National Quality Board

Safe, sustainable and productive staffing

An improvement resource for mental health

Contents

1. Introduction

We developed this resource for community and inpatient mental health services across all specialties. It takes a multiprofessional approach, recognising the importance of all members in the team.

This resource aims to link boards' and clinical teams' decisions on staffing with the needs of people who use mental health services. It gathers together existing guidance and approaches to making decisions on staffing. We hope it will make a sustainable difference to the quality of care.

We developed the resource to help commissioners and providers of NHS services create, review and sustain safe and effective specialist mental health services. It is based on the National Quality Board's expectations (see Figure 1) to ensure safe, effective, caring, responsive and well-led care on a sustainable basis, and to ensure that organisations employ the right staff with the right skills in the right place and at the right time.

Figure 1: National Quality Board's expectations

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We designed this resource for everyone involved in clinical establishment setting, approval and deployment – from the team manager to the board of directors. Board members are individually and collectively responsible for making judgements about staffing and delivering safe, effective, compassionate and responsive care within available resources.[1]

The resource outlines a systematic approach to identifying the organisational, managerial and environmental factors that support safe staffing. It makes recommendations for monitoring and taking action if not enough staff are available to meet people's needs. It is informed by the National Institute for Health and Care Excellence's (NICE) previous work[2] and a rapid review of literature in the public domain, which looked at staffing structures in mental health services associated with improved service user outcomes (including safety, effectiveness and service user experience).

We urgently need more empirical research on mental health staffing in multidisciplinary settings, particularly on linking staffing requirements to outcomes for people with mental ill health.

We involved service users and carers, inviting them to comment and contribute to our approach and the content. They helped us understand what 'safe and sustainable' means to people receiving care.

While this document focuses on providers' expectations, it will help commissioners develop their own assurance framework for safe and sustainable staffing. Its standards and tools will inform the staffing aspects of commissioning mental health services and pathways effectively in future.

Providers and commissioners must work in partnership to address workforce issues and challenges.

1.1. Other resources

We were guided by NHS Improvement's 'measure and improve' approach in developing this resource, which does not exist in isolation. You should also refer to the National Quality Board's (NQB) 2016 safe staffing resource, *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*. Also refer to the other setting-specific guides in this series, particularly those for the learning disability, community and children specific settings.

[1] *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time - Safe, Sustainable and Productive Staffing.* NQB, July 2016. https://www.england.nhs.uk/ourwork/part-rel/nqb/

[2] National Institute for Health and Care Excellence (2016) Sa*fe staffing for nursing in inpatient mental health settings*. Draft evidence review.

You will need to consider any specific guidance that may apply to specialised services and professional groups – for example, AIMS accreditation from the Royal College of Psychiatrists.

1.2. The mental health context

While mental health services face similar staffing challenges to other sectors, you need to consider how they differ.

Models of care These are complex: different local solutions have emerged over time, so provision can vary locally and regionally with no two provider organisations offering an identical mix of core, specialist and community services. Mental healthcare pathways may involve a single provider or multiple providers.

Distribution of staffing resources Few service users are admitted as inpatients. Most mental healthcare is delivered in the community, where 97% of people under the care of specialist mental health services are cared for and treated. But inpatient services continue to experience high levels of occupancy. Because they are residential in nature, they need higher staffing levels to support service users safely 24 hours a day. On average, inpatient settings use 45.6% of a mental health organisation's whole-time equivalents.[3]

Clinical risk mitigation There is a need to work with people who use mental health services and their carers to develop plans that reduce the likelihood and impact of behaviour posing risks to themselves or others.

Assessment Diagnosing and assessing mental illness largely relies on observing people's behaviour and understanding their cognition. This means engaging and interacting with people who use mental health services, demanding significant staffing resource (time).

Treatment As most people who use mental health services are living in the community, organisations use the Mental Health Act (as amended 2007) to compulsorily treat those who pose a risk to themselves or others. (Detention rates have increased for the fourth consecutive year.[4])

Environmental safety Mental health hospitals must control access to and exit from hospital under the Mental Health Act and the Mental Capacity Act 2005 to reduce risk in physical environments. The NHS Benchmarking Network reported in 2016 that self-harm involving ligatures on inpatient wards increased for the fourth year in a row.

[3] NHS Benchmarking Network; 2016 Report.

[4] Detentions in NHS hospitals increased by 4,000 (8.2%) on the previous year to reach 51,970 and in independent sector hospitals by 1,270 (24.6%) to 6,430. See *Mental Health Bulletin 2014/15*: http://www.hscic.gov.uk/pubs/mhb1415

Mental health officer status This enabled professionals to retire at 55, but was abolished for new entrants in 1995 and is not part of the 2015 pension. But it remains a significant factor to consider in workforce planning.

2. Right staff

> "The quality of staff is more important than any simple number of staff, and this includes attitude, professionalism, knowledge and skills to provide the care and support required" **– from the service user engagement process**

Safe and sustainable staffing is fundamental to good quality care and includes many variables beyond numbers of staff. Boards are accountable for ensuring sufficient staffing capacity and capability to provide safe and effective care that meets the needs of people using mental health services. They are also accountable for ensuring their staff's health and safety.

All staffing decisions must be aligned to strategic and operational plans to sustain high quality care.

Studies reveal that lower staffing levels in mental health services can affect staff morale, increase stress, decrease job satisfaction and increase concerns about personal safety. (See Appendix 1 for a summary of the literature review.)

A significant challenge for the mental health workforce is the age of those in some professional groups and numbers approaching retirement. More than 32% of mental health nurses (who form the largest proportion of teams) were aged over 50 in 2013.[5]

NHS Benchmarking Network data shows the vacancy rate for 2015 and 2016 remained at 13%.

Staff turnover affects continuity of care for patients and skill levels in teams (as new recruits need an induction period to adapt to local processes and procedures). The same data shows the turnover rate reduced slightly from 13% in 2015 to 12% 2016.

The number of mental health professionals in training is soon expected to fall short of demand. Health Education England's (HEE) *Workforce plan for England 2016/17* recognises this and predicts numbers required to address shortfalls.

Commissioners need to keep providers and HEE informed of strategic and contractual changes that may affect the supply of and demand for the mental health workforce. Mental health organisations need to work with higher education

[5] Royal College of Nursing (2014) *Frontline first: Turning back the clock? RCN report on mental health services in the UK*. London: Royal College of Nursing.

institutions, and provide clear data on demand and the skills required of their workforce to inform HEE strategic workforce plans.

2.1. Evidence-based workforce planning (strategic staffing reviews)

When undertaking staffing reviews, you need to focus on how staff are currently used and on strategic planning for the future workforce.

