National Quality Board

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Safe, sustainable and productive staffing

An improvement resource for learning disability services

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

The NQB provides co-ordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health & Social Security.

For further information about the NQB, please see:
https://www.england.nhs.uk/ourwork/part-rel/nqb/

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Summary

This improvement resource for community and inpatient learning disability services has been developed in the context of reducing health inequalities and increasing the life-expectancy of people with learning disabilities, as well as enabling sustainability and transformation plans in the NHS. It is designed to help providers of NHS-commissioned services to develop, review and sustain safe and effective, person-centred specialist health services for people with learning disabilities, who have a wide range of needs and varying levels of disability. It recognises the significance of the context of care due to the many different service models and providers of such services.

This resource makes several recommendations informed by a review of the literature and multiprofessional experience; NHS Improvement's 'measure and improve' approach and NHS England's *Leading change, adding value* underpin the resource. It provides a framework based on the National Quality Board's (NQB) *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* (July 2016), outlining the expectations for decision-making on staffing to enable improved health outcomes. It ensures delivery of safe, effective, caring, responsive and well-led care on a sustainable basis in learning disability services.

While this resource focuses on the expectations of provider organisations it can also support commissioners in developing their own assurance framework for safe and sustainable staffing.

Provider organisations are accountable for ensuring safe, sustainable and productive staffing and the board must receive a comprehensive staffing review annually. A robust approach to informed decision-making on staffing can:

- reduce numbers of staff leaving the service
- reduce number of incidents
- reduce the use of restraint on people
- reduce assaults on staff

- reduce inappropriate hospital admissions
- reduce cost to the system of inappropriate place of care provision
- improve service user and carer experience.

This resource includes tools and reference sources to help providers plan, measure and improve care including: an outline process for a staffing/establishment review and a summary of decision-making tools in learning disability services.

There is a pressing need for further robust research on safe, sustainable and productive staffing in learning disability services and a set of minimum standards to be developed. The following is recommended:
- development during 2018 of a set of minimum standards for 'always events'
- further research focused on the:
  - context of care: relationships between sustainability, safety, effectiveness, efficiency and staffing levels; the models of service provision and communication passports
  - reliability and validity of current workload/multiplier tools used in staff deployment decisions
  - impact of staffing on service user outcomes.

This will inform future safe staffing guidance and resources in specific areas and services.

Recommendations

Right staff
1. Workforce planning must be integral to a provider's strategy and operational planning process, and consider trends in retention (eg attrition, retirement profile and impact of maternity leave).
2. Workforce plans should provide for sufficient uplift (headroom) allocation for inpatient and community-based services.
3. Providers should ensure those making staffing decisions are competent to do so and that such decisions are objectively reviewed.
4. All workforce planning should consider the skills required to achieve holistic, person-centred health outcomes and identify the staff most appropriate to deliver them.
5. All healthcare providers should combine professional judgement with the use of evidence-based tools and processes for managing staff deployment to meet local needs.
6. Providers should consider the contextual factors that affect the delivery of safe, sustainable and productive services (see context of care tool).

Right skills
1. Service users and carers should be involved in the competency and values-based recruitment and development of staff.
2. Providers should collaborate with commissioners, primary care and acute hospitals, and learning disability liaison professionals to ensure there are sufficient skilled staff to implement communication passports and appropriate reasonable adjustments.
3. Commissioners and workforce planners should consider the importance of providing enough liaison posts in a range of services, including primary care, acute physical healthcare, mental healthcare and forensic/prison healthcare.
4. The local team's skill mix, number and form must be based on local needs and reflect the complex health and social care needs of people with learning disabilities.
5. Where community learning disability teams (CLDTs) provide intensive support, this must not compromise their public health, educational and preventive role. Skill mix and numbers need to be considered with both functions in mind.
6. Analysis of training needs should consider any skills or competence deficit in relation to physical and mental healthcare associated with the changing and increasingly complex needs of the population with a learning disability, and identify plans to resolve this.

7. Providers should consider where it is appropriate to introduce new roles in learning disability community services. Advanced and emerging roles should only be deployed at the appropriate level of assessed skill, competence and attitude.

8. Supervision policies must be in place and must recognise the value of profession-specific supervision and support outside normal working hours. Formal staffing reviews must consider leadership capacity and ring-fence a proportion of supervisory time for the team leader.

9. Providers should have retention strategies (with supporting processes) and consider flexible working and methods of deployment that recognise staff preferences, especially for those who wish to work beyond retirement age.

10. Providers should ensure a safe working environment by addressing the risks associated with workplace violence and health and safety, and promote opportunities for staff to improve their own health and wellbeing.

Right place and time

1. For inter-professional and interagency working arrangements such as joint community teams, providers must work together to provide seamless care and develop clear processes and understanding of roles.

2. Providers should monitor their staffing of unplanned care and develop a flexible, mobile and multi-skilled workforce from across the organisation that can respond seven days a week to changes in acuity and dependency.

3. Commissioners should consider the benefits of increased and flexible local funding to avoid expensive, inappropriate out-of-area residential social care.

4. Providers should consider the cost and quality benefits of equipping staff with portable technology that enables interactive approaches with people during active interventions and that improves staff safety.

5. Thresholds for using bank and agency staff should be set, and compliance monitored and addressed, with temporary staff recruited wherever possible from in-house staffing banks.

Measure and improve

1. Providers should monitor their delivery of safe and sustainable staffing using a combination of staff, person and process measures that reflect safe, effective, caring, responsive and well-led care on a sustainable basis.

2. Providers should use dashboards or balanced scorecards to ask 'so what' questions and the answers to review the context in which care is delivered. Effective delivery of services can also be informed by asking staff questions at the end of their shift.

3. Providers should ensure there is a framework for multidisciplinary staffing reviews (eg floor/team-to-board reporting). Decision-making should be supported and assurance informed by a local quality dashboard for safe and sustainable staffing that shows team-level data and is reviewed at least monthly.

4. Providers should measure and improve areas of inefficiencies associated with the poor flow of people through their services as part of their staffing reviews and, ideally, as an integral part of the operational planning process.

5. People with a learning disability and their carers must be involved in service design and evaluation.

6. Providers should determine processes that predetermine arrangements for rapid decision-making to lessen the likelihood of poor decisions in crisis situations.

7. Providers should ensure enhanced support and observation processes in inpatient settings include the right checks and balances so the approach used involves minimum restriction.

8. Providers must look after staff wellbeing. Staff survey results should be reviewed and acted on to improve staff experiences.

1. Introduction

The aim of this resource is to make a sustainable difference to the quality and consistency with which safe and therapeutic services for people with learning disabilities are delivered.

The resource draws on evidence from a commissioned rapid review of the literature (see Appendix 2) and a professional review of practice. People with learning disabilities, carers and other stakeholders have also informed the content. It provides principles and an assurance framework to help standardise approaches to making decisions about staffing in a multidisciplinary learning disability setting, within organisations and across the system to improve patient experience and outcomes.

