) are being viewed as another one of the solutions to the staffing difficulties in the NHS. However, NHSI are clear that the NAs are not a solution to the RN shortage but rather that they complement the skill mix and that we will achieve maximum impact from the NAs if they have adequate support and supervision from the registered staff.

Right Skills

Non Registered staff – When looking at the banding of staff employed across the NHS nationally, the numbers of staff at bands 2 - 4 are almost double that of staff in the registered bands. This means that we must consider the ways that we respond to staff in the non-registered bands in terms of their training and support needs whilst at the same time reviewing the impact of our staffing structures on patient care and safety. Developmental work has traditionally been focussed on the registered staff, but we are now planning to look at the best ways to meet the ongoing development of our non-registered staff.

AHP professional structures.- We have increasing numbers of AHPs coming to work in the organisation for the reasons identified above. For example we now have

a speech and language therapist who has started support with patients who are on the autistic spectrum.

We need to be mindful that we ensure that we have in place systems and structures to meet their professional, clinical and regulatory needs. For example, we need to be assured that managers use the information from the relevant professional bodies to support the appraisal and supervision processes. Our AHP and OT leads will be reviewing this and reporting back to their respective COATS (Clinical and Operational Assurance team)

Provision for people on the autistic spectrum – we have been looking at the skills our staff need to be able to provide appropriate therapeutic interventions for the increasing numbers of people admitted to our wards and are on the autistic spectrum. We now have ASD leads going into the wards to support and advise staff and work with people who have needs on the autistic spectrum to look at the environment and clinical approaches.

Skills for staff working people with personality disorder – we have continued to develop the skills of staff in this area and have commissioned Borderline Arts to provide training.

Right place and time

E-Roster – the introduction of the e-roster is still going through some introductory difficulties. Feedback from colleagues has shown a need to look again at the Trust's shift patterns across inpatient services, building on previous work.

The trust has a Rostering Efficiencies Project Team, made up of representatives from across all three campuses and a range of job roles that has reviewed current shift times and explored eight options in detail. Staff are also having their annual leave and TOIL balances reviewed.

The team has put forward two possible shift pattern options, both compliant with the Working Time Directive, and is now seeking colleagues' input on the two options.

It is important to note that there are a number of predictable challenges when introducing e-rostering that includes an increase in staff sickness and concerns about changes to shift patterns. The national message is that trusts need to think about the message that is being communicated about the introduction. The message should be clearly about the patient journey and the fact that we need the right staff on duty at the right time to provide the best care. It is not always about managerial grip; it should be about patient safety and care. E-roster isn't only a tool for calculating pay; it is about meeting patient need and keep staff and patients safe.

As we identified in the last report, the introduction of the e-roster has had an impact on staff well-being, as well as service delivery. It is crucial that, as the workforce is the main asset that we have as an organisation, we need to explore and support our workforce risks to maintain service continuity.

There is currently a Confirm and Challenge meeting to discuss and agree the e-roster. Whilst this is useful we are suggesting that the use of the Confirm and Challenge meeting move to a format of Check, Challenge and Coach. The Heads of Nursing will be proposing this move to support staff to move to increased confidence around identifying and managing their patient need through staffing/ e-rostering.

CHPPD data - Ward based AHPs who are part of the shift numbers are now included in the CHPPD (Clinical hours per patient day) reported data and the nursing associates will be included from August onwards

Reconfiguration of operational structures – our operational services are reorganising the structures of the management of the teams and services to ensure that they are best placed to respond to both internal and external requirements over the next three to five years.

Our clinical services also need to respond to this reconfiguration and so thought needs to be given to the input from the Heads of Nursing and Lead professionals.

Work is underway to look at how best they can support the new structure given that there are two additional divisions (Forensic and Older Adults). An update will be given in the half yearly update of this report.

Allocate Safe Care system - this is again being considered for use to support safer staffing and redeployment of staff for use both as a live tool but also for analysis over a longer period. It would also meet the requirements of the NQB in relation to using an evidenced based tool and metrics.

Neighbourhood Services

Right Staff

Recruitment in the Neighbourhood services continued to remain positive. The model of staffing in the neighbourhood team has remained relatively stable and the neighbourhood review has supported the maintenance of the existing structure.