Decision-making should be evidence-based, clear and logical. You must show:

- how your workforce planning links to strategic aims and service delivery outcomes
- the process is transparent and involves staff and service users
- you have a robust governance process to report on progress against the plan
- workforce plans are closely aligned with financial and service activity plans (ensuring the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients)
- how current staff will be supported as services transfer from one model to another
- you have defined a way to deploy staff safely when service need and staff availability varies
- you use a range of quality measures to inform and monitor your plan
- you evaluate measures identified and changes made in terms of their impact on quality care.

2.2. Headroom (uplift) considerations

Workforce plans should include a ‘headroom’ uplift allocation for inpatient and community-based services. The board needs to review and agree this annually so it reflects the organisation’s needs, is deliverable and takes account of:

- annual leave
- study leave (including mandatory training)
- continuing professional development
- maternity and parenting leave
- sickness and absence/carers and compassionate leave
- clinical supervision according to organisational policy
- continuing professional development and, where appropriate, supporting the component parts of revalidation

- leadership capacity
- shift patterns.

Consider local factors when calculating the percentage allowances to include in uplift. It is important that the level of uplift is realistic and reviewed at least annually.

Team leaders have a key leadership role. Organisations need to formally recognise this and specify the amount of direct care they expect team leaders to provide, reflecting this in the uplift calculations.

The key components of establishment reviews are:

- evidence-based staffing tools (see Appendix 2)
- comparison with peers
- professional judgement.

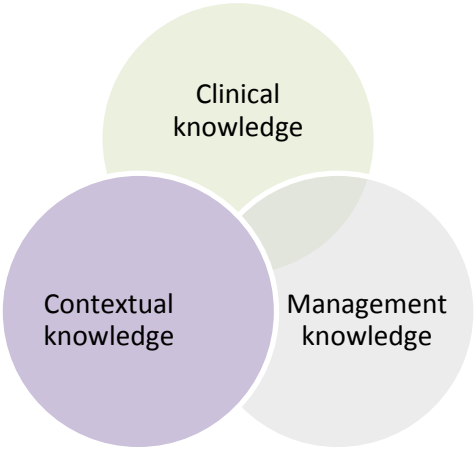
2.2 Professional judgement in reviewing establishments

Professional judgement is the use of accumulated knowledge and experience to make an informed decision. It takes account of the law, ethics and all other relevant factors. The multidisciplinary team's professional judgement ensures balance, and all teams should be subject to senior clinical oversight.

Professional judgement is crucial in establishment reviews when cross-checking data from evidence-based workforce tools with quality and outcome data. This ensures that decisions are not based solely on clinical staff's professional opinion.

A structured professional judgement model is of limited use on its own as decisions may be subjective, lack evidence and be influenced by individual preferences. To counter this, you should have a process for challenging and peer-reviewing staffing decisions. You should also monitor the experience, confidence and competence of those involved in making staffing decisions.

Figure 2: Professional judgement model



Using professional judgement in establishment reviews can help take account of the local context, which evidence-based workforce tools and benchmarking may not do. This includes:

- impact of working in community settings (eg working in a rural or urban area, travel time, lone working)
- inpatient physical environment factors and ward layout such as ease of observation (line of sight), ligature anchor point risks, impact of acoustics on people who use mental health services, use of staff alarm systems, geographical isolation of premises and locked doors
- service delivery factors such as the flow of people between clinical teams (rate of admissions, discharges and transfers, 'did not attend' rates), legal status of people who use mental health services (detained under the Mental Health Act, subject to the Mental Capacity Act), and diagnostic and gender mix of people in the team
- shift systems and working hours (NB: some argue that 12-hour shifts increases efficiency, but others that these may be associated with poorer quality care, compromised safety and care left incomplete)[6]
- the staff group's competence, capability and experience, including numbers on preceptorship, trainees, age range, physical health restrictions
- the impact of temporary staffing (bank and agency) on consistency (and familiarity with the service users).

[6] http://journals.lww.com/lww-medicalcare/Fulltext/2014/11000/Nurses__Shift_Length_and_Overtime_Working_in_12.7.aspx

2.3. Comparing staffing with peers

Organisations should use internal and external benchmarking in their staffing reviews to challenge the status quo and seek continuous improvement and opportunities to innovate. Benchmarking introduces evidence that is not in published literature.

Although service delivery varies among mental health providers, some existing datasets allow comparison:

- all NHS trusts, foundation trusts and some independent providers in England of secondary mental health services take part in an annual NHS Benchmarking Network exercise, which provides staff, people and process data at service-line and organisational level
- the Care Quality Commission (CQC) patient experience survey
- NHS Improvement collects data on care hours per patient day (CHPPD) across several inpatient settings (it expects to publish guidance on collecting and using this data in inpatient mental health settings in 2017) and is developing a community mental health productivity measure.

Appendix 2 outlines examples of decision-making tools for use in mental health services.

Table 1: Right staff – board assurance and accountability

The board will seek assurance that:
• The organisation has systems to monitor staffing requirements across all services (based on acuity and demand) and these are measured and reviewed against actual team staffing levels. • There is an agreed process for escalating to the board significant issues that affect safe and sustainable staffing. • Staffing reports take account of local factors that affect safe delivery of services. • The annually agreed 'headroom' percentage uplift reflects organisational needs, is deliverable and achieved. • Clinical leaders and managers have allocated sufficient time to supervise and lead effectively. • There is an annual review of the safe, sustainable, staffing references benchmarking data that the organisation has access to (both internal and external).

Expectations of clinical and managerial leaders
• Use professional judgement, local quality data and evidence-based workforce tools (see Appendix 2) when deploying staff. • Ensure there are plans to use the workforce flexibly to respond to temporary and unplanned variations in service need. • Regularly review the quality metrics and budget statements with line managers to understand how unplanned need affects sustainable, safe, effective, caring, responsive and well-led care. • Consider how the team reflects and responds to the diversity of the people who use its service. • Consider involving/employing people with experience of mental health issues as peer workers to support the professional workforce.

3. Right skills

> "Key attributes include human communication skills, being able to listen, showing respect, being consistent, showing compassion and having the courage to address things" – **from the service users group, highlighting the key skills that make users feel safe and cared for**

To use the workforce efficiently and effectively, identify the skills needed to deliver the care required and deploy staff who have them. The nature of the mental health workforce has changed in recent years to meet the changing needs of people who use mental health services, including:

- more focus on mental healthcare closer to home with more mental health staff working in the community
- more therapy staff in primary care to improve access to psychological therapies for people with mild-to-moderate mental illness
- embedding recovery as a central concept in mental health services and changing from expert-focused to person-centred, collaborative mental health, with more use of peer recovery workers
- sharing traditional, professionally defined functions across professional groups, to meet the needs of people who use mental health services more flexibly (ie responsible clinicians, approved mental health professional and non-medical prescribers).