NHS Improvement's 'measure and improve' approach has been a guiding principle in its development.

This resource aligns to Commitment 9 of *Leading change, adding value: a framework for nursing, midwifery and care staff* (NHS England 2016). Users of this resource should also refer to the National Quality Board's (NQB) three expectations concerning right staff, right skills, and right place and right time, and to the other setting-specific improvement resources in this series, in particular those for the adult acute, mental health, community and children's services.

Beyond this resource, providers will need to consider any specific guidance that may apply to specialised services and professional groups. It is also useful to recognise the support unions and professional bodies can provide in supporting this work.

1.1 Context

In October 2015 the national plan, *Building the right support*, was published to enable people to live more independent lives in the community, with support, and closer to home. This programme involves new service models to meet local needs. Its success will depend on the workforce being available in sufficient numbers with

the right skills, values and behaviours to deliver these service models across the system.

Sustainable safe staffing in learning disability services must take account of the complex nature of the care models and the number and skill mix of professionals and agencies involved in meeting the healthcare needs of people with learning disabilities.

We developed this resource in the context of reducing health inequalities and increasing the life-expectancy of people with learning disabilities, as well as sustainability and transformation plans in the NHS. The national transforming care programme aims to end over-reliance on assessment and treatment units, and unnecessary hospital admissions for people with learning disabilities and/or autism.

2.   Right staff

There must be sufficient and sustainable staffing capacity and capability in learning disability settings to provide safe and effective care to patients at all times.[1] Decisions about staffing must take account of the financial resources available, so that the highest quality care can be provided now and on a sustainable basis. NHS Improvement and the Care Quality Commission (CQC) will shortly jointly assess use of resources underlining the importance of financial efficiency when setting safe staffing levels and skill mix.

2.1   Evidence-based workforce planning

Workforce planning must be an integral part of an organisation's strategy, in particular its operational planning process. Importantly, it must consider trends in retention (eg attrition, retirement profile). The staffing required to deliver high quality learning disability services as effectively as possible within the resources available should be regularly reviewed.

The local team's skill mix, number and form must be based on local needs and required functions. Across the organisation and for all professions, there should be enough registered practitioners and assistant practitioners to deliver high quality care at all times, without over-reliance on agency staff.

Traditionally, learning disability teams have comprised nursing, speech and language therapy, psychiatry, psychological therapies, occupational therapy and physiotherapy. More commonly today, adult and community learning disability teams include social workers and other therapist roles – for example, audiology, podiatry and dietetics. A consistent theme identified in the literature review (see Appendix 2) is the need for clearly defined professional roles and accountabilities within teams.

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[1] www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

As set out in the Five Year Forward View, health and care services need to transform to meet today's challenges. We need to build an adaptable contemporary workforce that can respond as a profession to the required models of care, using resources efficiently while ensuring that careers remain attractive and accessible to all. Our ability as learning disability professionals to adapt and innovate is critical to achieving high quality care in the right place and at the right time. By modernising we can shape a workforce that is fit for purpose for the next decade and beyond and deliver positive outcomes and experiences for those we care for.

The introduction of new models of healthcare and service developments provides an opportunity to review traditional service delivery models utilising emerging roles in the NHS (see Appendix 6). These emerging roles include:

- advanced practitioner
- apprenticeship
- nursing associate
- consultant allied health professional and consultant nurse
- care navigator
- non-medical prescribing roles
- experts by experience/peer workers
- physicians associate
- assistant practitioner
- clinical academic.

These emerging roles should only be used at the appropriate level of assessed skill, competence as well as attitude, and organisations must be confident that the staff have the prerequisite skills to provide safe care. All workforce planning should consider the skills required to achieve holistic, person-centred health outcomes and identify the most appropriate staff to deliver them. Providers should ensure professional leadership of all professional groups is in place and sufficient time for leadership development.

Health Education England has published 'a set of five generic role templates' to support the development of different roles in learning disability community services.

The templates will help commissioners and providers of health and care services build a flexible workforce capable of delivering the aims of the *Building the right support* agenda.

2.2 Deploying multidisciplinary teams in community settings

When deploying staff in multidisciplinary community teams we recommend organisations refer to the five key roles of adult learning disability services identified by the Learning Disability Professional Senate in 2015 (see Appendix 6 for more details):

- supporting positive access to and responses from mainstream services
- enabling others to provide effective person-centred support to people with learning disabilities
- direct specialist clinical therapeutic support for people with complex needs
- responding positively and effectively to crisis
- quality assurance and service development in support of commissioners.

New roles for learning disability teams might also include:

- communication and relationship building within and between providers: these are multi-faceted roles with a recognised skill set and joint responsibility, accountability and autonomy across services
- cross-service leadership and collective leadership
- a role focused on the facilitative values-based elements of delivering services.

2.3 Uplift (headroom) considerations

Workforce plans are reviewed and agreed on an annual basis by boards, or more frequently in the context of significant service change. They should reflect the needs of the organisation and be deliverable. It is important that plans for inpatient and community-based services provide for an uplift (headroom) allocation that takes account of:

- annual leave in line with Agenda for Change or local terms and conditions

- study leave

- maternity and parenting leave

- sickness/absence/compassionate leave

- clinical supervision as per organisational policy and guidance from professional bodies

- leadership capacity and a proportion of supervisory time for the team leader[2]

- continuing professional development and mandatory training

- shift patterns (the higher the proportion of part-time staff, the greater the necessary allowance for study leave uplift).

2.4   Monitoring staffing and staffing reviews

NQB expects organisations to do annual strategic reviews and then prepare a comprehensive report for their board. High quality reviews are essential in ensuring sustainability and safety. The NQB model reminds us that patient outcomes are central to decision-making. Safe and sustainable staffing is an essential criterion for achieving quality outcomes.

The NQB model emphasises the importance of having the right staff with the right skills in the right place at the right time. Organisations' staffing decisions should respond to the 'here and now' as well as contribute to planning the workforce for the future within the resources available. Regular reporting on staffing numbers and board reporting is largely retrospective. This is important for safety and sustainability, but must be balanced with a focus on longer-term national and local intentions.

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http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

2.5   Decision-making tools in learning disability services

A variety of tools can help develop and sustain safe staffing from commissioning through to day-to-day practice. These are outlined in Appendix 4. As new evidence emerges it is likely more evidence-based tools will become available.

2.6   Informed decision-making for optimum staffing

A strategic staffing review must be done at least annually or sooner if changes to services are planned or incident investigations endorse this. It should be considered in the context of the whole system – as changes to one service will affect others – and ideally as part of the organisation's operational planning process.

