National Quality Board

Edition 1, January 2018

Safe, sustainable and productive staffing

An improvement resource for mental health: Appendices

This document was developed by NHS Improvement on behalf of the National Quality Board (NQB).

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- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
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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), and 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 findings form four 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.

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. The 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**

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

Context	Right staff	Right skills	Right place, right time
NHS Five Year Forward View for Mental Health	NICE guidance MH and LD 2016 Section 1.23 (Staff need to be part of care pathways)	Provision of mental healthcare for adults who have a learning disability. RCN	Lean thinking for the NHS. Daniel Jones and Alan Mitchell, Lean Enterprise Academy UK, NHS Confederation 2006 Going Lean in the NHS. NHS Institute for Innovation and Improvement
Mental health staffing framework. NHS England 2013	Horizon 2035 Centre for Workforce Intelligence	Green light toolkit – a guide to auditing and improving your mental health services so that they are effective in supporting people with autism and people with learning disabilities	Productive ward series http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html http://webarchive.nationalarchives.gov.uk/20150401090957/

Leading change, adding value: a framework for nursing, midwifery and care staff (2016)	Mind the gap: exploring the needs of early career nurses and midwives in the workplace Health Education England	Mental health core skills education and training framework. Skills for health	Operational productivity and performance in English NHS acute hospitals: unwarranted variations – an independent report for the Department of Health by Lord Carter of Coles
	QNIC standards, 7th edn (CAMHS). Royal College of Psychiatrists 2013		Scotland NHS CMHT toolkit
	Evidence-based nurse staffing levels: RCN policy position. RCN (2010)		Transition between inpatient mental health settings and community or care home settings. NICE guideline [NG53] published August 2016
Patient Safety First, The 'How to Guide' for Implementing Human Factors in Healthcare (2009)			

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 and will include team achievements as well as identifying areas of concern. A monthly dashboard will be in place to support real-time understanding of the staffing position.

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, right 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			
Feedback from staff/students 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.

Example of an escalation flowchart for staffing shortages

Inpatient and community teams

LEVEL 1 – GREEN

Insufficient staff available to meet service user need as per planned requirements

Examples:

Postponement of:

- Training/supervision
- Section 17 leave
- Planned appointments
- Therapy/intervention

Team leader level response

- Use professional judgement to reprioritise need
- Report to Matron level or next line leader
- Realign team workload
- Inform staff and service users
- Complete Incident form

Review and resolve through team management. If staffing remains unsafe escalate to line manager.

LEVEL 2 – AMBER

Inadequate staffing levels continue following Level 1 response

Examples:

- Delayed medicines administration
- Delay meeting physical health care
- Postponement of more than 1 consecutive

Line Manager Response

- Revisit level 1 actions
- Wider clinical team requested to cover clinical duties where appropriate
- Cancel essential but non urgent planned non direct care (eg staff training, appraisal)

Review and resolve through operational management. If staffing remains unsafe escalate to Divisional Director level/ Silver on Call

NB repetitive incidents should be escalated.

LEVEL 3 – RED

Inadequate staffing levels continue following level 2 actions

Examples:

- Inability to respond to crisis assessment
- Inability to meet statutory duties
- Inability to meet observation levels
- Repetitive level 2 incidents

Division Director in liaison with the Executive on call

- Review level 2 actions
- Stop admissions/internal transfer of care
- Implement Critical Incident Plan
- Inform Chief Executive / gold on call when out of hours
- Inform Commissioners

72-hour review to be completed to identify lessons learnt.

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