The Five Year Forward View for Mental Health will alter the skills that the mental health workforce and providers need. Commissioners will have to plan for the following by 2020/21:

- more evidence-based interventions for children and young people
- more evidence-based interventions for women accessing perinatal mental health services
- improved physical healthcare assessment and interventions for people with a serious mental illness
- improved access and intervention for people with a first episode of psychosis
- more evidence-based interventions for people with a long-term condition.

In delivering the requirements of the future, new ways of working may need to be considered. Developing new care models means building flexible teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to service user needs in different settings. Solutions are likely to be found in a multidisciplinary approach that focuses on outcomes for service users.

New ways of working in mental health services may include:

- advanced practitioners
- non-medical prescribing roles
- responsible clinicians
- apprenticeships
- nursing associate roles
- consultant allied health professional and consultant nurse roles
- experts by experience/peer workers
- physician assistant roles
- clinical academic roles.

Training needs should be analysed for specific roles and settings to identify essential and desirable skills. Include both clinical and non-clinical skills and competencies, such as skills that make the environment safe: for example, physical health skills and resuscitation.

As providers and commissioners develop sustainability and transformation plans, staffing decisions must support these new care models.

3.1. Mandatory training, development and education

The bio-psychosocial approaches in mental health require substantial training and development. Several studies (see the summary of the review of literature in

Appendix 1) suggest that leadership, education, workforce flexibility and effective use of staff significantly affect healthcare quality.

Services should ensure that workforce plans support teams to develop the right competencies for new and existing care models. They must also ensure teams have the time to undertake mandatory training and continuous professional development.

The organisation should ensure that people who use mental health services:

- receive evidence-based care and interventions that help them remain safe while they recover
- have access to interventions provided by professionals with the skills to meet their clinical needs, who work effectively together in a multidisciplinary team.

Organisations should recognise the value of professional development and revalidation as a regulation of quality and should look to support professionals with the component parts of revalidation to maintain their professional registration.

3.2. Working as a multiprofessional team

Effective team-based working is vital for high quality, continually improving and compassionate patient care and staff wellbeing. Research suggests team working, patient satisfaction, care quality, staff wellbeing and patient mortality are connected.[7] Teams with clear team objectives are associated with higher levels of staff and patient satisfaction.[8]

3.3. Recruitment and retention

Organisations should have an approved recruitment and retention strategy as part of the overall, board-approved workforce plan. It should take account of the local and national context. Recruitment approaches should include a competencies and values-based selection process and support flexible working arrangements.

Particular support should be provided for black and minority ethnic (BME) staff in their development and career planning, including bespoke programmes and talent mapping so that they can secure leadership positions.

Organisations should focus on staff wellbeing, encouraging the workforce to be emotionally resilient, compassionate and person-centred at all times.

[7] West M, Lyubovnikova J (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In: Salas E, Tannenbaum S, Cohen D, Latham G (eds) *Developing and enhancing teamwork in organizations.* San Francisco: Jossey-Bass, 331–372.
[8] Hughes AM, Gregory ME, Joseph DL, et al (2016) Saving lives: a meta-analysis of team training in healthcare. *J Appl Psychol* 101(9): 1266–1304.

Table 2: Right skills – board assurance and accountability

The board will seek assurance that:
• The organisation has processes to identify, analyse and implement evidence-based practice across services. • Where new care models are developed, a clear plan exists to support staff so that the change takes place safely and affordably (see NHS Improvement and Leadership Development Board leadership framework for system leadership competencies).[9] • There are clear plans to evaluate the changes and both are reviewed. • The organisation takes an evidence-based approach to support efficient and effective team working. • The organisation has systems and processes to promote staff's physical and emotional wellbeing and prevent fatigue and burnout. • The organisation has a strategy for retaining staff, which clearly states learning and development opportunities for all staff groups and plans for attracting, recruiting and retaining staff, aligned with the workforce plan.
Expectations of clinical and managerial leaders:
• Ensure the clinical team's skills can sustainably meet the needs of people who use services, by completing an annual team-level training needs analysis and evaluation. • Develop the team using clear objectives and outcomes agreed by the multidisciplinary team and in line with the evidence for effective team working. • Support clinical staff to embed and evaluate quality improvements and innovations to improve services. • Acknowledge and celebrate team members' achievements. • Respond to indicators of reduced staff resilience and increased stress. • Ensure access to supervision and reflective practice is facilitated and monitored. • Involve experts-by-experience in selecting staff.

[9] National Improvement and Leadership Development Board (2016) *Developing people – improving care: a national framework for action on improvement and leadership development in NHS-funded services*
https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf

4. Right place, right time

> "Inadequate staffing not only impacts on service users, carers and staff but also on self-management, rehabilitation and recovery resulting in longer hospital stays" – **carer member of our focus group**

Efficiency is integral to quality improvement. Efficiency is not only about how the available resource is deployed; it is also about ensuring the right model of care is in place so the right care and treatment is received first time, in the right setting.

Evidence shows the economic and clinical benefits of early detection, diagnosis and intervention in people with mental illness.[10]

4.1. Productive working and eliminating waste

Services should release productive time by eliminating waste (non value-adding activity) in clinical teams so that people who use mental health services can access more care and support. NHS England published the productive ward series in 2012,[11] which considered lost time to care and provided guidance on maximising productivity in wards and community teams. More recent recommendations are that services should identify and address unwarranted variation to maximise productivity and eliminate waste as described in *Leading change, adding value*.

Efficient rostering and flexible staff deployment are vital for responding to the fluctuating needs of people who use mental health services. *Operational productivity and performance in English NHS acute hospitals: unwarranted variations – an independent report for the Department of Health by Lord Carter of Coles* (the Carter review) recommends the use of electronic rostering systems to effectively deploy staff. Organisations should check whether they are using rostering effectively and efficiently.

Best practice guidance for effective e-rostering is available from NHS Employers and the Carter team's *Good practice guide: Rostering*.

[10] Tsiachristas A, Thomas T, Leal J, Lennox BR (2016) Mental health economic impact of early intervention in psychosis services: results from a longitudinal retrospective controlled study in England. *BMJ Open* 6: e012611.

[11] NHS Improving Quality. The productive series. theproductiveseries.com

4.2. Efficient deployment and flexibility

Providing effective mental healthcare and treatment depends on a safe and trusting relationship between people who use mental health services and staff. There is evidence of a link between the presence of regular (familiar) staff on mental health wards and mental health teams and lower rates of physical aggression and self-harm: more incidents occurred when regular staff were on leave.[12] This reinforces how important the continuity of these relationships is, and mental health services should be designed with this in mind. Dependency can change quickly, so staff must be deployed responsively. The Carter mental health review will look at testing and implementing a suitable metric to count the mental health clinical workforce.