In determining staffing requirements for learning disability settings, it is good practice to adopt a systematic triangulated approach, which will include:

- **defining quality requirements** based on local service specifications and appropriate relevant national guidelines (bearing in mind these may be based on professional consensus rather than a strong evidence base)
- **demand (volume)** includes hidden volume (individuals who would be seen by the service but are not currently known about) and created demand (which is individual to each team and relates to practice, poor risk assessment and error rates). A commissioner's view on this would be useful
- **reducing inefficiencies** to improve capacity: a review of how time is spent and its productivity is an essential component of staffing decisions.

Figure 1: Demand and capacity model for making decisions about staffing

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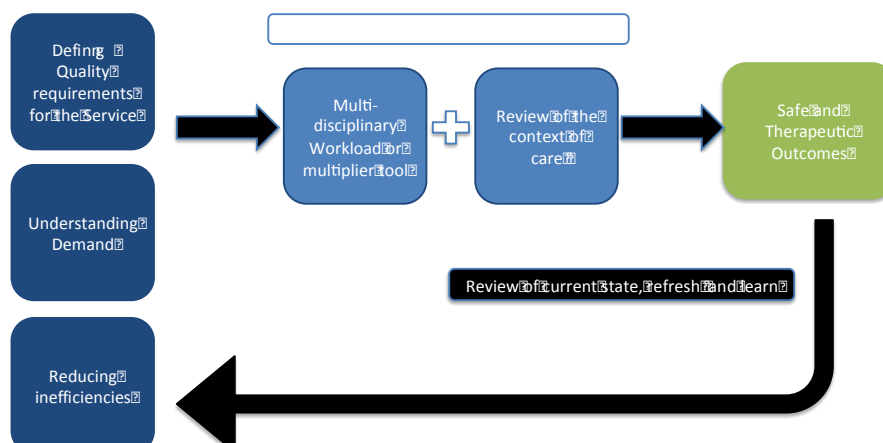
In its work to develop and implement measures for analysing staff deployment, NHS Improvement collects data each month on **care hours per patient day** (CHPPD) in inpatient settings. Specialty-specific ranges are emerging that organisations will be able to benchmark against when planning appropriate levels of staffing.

Workload tools can be used to determine the numbers of staff required in learning disability services. These should consider the multidisciplinary team involved, including the medical workforce, and enable trends and benchmarking to be analysed. The literature review recommends that healthcare organisations use evidence-based processes to manage staff deployment. Evidence-informed tools are available for both inpatient and community learning disability services (see Appendix 4).

In many areas community learning disability teams (CDLTs) use **caseload analysis tools** to assure themselves they are meeting the needs of the person and that waiting times, crisis referrals and acuity of need are regularly assessed and prioritised accordingly.

Organisations can use these tools to review their uplift at annual staffing reviews, to ensure it reflects the current context and includes sickness absence target, annual leave, supervisory time, parental leave, training and development time, and the preventative role of training other providers.

In addition, periodic service reviews (often used in line with applied behavioural analysis processes) can help providers identify gaps in particular areas of care delivery and what skill deficits exists and require investment or re-engineering of staff roles.

2.7   Context of care

Safe and sustainable staffing depends on many environmental factors as well as understanding the 'numbers' and 'skill level' of required staffing across the organisation. Current evidence suggests, within the context in which care is

delivered, the following elements influence the delivery of safe and compassionate care (see Figure 1):[3]

- understanding the level of client need
- staff attributes
- staff perception of challenging behaviour
- job satisfaction
- working as a team
- stress, burnout and work overload
- working in the community (unique to community services).

From the best available evidence, the University of West London developed the 'context of care tool' to support providers in maintaining high quality, compassionate and effective care.[4] This is shown in Figure 2 with full details given in Appendix 5. It can be used as a reference for organisations undertaking establishment reviews in learning disability services multiprofessional teams.

2.8 Regular outcomes/dashboard monitoring

The monitoring of outcomes and service-related measures is essential to ensure safety, to understand how effective decisions on staffing are made and to learn and review for sustainability.

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[3] *Final report of a systematic review of literature on learning disability nursing staffing levels, and its relation to the safety, quality and the delivery of compassionate nursing care.* University of West London, December 2014.
[4] Available at: http://repository.uwl.ac.uk/ Type *'Gates and Mafuba Context of Care V2*' in the search bar.

Figure 2: Factors directly or indirectly impacting on the delivery of safe and compassionate learning disability care
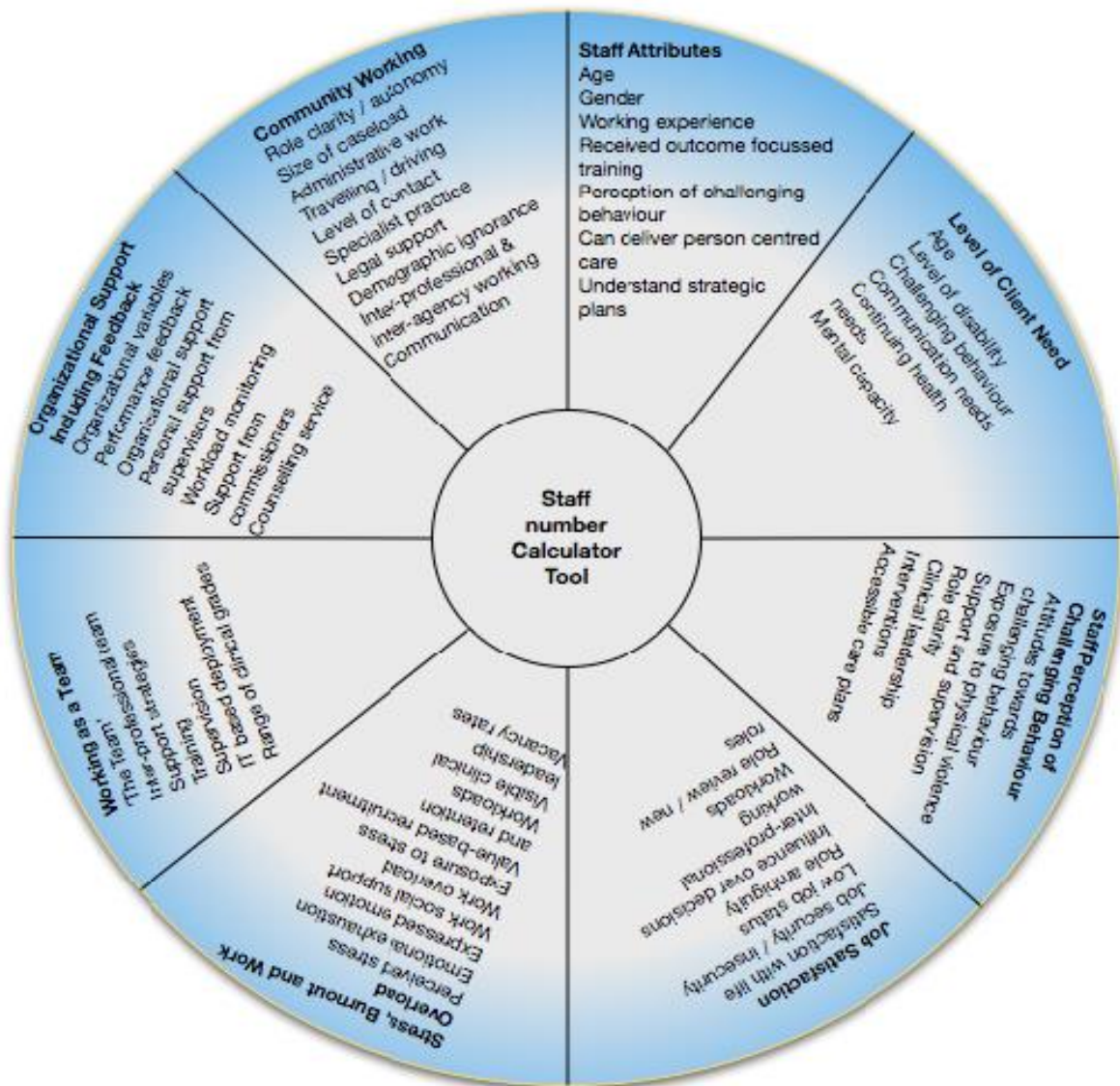
2.9   Decision-making tools in learning disability services