Right Skills

The new role of physical health support worker has been developed to specifically look at the physical health needs of people with complex mental health. These roles offer physical health screening, monitoring and signposting and we are reviewing how the nursing associate role may link with this role.

Right place and time

The group offer in neighbourhoods has been reviewed to ensure consistency and equity across the different neighbourhoods. Groups work and recovery clinics are now provided using a similar service configuration across all neighbourhood teams. This has also been linked into the clinical pathway project.
Teams also continue to offer clinics as well as individual appointments to address some of the issues around capacity.

Actions and progress

Data review – We have continued to publish our safer staffing data to the trust website in accordance with our schedule 6 reporting requirements and have reviewed our skill mix data in line with NQB guidance

The dashboard data presented in appendix 1 continues to be reflective of seasonal difficulties we have experienced as an organisation, as well as the national picture of increasing acuity

There is a notable increase in medication incidents in Q3, which correlates with the newly qualified nurses starting. Whilst this does not indicate causality, the HoNs will be working to review and address this with the universities as well as putting in additional support during this time.

Nationally, we supply continue to supply data to the NHSI Model Hospital Project which is designed to help NHS providers improve their productivity and efficiency.

Report on Actions

Action	**Progress - RAG rated**	**Timing**
Embed agreed alterations to shift alignment across campus services.	Now part of the Roster efficiencies project	Ongoing
Review the need for and complete substance misuse training across all clinical areas.	This work is being progressed as part of the neighbourhood review and was paused due to the reconfiguration of operational services	Paused
Complete an options appraisal for the recruitment of substance misuse workers on Campus sites.	The Head of Nursing for Hartington and Radbourne sites continues have this work on his agenda but had been unable to progress it due to competing priorities following the CQC inspection.	Paused
Develop and roll out a 3 year neighbourhood training plan for evidence based interventions	This work is now being progressed as part of the clinical pathways review work.	Ongoing

New Actions

Action	Progress - RAG rated	Timing
HoNs to explore use of safer staffing tool with Campus teams		End Q3 19/20
HoNs to introduce the Check. Challenge, Coach approach to e-roster process		End Q1 19/20
HoN Kingsway to support Clinical lead on Cubley wards to review the impact of the discharge nurse role		End Q2 19/20
HoNs to review and support managers to maximise the uptake of supervision		End of Q3 19/20
HoNs to promote the support and training for non- registered staff through workforce and operational structures		End Q4 19/20
The Lead AHP and Lead OT to seek assurance through the COAT structure of appropriate support and adherence to relevant professional requirements for AHP staff across all divisions		End Q3 19/20
HoNs to explore the increase in medication incidents in Q3 18/19 with the feeder universities and agree support for new starters.		End Q2 19/20
AD Clinical Professional practice to agree and communicate the revised structure for the HoN following the operation configuration.		End Q1 19/20

9. Conclusion

We continue to take the approach of skill mix and safer staffing supporting patient and staff safety and wellbeing. The safer staffing dashboard data continues to support the national picture of mental health services provision continuing against a backdrop of increasing acuity. We are maintain the approach of reshaping the skills of staff and ensuring that there are the right number of staff to safely cover services, though this remains a challenge.

We said in the last report that if we cannot recruit the skill mix of staff our structure requires then, perhaps our structure should change. The pathway work that is currently underway has commenced that process along with the reconfiguration of our operational structures. This work centers our provision on the needs of our

service users and patients rather than the staff we aspire to recruit, and may shift our skill mix and ease our recruitment issues.

We continue to seek creative solutions and clear measurable evidence that we will have the right staff with the right skills in the right place at the right time.

Bibliography

NHSE Mental health staffing framework https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf

Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, Lord Carter of Coles, Department of health, Feb 2016

Safe Sustainable and productive staffing, National Quality Board, July 2016, updated July 2017

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Appendix 1 Safer Staffing Dashboard