4.3. Observation

High staffing costs in mental health services can arise from high observation levels. Evidence about what is appropriate is lacking and there is no national policy. Staff should always engage meaningfully when undertaking observations and organisations should check that appropriate staff are carrying out enhanced observation, and that they are used efficiently and effectively with minimum restriction for the service user.

4.4. Escalation processes

Organisations should agree protocols to support frontline staff who escalate concerns about staffing levels, capacity and capability. Clinical leaders should take appropriate action to address any staffing shortfall and be supported by a robust escalation process. Review levels of concern and include clear reporting steps for teams to escalate concerns.

Appendix 5 outlines a sample escalation flowchart that you can adapt and approve for local need.

4.5. Efficient employment and minimising agency costs

Although temporary staff are a valuable part of the workforce and can help fill anticipated shortages, relying on high levels of agency staff is unlikely to be effective or sustainable in ensuring you have the right staff, with the right skills, in the right place at the right time.

Efficient employment and minimising agency staffing are vital to provide people who use mental health services with consistent high quality care. People who use mental

[12] Foster C, Bowers L, Nijman H (2007) Aggressive behaviour on acute psychiatric wards: prevalence, severity and management. *J Adv Nursing* 58(2):140–149.

health services should have a good experience if organisations ensure availability of staff and continuity in relationships.

Table 3: Right place, right time – board assurance and accountability

The board will seek assurance that:
• Standard approaches across services prevent unwarranted clinical variation in service provision. • Technology is available to staff to undertake their duties safely, efficiently and effectively. • Embedded quality improvement methods enable clinical teams to identify waste and make changes at service level to improve quality. • Regular reviews of shift patterns and e-rostering support the efficient delivery of care and treatment. • Thresholds for using bank and agency staffing are set, monitored and responded to, with temporary staff recruited wherever possible from in-house staffing banks. • Service models and staffing deployment reflect demand, including seasonal or other variation (across seven-day services where appropriate).
Expectations of clinical and managerial leaders:
• Review local systems and processes to ensure they are lean and responsive to the needs of people who use mental health services. • Identify unwarranted variations in care and treatment, and implement plans to eliminate these. • When planning staffing and caseloads, consider (and plan to minimise) community teams' travel time. • Review the use of technology to ensure it enables staff to work remotely, efficiently and safely. • Ensure staff rosters are used in line with local procedural guidance. • Ensure bank and agency staff have appropriate clinical skills to meet the needs of people who use mental health services. • Ensure bank and agency staff receive an effective local induction. • Identify over-dependence on bank and agency staffing and reduce it. • Set up checks and balances to ensure enhanced observations are appropriate and deployed efficiently and effectively with minimum restriction on the service user.

5. Measure and improve

> "If you are to have meaningful engagement with service users and carers and things are not safe, then there needs to be a process, a visible process for these concerns to be escalated from team to board" – **carer member of our focus group**

NQB's guidance includes expectations that boards will fully implement the Carter review recommendations. These include:

- using local quality and outcomes dashboards that are published locally and discussed in public board meetings, and that include nationally agreed quality metrics to be published for each provider
- developing metrics that measure patient outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and NHS experts' views, taking account of underlying differences
- reducing wasted time by helping staff spend as much time as possible providing direct or relevant care or care support.

The review includes information on peer comparisons, which support professional judgement, as well as the use of care hours per patient day (CHPPD). In its work on analysing staff deployment, NHS Improvement is collecting data on CHPPD across several inpatient settings.

5.1. Measure patient outcomes, people productivity and sustainability

Given that mental health providers offer a range of services, are configured differently and have different data collection systems, we recommend a framework approach to monitoring safe staffing levels rather than a prescriptive or standardised model. This enables organisations to tailor their reporting and assurance process to reflect the services they provide.

Mental health service providers must collect team and organisation-level metrics to monitor the impact of staffing levels on the quality of patient care and outcomes, the use of resources and the staff themselves. This fosters a culture of engagement, accountability and learning that allows teams and organisations to continuously improve patient outcomes and monitor their use of resources.

5.2. Safe staffing dashboard for mental health services

You should have a local quality dashboard for safe and sustainable staffing across all services that includes team-level data to support decision-making and inform assurance. You should review this at least monthly. The purpose of a triangulated approach to staffing decisions is ultimately to measure and improve outcomes, learning from incidents and service user feedback.

We encourage organisations to monitor safe staffing using a combination of staff, service user and process data that focuses on safe, effective, caring, responsive and well-led care on a sustainable basis. For helpful measures to consider in a safe staffing dashboard, see Table 4.

Taken at face value, no single measure will give you a comprehensive view on how staffing levels affect safety and quality of care. But they should individually and collectively prompt the 'so what?' questions that trust boards and team managers need to consider as part of the whole picture, particularly when consistent upward or downward trends occur across the suite of metrics, or when a particular team's measures are significantly different from benchmarking data.

Table 4: Dashboard – examples of measures that matter

Potential staff-related indicators	Sickness; staff turnover; vacancies; bank/agency/locum use; completion of mandatory training; clinical supervision completion rates; staff survey measures; completed appraisal; RIDDOR incidents[13]; actual expenditure against planned expenditure; care hours per patient day; reference cost index; patient-level cost benchmarking.
Potential service-user related indicators	Restraint, prone restraint; levels of harm; cancelled one-to-one sessions, ward activities, therapy sessions or escorted leave (including under Section 17) or failure to observe ward protected time. Ligature incidents; percentage of new admissions who have had physical health screening completed (NAS standard); percentage of community service users on a care programme approach (CPA) who receive a physical health check once a year; access to therapy. Incidents, complaints; meeting duty of candour threshold, levels of observations on wards, 12-hour A&E waits, unplanned out-of-area treatments; experience data (feedback) (friends and family test – FFT); safeguarding data; caseload size/complexity, patient-

[13] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

	reported outcome measures; patient experience measures; falls; increased use of 'when required' medication, self-harm; unexpected deaths.
Potential process-related indicators	Complaints; DNA rates; waiting times; level of reporting of incidents; readmission rates; length of stay; delays in transfer; delayed discharge; occupancy levels; medication errors.

5.3. Report, investigate and act on incidents

Unless incidents are reported, you cannot learn systematically from them. Organisations need a culture where staff can report incidents and be supported by the principles in the *Freedom to speak up review* (2015) and duty of candour arrangements.