The list of tools in Appendix 4 is not comprehensive but does provide examples of:

- multiplier tools
- outcomes monitoring tools
- caseload weighting tools
- benchmarking tools.

Using such tools across a range of settings can refine a framework that covers not only safe staffing issues, but also therapeutic outcomes and cultural and environmental factors.

It is best practice to cross-check the information provided by the tools to ensure decisions are based on the wider context and professional judgement.

2.10 Professional judgement

Professional judgement is the use of accumulated knowledge and experience to make an informed decision. It considers the law, ethics and all other factors relevant to the surrounding circumstances. Multiprofessional input ensures balance and there should be senior clinical oversight.

Despite a widely held belief that professional judgement is crucial in identifying the staffing that meets people's needs, staffing decisions based on professional judgement alone are seen as subjective, lacking evidence and potentially influenced by individual preferences. We recommend organisations ensure that professional judgement is valued but objectively reviewed, and the experience, confidence and competence of those involved in making staffing decisions is monitored.

- Use professional judgement and scrutiny to interpret results from evidence-based tools, taking account of the local context and care needs.
- Respect the law and ethical considerations, and exercise professional judgement properly and for valid reasons.
- Draw on theoretical knowledge, experience and skills.

- Use professional judgement and knowledge to inform the skill mix of staff at all levels and real-time decisions about staffing that reflect changes in caseload mix, acuity/dependency and activity.
- Ensure the skill mix between registered and non-registered multidisciplinary staff reflects the likely workload and the skills and competencies required to care for people locally.
- Include environmental factors in decision-making (building layout, rural locations versus town centre, etc).

2.11 Unplanned care/intensive support

Some people using learning disability services may require unplanned, more intensive or extra support. Service development should include contingency planning for this and will involve a flexible, mobile, multi-skilled workforce drawn from across the organisation that can quickly respond to people's often rapidly changing needs.

Commissioners should consider the benefits of increased and more flexible local funding to prevent expensive, inappropriate inpatient or out-of-area residential social care. We recommend arranging a means to immediately access funds to support increased and flexible skilled staffing when it is needed.

We recommend providers collect data on flexible staffing use and cross-reference to workforce planning, staff training and staff rotas to explore predictability and patterns of extra staffing need. This will provide trend data to inform staffing decisions on how to respond to unplanned care needs.

We recommend providers ensure a skilled temporary workforce is available through a 'staffing bank' or other flexible working arrangements, that can respond 24 hours a day, seven days a week and adapt to specialing needs and unplanned variation in acuity and dependency levels – which are likely to vary through the day, for example off-site activity. This will minimise the use of agency staff.

Over-reliance on agency staff is unlikely to be an effective or sustainable solution to ensuring the right skill mix and workforce. Reducing the use of external agency staff by covering temporary vacancies and absences with skilled staff familiar with how the organisation works can save money and vastly improve the quality of the service offered to people with learning disabilities by ensuring they are cared for by skilled staff who are familiar to them. People with learning disabilities tell us they feel safer with staff they know and the evidence indicates that effective teamworking improves outcomes.[5]

Individuals making unplanned staffing decisions based on professional judgement should be backed and guided by senior staff in the management team. In many cases it is helpful to have predetermined arrangements to support rapid decisions to lessen the likelihood of poor decisions being made.

2.12 Learning disability teams

2.12.1 Community learning disability teams

CLDTs are acquiring an increasingly complex caseload as people with learning disabilities move back into local areas from out-of-area long-term placements or are supported more effectively in the community.

Knowledge of this complexity and the skill to deliver care in this context are essential to effectively provide the support and guidance needed by people with learning disabilities, their families and health and social care colleagues.

It is important that these changes are acknowledged in workforce development, review of skill mix, staff training plans and commissioners' expectations. The rising level of need and greater urgency of the needs of some people can affect the team's

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[5] Hughes AM, Gregory ME, Joseph DL et al (2016) Saving lives: a meta-analysis of team training in healthcare. *Journal of Applied Psychology* 101(9):1266–1304.

public health role and its capacity to prevent ill health, improve health outcomes and support people with less demanding or urgent needs in maintaining good health.

Organisations should ensure their staff have the appropriate competencies and skills to meet people's increasingly complex physical health needs.

CLDTs can be provided by interagency services working together to ensure the right staff with the appropriate professional support and networks can deliver effective multidisciplinary services. One example is the mental health learning disabilities community model (MHLD).[6]

In addition, many areas have developed joint protocols between mental health and learning disability services to support people's access to the right assessment and treatment. In such examples, professional staff from mental health services, specialist health services such as allied health professionals (AHPs), community learning disability nurses and social workers share skills, and together solve problems and enhance the person's experience of care.

2.12.2 Liaison roles

Concern continues around the identification of people with learning disabilities when they access acute care services. Unless their needs can be identified, the reasonable adjustments cannot be made. Our focus group of people with learning disabilities highlighted the need for liaison roles in acute settings. They said:

- "When I spent time in hospital recently I felt alone."
- "I want to have my anxieties understood. I do not feel safe if people don't understand me."
- "Not knowing the hospital routine made me feel unsafe."

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[6] Chaplin E, Paschos D, O'Hara J et al (2010) The specialist mental health model and other services in a changing environment. *Research in Developmental Disabilities* 31(2): 458-463.