Date	Level	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Clinical Quality									
Acuity/ PbR									
	Cluster 0	0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	1.0%	1.0%
	Cluster 1	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.0%	0.0%
	Cluster 2	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	0.0%	0.0%
	Cluster 3	1.1%	1.2%	1.2%	1.0%	0.9%	0.8%	1.0%	1.0%
	Cluster 4	11.5%	11.5%	11.4%	11.5%	11.3%	10.9%	11.0%	10.0%
	Cluster 5	8.9%	8.9%	9.2%	9.8%	10.3%	10.3%	10.0%	10.0%
	Cluster 6	3.8%	3.9%	4.4%	4.9%	5.1%	5.3%	6.0%	7.0%
	Cluster 7	12.3%	12.4%	12.9%	13.5%	13.7%	13.9%	14.0%	14.0%
	Cluster 8	6.7%	6.7%	6.8%	6.9%	6.9%	7.0%	7.0%	8.0%
	Cluster 10	2.3%	2.3%	2.3%	2.5%	2.5%	2.6%	3.0%	3.0%
	Cluster 11	10.3%	10.3%	11.0%	11.6%	11.7%	11.7%	12.0%	12.0%
	Cluster 12	5.8%	5.9%	5.8%	6.1%	6.3%	6.5%	7.0%	7.0%
	Cluster 13	3.6%	3.6%	3.4%	3.4%	3.3%	3.2%	3.0%	3.0%
	Cluster 14	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	1.0%	1.0%
	Cluster 15	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.0%	0.0%
	Cluster 16	1.0%	1.0%	1.0%	1.1%	1.0%	1.0%	1.0%	1.0%
	Cluster 17	0.9%	0.9%	0.9%	1.0%	0.9%	0.8%	1.0%	1.0%
	Cluster 18	11.0%	11.0%	10.7%	10.2%	10.6%	11.0%	11.0%	11.0%
	Cluster 19	11.8%	11.6%	10.1%	8.9%	8.2%	7.6%	7.0%	7.0%
	Cluster 20	5.6%	5.6%	5.2%	4.6%	4.1%	4.3%	4.0%	5.0%
	Cluster 21	1.4%	1.4%	1.5%	1.4%	1.4%	1.3%	1.0%	1.0%
Obs Levels									

Date	Level	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
	Level 1	64	12	33	52	70	52	89	104
	Level 2	209	670	762	1,120	1047	856	821	825
	Level 3	2,276	5,346	5,576	5,490	5877	6129	6099	6324
	Level 4	10,530	15,943	15,257	13,881	15304	15884	14888	14006
Total incidents									
	SIs	65	61	75	108	146	64	84	84
	Restraint	127	152	137	163	149	125	122	154
	Medicines incidents	152	202	152	152	191	132	204	182
	Seclusion	51	48	59	65	55	53	29	45
	Self-harm incidents	118	113	107	137	183	198	246	229
Patient and carers									
Proms									
	HONOS	99.86%	99.91%	99.89%	99.88%		99.88%		99.86%
	WEMWbbs	3.44%	3.53%	3.58%	3.58%		3.69%		3.85%
	ReQol	0.58%	2.11%	2.54%	3.38%		6.02%		8.07%
Complaints		47	45	40	60	40	58	44	51
Compliments		281	304	305	298	393	380	511	371
Friends and family		249	193	164	197	1149	1114	1149	1156
Staff									
Vacancies		8.49%	7.86%	5.95%	4.97%	12.5%	11.8%	9.6%	
Average on shift *		98.7%	104.4%	103.7%	102.6%	96.8%	92.8%	97.3%	92.8%
Bank rates		6.81%	6.54%	5.85%	5.49%	5.24%	5.26%	4.99%	5.32%
Agency rates		1.46%	1.73%	1.37%	1.06%	0.92%	1.04%	0.92%	0.93%

Date	Level	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Training		86.93%	86.88%	86.41%	87.09%	82.35%	82.79%	84.44%	85.59%
Supervision									
	Managerial Supervision	69%	72%	71%	72%	73%	70%	73%	70%
	Clinical Supervision	58%	61%	62%	61%	67%	65%	68%	67%
	Professional Supervision	44%	49%	49%	51%	54%	54%	56%	52%
	Safeguarding Children	90%	88%	85%	79%	82%	76%	82%	69%
Nos of volunteers							15	61	46
Nos of peer supporters							46	20	24
Throughput									
Length of stay		65.06	57.21	71.46	62.53	60.01	69.78	56.4	57.32
Admissions		369	384	345	374	382	358	376	362
Discharges		364	404	346	376	364	363	374	369
Readmission		9.34%	9.41%	7.51%	8.24%	9.89%	4.68%	6.95%	4.61%
Bed occupancy rate		88.91%	92.12%	88.47%	87.66%	89.67%	91.75%		