Best practice in investigating patient safety incidents requires a root cause analysis for serious incidents. Services must reflect this principle in local approaches to learning from incidents. They must also consider staff capacity and capability during their investigations and recommendations, if appropriate, and respond to these.

Consider allowing time for all staff to participate in serious incident investigations. The NHS England Serious Incident Framework provides guidance on the type of incidents that require a formal investigation.

Also consider empowering service users and carers to report issues and incidents.

5.4. Escalation

Clinical teams should assess safe staffing daily. This routine monitoring will help manage immediate implications and identify trends for monitoring and audit.

Organisations should have a team escalation process for reporting all staffing shortages. Encourage all multidisciplinary team members, including all staff working directly with service users, to escalate concerns about the safety and effectiveness of care to a senior level.

See Appendix 5 for an example of a flowchart you can adapt for local use.

5.5. Service user, carer, family and staff feedback

Data informing staffing review decisions should reflect the views of service users and their carers and families. An approach to capturing and analysing service user, carer, family and staff feedback should be agreed and included in the annual staffing report to boards. A process for responding to meaningful real-time data should be in place and inform the annual report.

It is good practice to include experts-by-experience in ensuring safe and sustainable staffing. Examples include:

- peer support workers
- involvement in recruitment and selection
- providing face-to-face feedback on their experiences
- providing training
- involvement in service development and redesign
- involvement in staffing reviews.

6. Reporting

> "I want to ask staff how are you going to ensure that my son, daughter, etc is safe?" – **carer member of our focus group**

6.1. Strategic staffing reviews

NQB expects boards to receive an annual strategic staffing review from the nurse director, medical director and finance director. The annual staffing review should identify safe sustainable staffing levels for each team with evidence these were developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers). The review should take account of all healthcare professional groups, and be an integral part of the wider operational planning process, including financial plans. The report's contents should reflect the principles in this document.

See section 7 for our recommendations on a board report's content. Appendix 4 provides an example of areas to consider in team-level staffing reviews to inform the strategic staffing review paper to the board.

6.2. Comprehensive staffing report

The annual strategic staffing review should be followed six months later by a comprehensive staffing report to the board, to confirm workforce plans are still appropriate and being achieved.

A team or service-level review should also follow any significant service change or where significant quality or workforce concerns have been identified. Include this in the report to the board.

6.3. Reporting frameworks

NHS providers report and monitor staffing levels in different ways. Regardless of which reporting systems are used, there should be a clear framework for monitoring how staffing resources are deployed at team service and trust-wide level.

We recommend that trusts organise the dashboard or balanced scorecard 'view' at three levels:

1. **team or ward level –** this provides clinical managers with a local view of staffing levels and indicators at single team or ward level
2. **service, locality or network level –** this enables clinical leaders and service managers to monitor and systematically deploy staff across multiple sites using a framework, which shows where demand is greatest or risk is highest; we recommend a multidisciplinary approach – and consider including a service user perspective
3. **trust-wide level –** this gives boards a whole-organisation view of staffing levels and indicators.

6.4. Visibility

Reporting alone will not provide assurance that staffing levels are safe and sustainable, so it is good practice to supplement data and assurance reports with discussions with frontline staff. 'Walking the floor' enables team and ward managers, clinical leaders, service managers and board members to cross-check their understanding of the safety of staffing levels in teams or on wards gained from dashboard or balanced scorecard views.

Detailed expectations in the CQC 'well-led domain' outline approaches to assurance under the key lines of enquiry.

7. Conclusions and recommendations

The overall conclusion and summary recommendation is that provider boards should ensure that the staffing review report references the highlighted points in each of the sections of this resource. These are pulled together below along with the expectations of clinical and managerial leaders.

The board will seek assurance that:
Right staff
1. The organisation has systems to monitor staffing requirements across all services (based on acuity and demand) and that these are measured and reviewed against actual team staffing levels. 2. There is an agreed process for escalating to the board significant issues that affect safe and sustainable staffing. 3. Staffing reports take account of local factors that affect safe delivery of services. 4. The annually agreed 'headroom' percentage uplift reflects organisational needs, is practical and achieved. 5. Clinical leaders and managers have allocated sufficient time to supervise and lead effectively. 6. There is an annual review of safe sustainable staffing references benchmarking data that the organisation has access to (both internal and external).
Right skills
1. The organisation has processes to identify, analyse and implement evidence-based practice across services. 2. Where new care models are developed, a clear plan exists to support staff so that the change takes place safely and affordably (see NHS Improvement and Leadership Development Board leadership framework for system leadership competencies).[14] 3. There are clear plans to evaluate the changes and these are both reviewed. 4. The organisation takes an evidence-based approach to support efficient and effective team working. 5. The organisation has systems and processes to promote staff's physical and emotional wellbeing and prevent fatigue and burnout. 6. The organisation has a strategy for retaining staff, which clearly states learning and development opportunities for all staff groups and plans for attracting, recruiting and retaining staff, aligned with the workforce plan.
Right place, right time
1. Standard approaches across services prevent unwarranted clinical variation in

[14] Developing People, Improving Care A national framework for action on improvement and leadership development in NHS-funded services
https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf

service provision.

2. Technology is available to staff to undertake their duties safely, efficiently and effectively.
3. Embedded quality improvement methods enable clinical teams to identify waste and make changes at service level to improve quality.
4. Regular reviews of shift patterns and e-rostering support the efficient delivery of care and treatment.
5. Thresholds for using bank and agency staffing are set, monitored and responded to, with temporary staff recruited wherever possible from in-house staffing banks.
6. Service models and staffing deployment reflect demand, including seasonal or other variation (across seven-day services where appropriate).

Expectations of clinical and managerial leaders

Right staff

- Use professional judgement, local quality data and evidence-based workforce tools (see Appendix 2) when deploying staff.
- Ensure there are plans to use the workforce flexibly to respond to temporary and unplanned variations in service need.
- Regularly review the quality metrics and budget statements with line managers to understand how unplanned need affects sustainable, safe, effective, caring, responsive and well-led care.
- Consider how the team reflects and responds to the diversity of the people who use its service.
- Consider involving/employing people with experience of mental health issues as peer workers to support the professional workforce.

Right skills

- Ensure the clinical team's skills can sustainably meet the needs of people who use services, by completing an annual team-level training needs analysis and evaluation.
- Develop the team using clear objectives and outcomes agreed by the multidisciplinary team and in line with the evidence base for effective team working.
- Support clinical staff to embed and evaluate quality improvements and

innovations to improve services.

- Acknowledge and celebrate team members' achievements.
- Respond to indicators of reduced staff resilience and increased stress.
- Ensure access to supervision and reflective practice is facilitated and monitored.
- Involve experts by experience in selecting staff.