Evidence shows that in areas with learning disability specialist liaison practitioners, people with learning disabilities are at less risk of significant morbidity and premature death, and their health outcomes improve.[7] Hospitals with a learning disability liaison nurse (LDLN) are better able to identify people with learning disabilities in their service. LDLNs can identify individual needs for reasonable adjustments to services and ensure their implementation. Research in acute settings[8] concluded that on-site LDLNs were better than community-based LDLNs at raising staff awareness, gaining staff trust and increasing the numbers of people with learning disabilities identified in a hospital. Note, for this enabling role to be effective, it has to be supported at senior management level, post-holders need to have sufficient seniority and authority to change patient care pathways, and there needs to be sufficient cover.

The *Five Year Forward View for mental health* also highlights the importance of liaison roles and sets clear targets for these.

Commissioners and workforce planners should consider the importance of providing these posts in a range of services, including primary care, acute physical healthcare, mental healthcare and forensic/prison healthcare.

In 2013 the Royal College of Psychiatry and the Royal College of General Practitioners published their commissioning guide to improving the health and wellbeing of people with learning disabilities: *Improving health and lives* (IHAL).

2.12.3 Intensive support services and community forensic services

Intensive support services are interdisciplinary community-based teams that work with people requiring a level and intensity of intervention much greater than can

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[7] Turner S, Robinson C (2011) *Reasonable adjustments for people with learning disabilities – implications and actions for commissioners and providers of healthcare*. Evidence into practice report no. 3.

[8] Hatton C, Roberts H, Baines S (2011) Reasonable adjustments for people with learning disabilities in England: A national survey of NHS trusts.
www.improvinghealthandlives.org.uk/projects/reasonableadjustments

[8] http://eprints.kingston.ac.uk/27878/1/HSDR_2013_Tuffrey-Wijne_full%20report.pdf

reasonably be expected of the CLDT and who may require support outside normal working hours.

Intensive support services need appropriately skilled practitioners to enable adequate[9] and flexible staffing to support people with learning disabilities at times of crisis or when there is a very high risk of either home or placement breakdown. NHS England predicts from its risk registers that there are currently around 26,000 adults with learning disabilities in the high risk category; these are those most likely to need inpatient care unless appropriate community services are available. To prevent or minimise this, high intensity community-based staff will be needed to meet people's mental health, behavioural and forensic needs.

In some areas CLDTs include intensive support functions. It is important that these do not compromise the CLDT's fundamental public health and preventive roles. Skill mix and numbers need to be considered with both functions in mind.

NHS England has published guidance for commissioners, *Supporting commissioners to develop service specifications for enhanced/intensive support.* This includes recommendations about the nature of appropriate workforce skill mix for enhanced services.

2.12.4 Learning disability specialist inpatient services (including forensic, assessment and treatment, mental health)

When community care is not possible or appropriate, short-term inpatient specialist care or forensic care may be needed. Services should be staffed to meet the expected needs of people requiring inpatient assessment, treatment and interventions. High levels of observation and intensive support are often necessary, plus extra support to communicate effectively and to reduce anxiety and confusion. At times challenging behaviours may require enhanced staffing to ensure safe care.

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[9] 'Adequate' is defined as the number of staff required to deliver the requirements of the service as identified through staffing reviews.

We recommend that providers ensure enhanced support and observation processes include the right checks and balances so the approach used involves minimum restriction.

In *Building the right support*, NHS England predicts the need for a reduction in learning disability bed numbers to about 40 per million population (15 assessment and treatment and 25 secure beds). Staff with appropriate skills will be needed in sufficient numbers to deliver setting-specific services.

NHS England developed guidance from this for commissioners in response to the agenda for transforming healthcare: *Supporting commissioners to develop service specifications to support implementation of the national service model for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.* This includes areas for commissioners to keep in mind when commissioning and measuring the outcomes of service provision.

NHS England has also published model service specifications for commissioners,[10] including for enhanced intensive support, community-based forensic services and acute learning disability inpatient services. These include recommendations on the workforce skill mix.

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[10] www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf

3. Right skills

Decision-makers should give appropriate consideration to the number of staff and skill mix required to deliver high quality learning disability services as effectively as possible within the resources available. Clinical leaders and managers should be appropriately developed and supported to deliver high quality, efficient services that are resilient and sustainable. Staffing should reflect a multiprofessional, holistic team approach. Clinical leaders should use the workforce's competencies to the full, developing and introducing new roles where they identify a need or skills gap.[11]

New models of transformed and integrated care will rely on healthcare professionals providing expert care to more people 'living in the community', alongside families, personal assistants and social care providers. Learning disability services need to respond to the increasing complexity of need. Clinical intervention should always be based on ensuring safety, minimising risks, reducing health inequalities and improving health outcomes within the resources available.

The significant number of highly skilled health professionals approaching retirement age is already affecting retention. The reduction in workforce commissions for education and training and in the number of professional courses available is already affecting recruitment and retention. The number of psychiatrists, nurses and AHPs in training today is expected to fall short of future demand for their services. If this is not addressed there will be a serious deficit of skills in the workplace. Organisations need to take an active role in providing workforce planners and those responsible for education and training with reliable data on service demands and the skills required.

To be sure of having the right skills, an organisation must have a system for evaluating and reporting on:
- an individual's performance, linked to their continuing development
- sufficiency of the levels of supervision and reflective practice

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[11] www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

- a team's capacity and capability to meet the needs of those it serves by using its resources as appropriately, flexibly and efficiently as possible
- the accuracy of demand and capacity planning as services are changed/commissioned.

Additionally the new professional regulatory revalidation requirements aim to encourage a culture of sharing, reflection and improvement while promoting good practice across the professions, as well as strengthening public confidence in both the nursing and midwifery professions.[12]

Competency frameworks and learning needs analysis tools can help with this and with ongoing staff development and organisational capability, as described below.

3.1 Clinical skills

Developing and maintaining the clinical skills of staff in accordance with professional, local and national guidance is essential to ensuring safe services.

Within multidisciplinary teams some activities will be provided across professional groups; for example, basic assessment. Specific activities will also be undertaken by individuals with advanced skills and qualifications. Levels of required clinical expertise will be determined through local skills analysis and caseload need.

3.2 Education and training framework

The learning disabilities core skills education and training framework supports the implementation of the transforming care plan, and contains a learning needs analysis tool. This is a useful guide to looking at skills requirements, from a basic awareness to specialist roles. Various e-learning packages can be accessed from this tool.

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[12] http://revalidation.nmc.org.uk/

3.3   Non-clinical skills

Learning disability services should also consider the non-clinical skills and roles needed to enable providers to collaborate effectively with others in the wider system. For example:

- leadership
- facilitation between people accessing services, their families, carers and other providers
- negotiation
- communication
- strategic thinking
- collaboration
- economic evaluation
- operational workforce planning
- quality monitoring
- data collection, analysis and management
- resource management and allocation
- information technology
- training and enhancing skills of others.