Right place, right time

- Review local systems and processes to ensure they are lean and responsive to the needs of people who use mental health services.
- Identify unwarranted variations in care and treatment and implement plans to eliminate them.
- When planning staffing and caseloads, consider (and plan to minimise) community teams' travel time.
- Review the use of technology to ensure it enables staff to work remotely, efficiently and safely.
- Ensure staff rosters are used in line with local procedural guidance.
- Ensure bank and agency staff have appropriate clinical skills to meet the needs of people who use mental health services.
- Ensure bank and agency staff receive an effective local induction.
- Identify over-dependence on bank and agency staffing and reduce it.
- Set up checks and balances to ensure enhanced observations are appropriate and deployed efficiently and effectively with minimum restriction on the service user.

Appendix 1: Review of literature – Summary report from the National Collaborating Centre for Mental Health

What is the context?

The *Five Year Forward View for Mental Health* identified mental illness as the single largest cause of disability in the UK, costing around £100 billion annually. People with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.

The Forward View's implementation plan described development and investment in mental health services for adults, older adults and children and young people in England. To deliver these ambitions, the mental health workforce must change significantly. This includes numbers of staff, competences across the workforce, leadership, governance and support provided to staff.

There is currently no standardised method to determine safe staffing levels in mental health settings. Evidence to inform staffing decisions is lacking, resulting in an array of staffing policies and varying advice. Current staffing models are based mainly on the traditional dual (doctor–nurse), role-based model. This does not reflect the current workforce, and limits staffing decisions. In addition, mental health staffing provision varies widely between regions. While new roles and new staff will play an important role in mental health services in future, we need a clear plan for how the current workforce can meet the challenges ahead.

This review aims to summarise the best available evidence on safe staffing structures for mental health teams to inform the development of setting-specific sustainable safe staffing guidance for the National Safe Sustainable Staffing Guidance Programme Board.

Data sources

We used a rapid review strategy to make best use of the time we had. Preliminary evidence gathering involved searching internet resources such as Google Scholar and websites of key organisations for relevant review articles. Our aim was to use a snowballing process, tracking reference lists of identified studies and reports and using them to identify further reviews. We conducted two comprehensive literature searches in PubMed using terms such as ‘mental health’ linked with terms depicting professional groups (nursing, psychologist, therapist, etc), linked with other relevant terms such as ‘leadership’, ‘hospital organisation’ and ‘client staff ratio’. Finally, we supplemented this with hand searches of the reference lists of all reviews included from the initial electronic database to identify other relevant papers. We conducted a separate rapid search of internet sources to specifically explore service user experience in mental health services.

Key themes

It is evident from the review that the issue of safe and sustainable staffing in mental health is complex and research is lacking. To produce effective guidance for mental health service commissioners and providers, further research is needed across the board. Our review’s findings form five categories:

Staff numbers and skills [3, 9, 12, 16, 19]

Staff numbers are central to all healthcare settings. Ensuring an adequate number of skilled staff is vital for providing therapeutic mental healthcare. However, research in mental health settings indicates this is only part of what creates safe staffing and implies other factors need to be considered. These include consistency of staff, use of staff time and staff skills. The skills to foster effective therapeutic relationships are frequently highlighted as a key area needing further investigation and clarification. These are not only clinical skills but interpersonal attributes and communication skills. This adds a layer of complexity when considering training needs at all levels.

Staff productivity and therapeutic relationships [1, 4, 14, 15, 19, 20]

As resources are increasingly constrained, staff productivity and using staff time effectively are critical to creating safe staffing models of care. The research particularly fails to consider professional groups such as allied health professionals and how these roles can be used most effectively in a safe staffing model. Most research focuses on nursing. Although this is a core group, creating more innovative solutions to staffing problems will involve the full multidisciplinary team. The research suggests a move away from current working practices is needed to reorganise the priorities of patient care. The emphasis needs to be on competences and developing therapeutic relationships. We need to consider care models beyond the traditional doctor–nurse model.

Staff wellbeing and support [1, 5, 7, 12, 13, 18, 20]

The emotional demands of working in mental health services appear as a theme throughout the literature. Empirical evidence relating to staff burnout and its effect on mental health is lacking, but literature indicates that stress and burnout are high across all mental health services. Many factors contribute to burnout and stress, and the issue underlies all the categories here. Further longitudinal research is needed into interventions to combat burnout and their impact. These interventions may include staff support systems, professional development and training, more collaborative multidisciplinary working or changes in team structure. Improvements here could potentially improve outcomes for patients, staff and organisations.

Organisation culture and leadership [3, 8, 9, 12, 14, 16, 17]

Research is lacking on how to implement and foster a successful unit culture and leadership in mental health. However, the literature points towards effective leadership instilling a culture that values the quality of all interactions between staff and patients, emphasising therapeutic alliance. Strong leadership in mental health settings appears to help create a climate where staff and patients are treated with dignity and respect, which in turn has a positive impact on patient outcomes.

Clarity of roles and of shared team goals is also an important aspect of creating a sustainable workforce. Role clarity is related to job satisfaction and higher staff morale.

What comprises good leadership in mental health settings and how this can be fostered are areas for future research.

Conclusions

The evidence indicates the complexities of developing comprehensive recommendations on safe, sustainable staffing in mental health. Though further research is needed, clear themes can guide this. Staffing numbers and skills should be the core focus. Staff wellbeing, support and productivity will be essential in harnessing current staff skills and creating a more sustainable mental health workforce. Underpinning all this, effective service organisation, teamwork and leadership will be central to developing safe, sustainable staffing models.

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Appendix 2: Decision-making tools in mental health services

The table below gives examples of the tools that may help organisations with staffing and establishment decisions.