3.4   Quality assurance

Quality assurance mechanisms such as quality checking schemes run by people with learning disabilities are one way employers can actively seek to determine where and how to improve the quality of their service and those working for them.

Staff working in learning disability settings should support skills transfer to carers. They also deliver training to other community providers and have a vital role in prevention and safeguarding. Our focus group of people with learning disabilities endorsed the importance of this:

- "Health plans are good but they are used by staff who do not value the individual."
- "Staff need better training."

- "Safeguarding and knowing information about me is in a safe place.

Quality monitoring should include evaluation of the knowledge, skills and attitudes of staff, to make sure their approach is person-centred and to identify deficiencies in their knowledge or skills. The organisation and individual staff share responsibility for maintaining and developing skills and upholding values.

3.5   Recruitment and retention

Good recruitment strategies are essential to recruiting the right staff with the right skills. Values-based recruitment plays a major part in ensuring the quality of a service as well as safeguarding people from abuse and exploitation. (This was an important theme expressed by our focus group of people with learning disabilities when we asked questions about safety.) Safe staffing levels can in themselves assist recruitment and retention of staff.

Organisations should have retention strategies (with supporting processes), and consider flexible working and different methods of deployment for staff, especially those who wish to work beyond retirement age. The Royal College of Nursing (RCN) and others have identified lack of flexible working opportunities as a key reason for people leaving NHS employment and widening these opportunities is a particularly important consideration for organisations with an ageing workforce.

Shift systems and working hours need to be considered as part of establishment reviews. The RCN guidance *A shift in the right direction* highlights good practice in shift work design and reducing cumulative fatigue.

When managing flexible working, organisations will be compliant with working time regulations.

It is generally acknowledged that there will not be enough learning disability nurses and other professionals with experience of learning disabilities in the future for NHS organisations to employ. NHS organisations must promote this career choice and

closely monitor those entering graduate placements as well as considering alternative routes to qualification. Clear career pathways for professional roles provide a pipeline of succession for key posts in the structure.

As new generations enter the healthcare workforce, expectations of autonomy, flexibility and loyalty will change. Employers need to consider these issues alongside retirement, population and education profiles when planning a capable, sustainable workforce.

The culture of the organisation and the wellbeing of staff is an important factor in ensuring good retention and recruitment: "For the service to deliver world class care to its users, it first needs to ensure its staff are well looked after. We call on the leaders of all NHS organisations to review their own staff survey results in detail and work with staff to identify and enact action plans to improve people's experiences" (Dr Andrew McCulloch, Chief Executive at Picker Institute Europe, 24 February 2015).[13]

The context of care tool (see Appendix 5) considers the factors important to the culture in which teams deliver services.

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[13] www.pickereurope.org/news/picker-institute-europe-responds-nhs-staff-survey-2014/

4.   Right place, right time

Staff should be deployed in ways that ensure people receive the right care, first time, in the right setting to make the best possible use of local resources. This will include effective management and rostering in line with local and national procedural guidance, with clear escalation policies if concerns arise,[14] as well as effective system-level planning.

The literature review (see Appendix 2) suggests that where there is inter-professional and inter-agency working such as joint community teams, collaboration and integration mechanisms need to be clear. Achieving safe and sustainable staffing in learning disability services requires a great deal of co-ordination over a long period. A care co-ordinator must also be a service navigator for the person with learning disabilities, aware of potential pitfalls and service gaps as well as individual vulnerability during transition. Much of the clinical work with people with learning disabilities is delivered where they spend most of their time. This will vary.

Services should be centred on the person. Under the transforming care agenda, most services will be provided where people live in the community. However, some specialist inpatient services will continue to be needed.

Many variations of service models, team structures and provider organisations are involved in delivering community-based learning disability services. Community learning disability provision is multi-agency and inter-professional across adult and children's services, and delivers a wide variety of services through integrated teams managed by local authorities, the NHS, third sector and private sector organisations, and family and carers.

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[14] www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

4.1　Prevention through education role

Staff in NHS-commissioned learning disability services use their expertise and role modelling to teach delivery of person-centred healthcare and interventions. They have a role in ensuring the wider workforce is skilled in this approach. They also provide some scrutiny of whether people's needs are being met. They must understand and invoke adult safeguarding processes where necessary to ensure safe and adequate support. This keeps the focus on prevention and promotion of appropriate early interventions so people can remain living at home and the need for more invasive interventions is minimised.

Capacity should be adequate for this preventative role to minimise avoidable cost of people re-presenting to higher dependency, into more restrictive services.

Capacity should also be sufficient to allow time to meet the accessible information standard (Section 250 of the Health and Social Care Act 2012). Staff interventions take longer than in other specialist areas due to this requirement. Our learning disability focus group highlighted this as important:

- "Doctors and professionals need to give extra time."
- "Talking and explaining things clearly, including changes for me."

## 4.2　Productive working and eliminating waste

4.2.1　Managing productivity in this context

Given the variation in place and provider of learning disability services, providers need to operate at a systems level to create a seamless and person-centred 'flow' across teams. Planning around each part of the pathway must be done in relation to the whole system. People may enter the system at various points and require support over their lifetime across the whole system.

Agreed templates shared between organisations in the pathway will support transitions across boundaries.

Figure 3 shows an example of the flow of people through a complex system with multiple providers. Managing this flow effectively and productively will have a significant impact on a person's experience, clinical outcomes and costs. Poor management of the flow will create inefficiencies, poor experience and less effective clinical outcomes.

Figure 3: Example of how people flow and transfers between teams
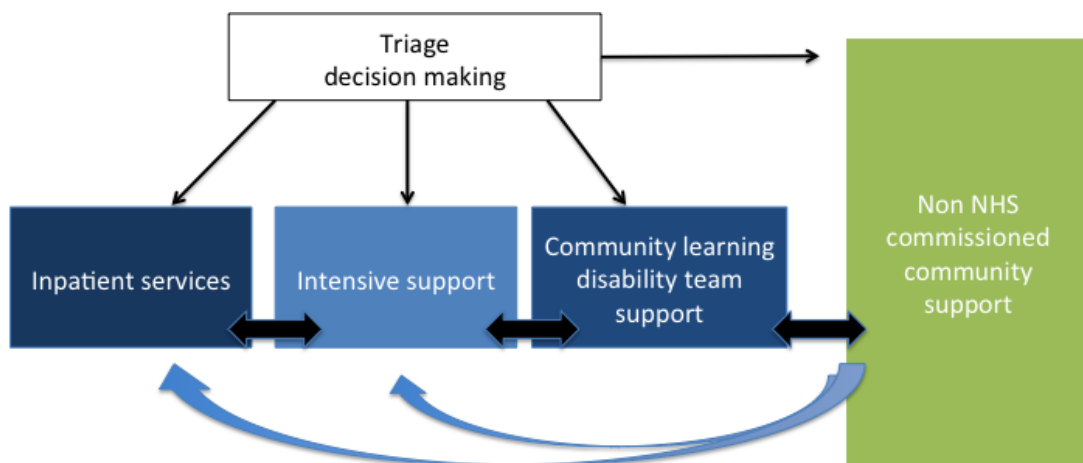
Cost and inefficiency increase when:
- triage is ineffective and people are referred to specialist services inappropriately
- people present back into avoidable NHS-provided services or hospital care
- preventive work is lacking (reducing the capacity of carers and third-sector providers)
- risk assessment is poor or inconsistent throughout the person's journey
- people have to wait for assessment due to lack of specialist staff
- there is ineffective transfer between intensive support teams and the CLDT
- eligibility criteria are incorrectly applied or used in a risk-averse way
- relationships between the intensive support teams and CLDTs are poor
- partnerships are poor, communication inadequate and influencing skills limited in the wider health and social care system to respond to people's needs