Multiplier tools
• Hurst Tool - 'The Ward Multiplier Tool' (Dr Keith Hurst) was developed for learning disability inpatient and community (multidisciplinary) settings during 2014/15. The multiplier tool is based on the UK database system (from which the 'safer nursing care tool acute multipliers' were developed). This allows organisations to measure levels of need and service users' dependency, and to calculate the number of staff required to meet the need based on quality benchmarked data from other providers • Scottish Multiplier Tool • Scotland NHS CMHT toolkit
Caseload weighting tools
• Caseload weighting and/or acuity levels are used to manage capacity in teams supporting the allocation of work in the community
Benchmarking tools
• Mental Health Benchmarking NHS Benchmarking Network data reports (NHS Benchmarking Network is a member-driven benchmarking process providing comparison data to contributors based on data submitted by members (which includes all NHS mental health trusts) • Keith Hurst Tool https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability

Appendix 3: Summary of documents relevant to safe and sustainable staffing in mental health services

These publications will help in decision-making and developing safe staffing strategies, establishment reviews and sustainability and workforce planning, alongside professional guidelines. **NB this is not a comprehensive list.**

Context	Right staff	Right skills	Right place, right time
NHS Five Year Forward View for Mental Health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf	NICE guidance MH and LD 2016 Section 1.23 (Staff need to be part of care pathways) https://www.nice.org.uk/guidance/ng54/resources/mental-health-problems-in-people-with-learning-disabilities-prevention-assessment-and-management-1837513295557	Provision of mental healthcare for adults who have a learning disability. RCN https://www2.rcn.org.uk/__data/assets/pdf_file/0020/543026/004_445.pdf	Lean thinking for the NHS. Daniel Jones and Alan Mitchell, Lean Enterprise Academy UK, NHS Confederation 2006. http://www.nhsconfed.org/resources/2008/12/lean-thinking-for-the-nhs Going Lean in the NHS. NHS Institute for Innovation and Improvement http://webarchive.nationalarchives.gov.uk/20121108094911/http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/lean.html
Mental health staffing framework. NHS England 2013 https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf	Horizon 2035 centre for workforce intelligence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file	Green light toolkit – a guide to auditing and improving your mental health services so that they are effective in supporting people with autism and	Productive Ward series http://www.theproductives.com/ http://webarchive.nationalarchives.gov.uk/20150401090957/http://www.institute.nh

	/507498/CfWI_Horizon_2035_Future_demand_for_skills.pdf	people with learning disabilities http://www.ndti.org.uk/uploads/files/Green_Light_Toolkit_22_Nov_2013_final.pdf	s.uk/quality_and_value/productivity_series/the_productive_series.html
Leading change, adding value: a framework for nursing, midwifery and care staff (2016) https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf	Mind the gap: exploring the needs of early career nurses and midwives in the workplace Health education England http://www.nhsemployers.org/~/media/Employers/Documents/Plan/Mind%20the%20Gap%20Smaller.pdf	Mental health core skills education and training framework. Skills for health. http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework	Operational productivity and performance in English NHS acute hospitals: unwarranted variations – an independent report for the Department of Health by Lord Carter of Coles https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
	QNIC standards 7th edition (CAMHS). Royal College of Psychiatrists 2013 http://www.rcpsych.ac.uk/PDF/QNIC_Standards_Seventh_Edition.pdf		Scotland NHS CMHT toolkit http://www.qihub.scot.nhs.uk/quality-and-efficiency/mental-health/effective-and-efficient-community-mental-health-services.aspx
	Evidence-based nurse staffing levels: RCN policy position. RCN (2010) www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2011/april/pub-003870.pdf		Transition between inpatient mental health settings and community or care home settings. NICE guideline [NG53] published date: August 2016 https://www.nice.org.uk/guidance/ng53

Appendix 4: Strategic clinical team establishment review template

This provides an example of areas to consider at safe and sustainable staffing team reviews.

Review template

The approach assumes as a minimum an annual face-to-face meeting between the clinical team and the review team. The meeting will enable teams to formally discuss key areas for supporting and underpinning staffing-level decisions for annual and six-monthly staffing reviews. It will support the approach to agreeing clinical staffing requirements based on a person's assessed needs, acuity and risk, helping identify core areas of consideration. You can highlight areas that identify positive practice and issues for action.

This review is an opportunity to determine whether the current staffing establishment meets service users' needs most productively. A thorough review must be completed at least annually.

Review team membership

Consider a multidisciplinary team approach to the review, which should include:

- team manager
- representative involved in providing direct care
- finance representative
- workforce and staff side
- service user or carer attending.

A senior clinical lead (8A or equivalent) should chair the review.

Preparation

Before the meeting the review chair will access the self-assessment document, acuity and dependency data and trend data from the quality dashboard.

Review process

The review team will consider all data relating to team activity and discuss required staffing levels. The checklist below will be useful for this. RAG rating will support reporting. This will provide assurance that the team is cross-checking data using evidence-based guidance and presenting a rounded view of staffing requirements to support professional judgements and decisions about delivering high quality, safe care to patients. The discussion will review all budgeted establishments/teams to identify any resource variances.

After the review meeting a report will be submitted to the director of nursing to make the process transparent and enable team requirements to be included in the final board report (and reports to any relevant subcommittees, eg quality or workforce.)

A report will also be presented to commissioners as agreed by the organisation.

Evidence reviewed	RAG	Action required	Review date
Expectation 1: Right staff			
There is continuity in the multiprofessional team			
Continuity of team leadership with sufficient allocated time for managerial activities			
Caseload within evidence-based recommendations/clustering data			
Administrative support is available			
Benchmark data for an equivalent team			
Positive staff experience measures			
Team budget meets requirements, including a review of headroom			
Expectation 2: Right skills			
Technology to support team function			
Effective appraisals are conducted			
Mandatory training standard met			
CPD plan for all staff in place			
Staff supervision/reflective practice processes in place			
All staff have had an appropriate induction (including temporary staff), including evidence of implementation			
Skill mix data reflects need			
Expectation 3: Right place and time			
Care hours per patient day data (inpatient)			
Fill rate data reflects requirement			
Team environment appropriate			
Staff sickness within trust threshold			
Use of bank/agency within threshold			
Staff turnover measures			
Shift patterns match patient need			
Therapeutic activity matches person's needs and is consistently delivered			
Quality dashboard trend data			
Escalation process and a review of escalated events			
Dependency/acuity data using evidence-based tools			
Escalation plans in place			
Feedback from regulators			
Patient experience measures			
Student feedback considered			
Staff feedback considered			
Incident data			
Bed occupancy			
Organisational clinical handover standards are met			