- discharge from inpatient services to non-NHS providers is slow

- staff take an inflexible attitude to change in developing and delivering services

- systems and processes impede creative solutions

- medication reviews are infrequent

- inappropriate diagnosis is linked to inappropriate medication

- environment-specific issues increase specialing requirements (for example, poor building design creating dark or restricted visibility areas; layout of single sex accommodation resulting need to share corridors to access bedrooms and bathrooms)

- people themselves and their family or carers are not actively engaged in the design and delivery of care.

Organisations should consider efficiency and how it can be improved as part of the staffing reviews, ideally in parallel with the organisations' operational and strategic planning process. Example improvements may include involving the intensive support team to prevent people presenting back to hospital care, or creating new or redesigned roles to mitigate or lessen inefficiency and costs.

Costs increase and outcomes are adversely affected when reasonable adjustments are not made to mainstream services. The Learning Disabilities Public Health Observatory has identified the importance of reasonable adjustments and suggests they need to be embedded into routine practice.

(The statement in Appendix 9 for acute and other mainstream health services highlights requirements for safe and sustainable staffing to ensure compliance with the Equality Act 2010.)

4.3   Using technology

As staff working with adults with learning disabilities work across multiple agencies there is a need for innovative solutions to joining up IT systems across primary and secondary care, mental health services and social services.

Community services are most efficient when teams are agile and have appropriate technology to minimise travel and administration. Organisations should consider the cost and quality benefits of providing staff with technology that enables better interaction with people during interventions and improves staff safety.[15] Equipment that provides a direct real-time interface – for example, ipads, tablets, video technology and apps – can enable innovative approaches to care.

Recording and real-time information systems that feed back to master systems can show information to other specialists when seeking their help with interpretation, diagnosis, measurement, etc.

Community-based systems can give immediate access to information and resources, cutting down on time spent travelling and improving service user and carer satisfaction.[16] This is in keeping with the NHS England accessible information standard.

Technology can also be used within teams to review staffing levels and redeploy staff based on changes in dependency and remote assessment monitoring.

Innovative technology such as motion sensors in corridors in inpatient facilities can be used to protect people and alert staff when there is a need (rather than having a member of staff always present).

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   www.nhsbsa.nhs.uk/Documents/SecurityManagement/NHS_Lone_Worker_Protection_Service_User_guide.pdf

[16] www.england.nhs.uk/wp-content/uploads/2015/07/access-info-implmntn-guid.pdf

5.   Measure and improve

Organisations are encouraged to monitor safe and sustainable staffing using a combination of staff, person and process data that focuses on safe, effective, caring, responsive and well-led care on a sustainable basis.

5.1   Safe staffing dashboard

Given that NHS trusts provide a range of services and are configured in different ways, we recommend a framework approach to monitoring safe and sustainable staffing rather than a prescriptive model. This also enables organisations to tailor their reporting and assurance process to reflect specialist services. A local quality dashboard for safe and sustainable staffing that includes team-level data should be used to support decision-making and inform assurance. This should be reviewed at least monthly. The framework is outlined as a triangulated approach to improve outcomes informed by data, incidents and feedback. The dimensions outlined are related to staff, people using services and process.

A set of measures that may be helpful to include in a safe staffing dashboard are outlined below and can be localised by providers.

5.2   Measures that matter – safe staffing

Providers of learning disability services should use dashboards or balanced scorecards to ask 'so what' questions (to reflect on what the data is indicating) and the answers to these questions to inform decisions and actions.

Some of the measures outlined below are directly linked to staffing levels (for example, planned leave not going ahead); others are more indirectly associated (for example, length of stay, delayed discharge).

It is important to understand the impact of the combined effect of these indictors. Taken at face value, none of the indicators tells us much about staffing levels and

the quality of care. However, each prompts 'so what?' questions that trust boards and ward or team managers may need to ask – particularly when upward or downward trends are consistent across the suite of metrics.

For example, there is evidence that poor staffing and a significant increased risk of needle stick injuries are related.[17] The review associates these results with excess working hours and overtime, cumulative working hours with no rest days, missing breaks within shifts and short breaks between shifts.

Table 1: Examples of measures that can be monitored as part of staffing reviews and early indicators of concern.

Staff-related indicators	People-related indicators	Process-related indicators
Sickness; staff turnover; bank and agency/locum use	Restraint, physical/restrictive practice Levels of harm	Reporting of incidents; open learning from incidents; open learning from complaints
Clinical supervision; essential learning; staff survey scores	Untreated conditions	Repeat and admission to hospital
Inability to engage in wider agency meetings	Length of stay; readmission rates	Tightening of eligibility criteria
Training uptake	Delays in transfer; occupancy levels	Waiting times
Friends and Family Test (FFT) staff	Planned leave going ahead	Mortality reviews
Staff satisfaction survey (answers to many questions in this can be used)	Physical health presentations Caseload size	Increased use of 'when required' medication
Care hours per patient day	Access to therapy and activities	
HSE stress indicator tool	Medicines incidents	

[17] www.ncbi.nlm.nih.gov/pmc/articles/PMC1447200/)

Staff-related indicators	People-related indicators	Process-related indicators
	Unmet needs, missed care	
	Incidents, complaints	
	Levels of observations on wards	
	People safety metrics	
	Redirection of referrals internally	
	Teams placement breakdown	
	Undiagnosed dysphagia	
	Access to activities	
	Care programme approach compliance	
	Experience data (feedback) (FFT)	
	Safeguarding incidents Unexpected death	

5.3   Designated roles and responsibilities

To ensure board-level staffing reports are consistent with team-level reporting, providers should have a safe staffing framework setting out roles and responsibilities in relation to 'practice area to board-level assurance'. This should include a locally standardised procedure for raising concerns about staffing; reporting exceptions to planned staffing levels; and monitoring actual staffing levels. In particular, the roles and responsibilities of professional leads, team managers, matrons, service managers and directors should be clearly outlined.