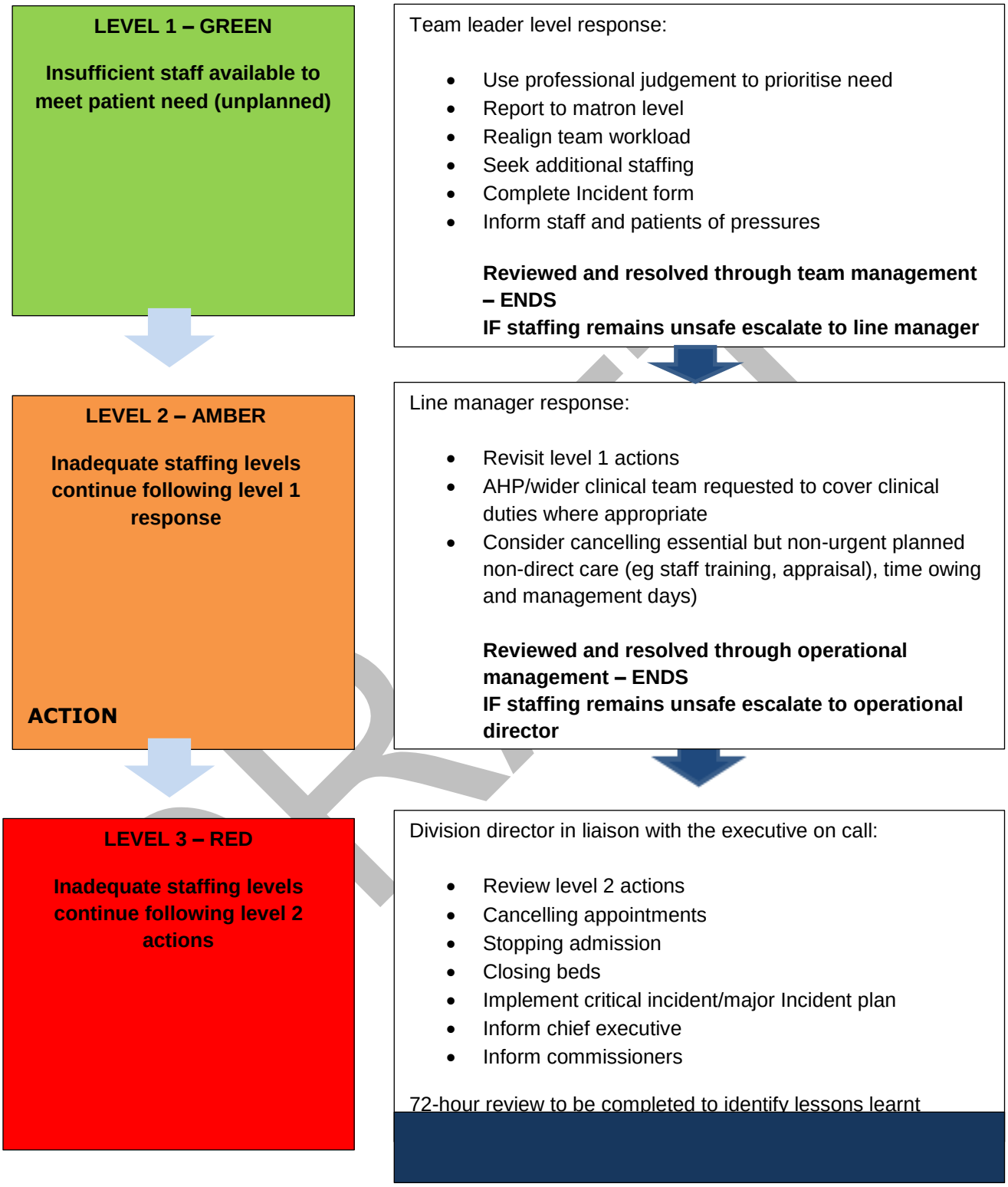
Appendix 5: Team escalation process for reporting impact of staffing shortages

Organisations should have a protocol for frontline staff to escalate concerns about the safety and effectiveness of care to a senior level. Clinical teams should carry out a daily safe staffing assessment**.** This routine monitoring will help manage immediate implications and identify trends for monitoring and audit. Concerns will be recorded through the incident reporting system or rostering system for monitoring and audit:

- green level 1 concerns; may be resolved at team level
- amber level 2 concerns; require escalation to matron/operational lead for resolution across the organisation
- red level 3 concerns; will be escalated to director level.

The flowchart below outlines the process required to address and monitor actions.

An example of an escalation flowchart for staffing shortages



Appendix 6: Working group members (including any declaration of interest)

Ray Walker	Director of Nursing and Operations	Merseycare NHS Foundation Trust
Kenny Laing	Deputy Director Nursing	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Lindsey Holman	Project Manager	
Tim McDougal	Deputy Director Nursing	Greater Manchester West
Helena McCourt	Deputy Director Nursing	Merseycare NHS Foundation Trust
Jane Stone	Group Director of Nursing	Priory Group
Ian Hulatt	Professional Lead Mental Health	RCN
Professor Alan Simpson	Professor of Collaborative Mental Health Nursing	City, University of London
Professor John Baker	Professor of Mental Health Nursing	University of Leeds Non-Executive Director, Leeds and York NHS Partnership Trust
Steve Barrow	Deputy Director Finance	Warrington and Halton Hospitals
Debbie Moores	Head of AHP	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Dr Tim Devanney	Workforce Specialist	Health Education England
Dr Jane Padmore	Executive Director Quality and Safety	Hertfordshire Partnership University NHS Foundation Trust
Jamie Soden	Deputy Director Nursing	Coventry and Warwickshire CCG
Amanda Pithouse	Deputy Director Nursing	South London and Maudsley NHS Foundation Trust
Emma Corlett	Mental Health Professional	Unison
Vanessa Ford	Executive Director of Nursing and Quality	West London Mental Health Trust
Shirley Baah-Mensah	Chief Nursing Officer, Black Minority Ethnic Strategic Advisor Operational service Lead	NHS England North East London Foundation Trust

Appendix 7: Stakeholder engagement

- Focus group of service users and carers facilitated by Liverpool John Moores University
- Providers and professional representatives at an engagement event
- Multidisciplinary twitter chat
- Health Education England
- NHS England
- Department of Health
- Mental health national leads
- Royal College of Psychiatrists (through the steering group membership)
- Unison
- Mental Health and Learning Disability Nurse Directors Forum
- Care Quality Commission representatives (mental health)
- Finance representatives (through the steering group membership)
- College of Occupational Therapists specialist section
- Service User and Carer Group Advising on Research (SUGAR), City, University of London
- HR Network
- Chief Executive Network
- Psychology

Organisations that have contributed through feedback:

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Liverpool John Moores University
- Health Education England
- 2gether NHS Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust
- St Andrew's Healthcare

- Coventry and Warwickshire Partnership Trust
- Cheshire and Wirral Partnership NHS Trust
- Merseycare NHS Foundation Trust
- Unite
- Betsi Cadwaladr University Health Board
- Tees, Esk and Wear Valley NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Cygnet Healthcare
- Bradford District NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- East London NHS Foundation Trust
- 5 Boroughs Partnership NHS Foundation Trust
- South London and the Maudsley NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- North Staffordshire Combined Healthcare NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Central London Community Healthcare NHS Trust
- Humber NHS
- The Priory Group
- Leicestershire Partnership NHS Trust

Organisations to thank

- Liverpool John Moores University – Experts-by-experience focus groups
- National Collaborating Centre for Mental Health (NCCMH) review of literature
- NQB safe sustainable staffing team