5.4   Reporting frameworks

Providers of learning disability services 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 ward or team, and service or locality level. Those in designated roles should have access to a regularly

updated dashboard or balanced scorecard, which gives them a view of the services for which they are responsible. We recommend sharing the dashboard with the multidisciplinary team.

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

- **team or ward level** – provides clinical managers with a local view of staffing levels and indicators at single team or ward level
- **service, locality or network level** – enables clinical leaders and service managers to monitor and systematically deploy staffing resources across multiple sites using a framework, which shows where demand is greatest, or risk is potentially highest; we advise a multidisciplinary approach, and reviews including people with learning disabilities are becoming more popular
- **trust-wide level** – provides boards with a whole-organisation view of staffing levels and indicators.

5.5   Assurance tools

Reporting and monitoring alone will not provide assurance that staffing levels are safe and sustainable, so it is good practice to use a range of mechanisms to cross-check data from dashboards or balanced scorecards. Like the staffing indicators, these mechanisms in isolation tell us little about the safety or effectiveness of care but in combination they form part of a systematic assurance framework. Such assurance mechanisms include:

- **walkabouts** – enable team and ward managers, clinical leaders, service managers and executive directors to cross-check their understanding of the safety of staffing levels in teams or on wards based on dashboard or balanced scorecard views
- **exception reports** – enable clinical leaders, service managers and executive directors to gain assurance that upward or downward trends on dashboards or balanced scorecards are not compromising the safety or quality of care at team, ward, service or network level

- **acuity and skill mix reviews** – enable team or ward managers to continually and systematically review whether people's needs are reflected in ward or team-level establishments
- **person and family/carer feedback** – the engagement and inclusion of the person and their family or carer can be of real value in understanding how the service feels for those accessing it and gaining ideas about potential improvements.

5.6   Shift (or end of the day) questions

Information on effective delivery of services can be reviewed at a local level by asking staff questions at the end of their working day or shift. This is a technique used by Care Point – Care Capacity Demand Management (New Zealand Nurses Organisation). Examples include:

- I was able to complete all care and to a satisfactory standing without undue delay: Y/N.
- If no, was the deficit:
  - inconvenient to people
  - distressing to people
  - putting people at risk
  - resulting in harm to people.
- The degree to which I felt satisfied with what I achieved today was:
  - very dissatisfied, dissatisfied, satisfied, very satisfied.
- The amount of effort I put in to get the work done was:
  - easily manageable, about right, too high, exhausting.
- I was able to take all my breaks full length and on time.
- I came to work early to get my work done.
- I stayed after the end of my shift to get work done.
- One or more people suffered a harm incident today.
- One or more of the people I cared for had an unexpected clinical deterioration on this shift.

Collecting this data regularly allows providers to keep track of trends, monitor quality of outcomes and determine the benefits from improvement actions. The data should inform the staffing reviews.

6.   Working group members

Alison Bussey	Director of Nursing and Operations	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Professor Oliver Shanley	Executive Director of Quality and Safety	Hertfordshire Partnership University NHS Foundation Trust
Lindsey Holman	Project Manager	
Bob Gates	Academic representative	Professor of Learning Disabilities, University of West London
Ann Norman	RCN Advisor Criminal Justice Nursing/Learning Disability Nursing	
Dr Julie Hall	Executive Director of Nursing	Nottinghamshire Healthcare NHS Foundation Trust
Judith Reep	Consultant AHP	Guy's and St Thomas' NHS Foundation Trust
Helen Rae	Lead Allied Health Professional	Coventry and Warwickshire Partnership Trust
Dr Tim Devanney	Workforce specialist	Health Education England
Rachael Garvey	Lead Nurse	Birmingham Community Healthcare Foundation Trust
Dr Judith Samuel	Consultant Allied Health Professional	BPS Chair
Michele Bering	Nurse Consultant	Cheshire and Wirral Partnership NHS Foundation Trust
Gwen Moulster	Clinical Director/Consultant Nurse	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Ashok Roy	Consultant Psychiatrist	Coventry and Warwickshire Partnership Trust Royal College of Psychiatrists Health Education England
Jean O'Hara	Clinical Director and Consultant Psychiatrist	South London and Maudsley NHS Foundation Trust

		NHS England
Keith Loveman	Executive Director of Finance	Hertfordshire Partnership University NHS Foundation Trust
Dean Howells	Executive Director of Nursing & Quality	St Andrew's Healthcare
Bijil Simon	Consultant Psychiatrist and Committee Member	Royal College Psychiatry
Daphne Turner	CNO BME representative Specialist Community Nurse MOSAIC CAMHS	Tavistock and Portman NHS Foundation Trust
Julie Shepherd	Director of Nursing, AHPs and Quality	North East London NHS Foundation Trust

7. Stakeholders consulted

- LD Professional Senate
- Focus Group Service Users and Supporters Facilitated by BILD
- Providers and Professional Representatives at an Engagement Event
- Multidisciplinary Twitter Chat
- Health Education England
- NHS England
- Department of Health & Social Care
- NHS Improvement LD Lead
- Royal Colleges (through the steering group membership)
- Unison
- Mental Health and Learning Disability Nurse Leads Forum
- CQC representatives
- Finance Representatives
- College of Occupational therapists Specialist Section People with Learning disabilities
- HALD. Special Interest group of professionals working with people with hearing and Learning disabilities

8. 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 NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Merseycare NHS Foundation Trust
- Unite the union
- Betsi Cadwaladr University Health Board
- Tees, Esk and Wear Valleys 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 Foundation Trust
- The Priory Group
- Leicestershire Partnership NHS Trust

Other organisations to thank

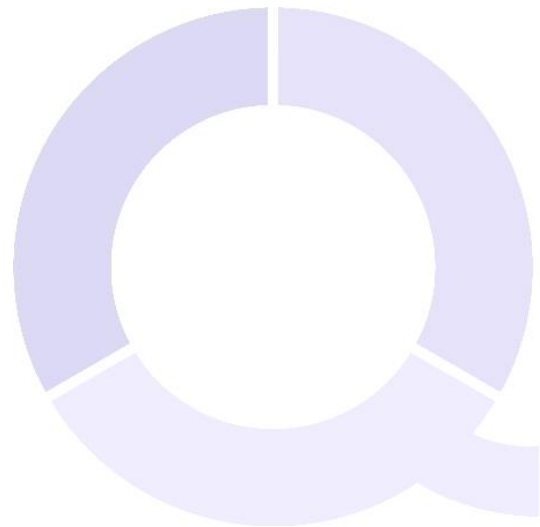- University of West London – Review of literature

- British Institute of Learning Disabilities – Service User Engagement Facilitation

Twitterchat – Wecommunities

Minimum of 55 people on the chat 15 November 2016

(Finance, commissioners, AHPs, mental health nurses, learning disability nurses, workforce specialists)