National Quality Board

Edition 1, January 2018

Safe, sustainable and productive staffing

An improvement resource for mental health

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

The NQB provides coordinated 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 Care

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

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Summary

The National Quality Board (NQB) in its July 2016 publication *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* outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to improve health outcomes. It ensures delivery of safe, effective, caring, responsive and well-led care on a sustainable basis, and that organisations employ the right staff with the right skills in the right place and at the right time.

This improvement resource makes specific reference to adopting these expectations in mental health services, recognising the nuances that exist in this provision. The content has been developed by a reference group of sector leaders and was informed by a review of literature, in consultation with service users and carers. It aims to provide quality and consistency through the recommendations for board accountability and expectations of clinical leaders at service and team levels.

Example dashboard templates to monitor safe, sustainable and productive staffing, and escalation processes have been included, as well as an outline of a strategic staffing review. This resource also lists documents relevant to safe, sustainable and productive staffing in mental health services.

While this improvement resource focuses on the expectations of provider organisations, it also supports commissioners in developing their own assurance framework. Furthermore, the standards and tools given in this resource inform the staffing aspects of effective commissioning of future mental health services and pathways.

Boards are accountable for ensuring safe, sustainable and productive staffing and a comprehensive staffing review must be provided annually to them. A summary of the key issues to consider in the delivery of safe, sustainable and productive staffing is outlined below.

Recommendations

The board will seek assurance that:

Right staff
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 contextual factors which affect safe delivery of services.
The annually agreed uplift (headroom) percentage reflects organisational needs, is practical and is achieved.
Clinical leaders and managers have allocated sufficient time to supervise and lead effectively.
The annual review of safe sustainable staffing references benchmarking data available to the organisation (both internal and external).
Right skills
Processes are in place to identify, analyse and implement evidence-based practice across services.
Where new care models are developed, a clear plan exists for organisational development support to enable such change to take place safely and affordably and these plans are evaluated (see the national leadership framework for system leadership competencies *Developing people – improving care*).
An evidence-based approach in the organisation supports effective team working.
Systems and processes are in place to promote staff wellbeing and prevent fatigue and burnout.
The organisation has a clear strategy for staff retention, which clearly states learning and development opportunities for all staff groups, and plans for attracting, recruiting and retaining staff that are aligned with the workforce plan.

Right place and time
Standard approaches across services identify and prevent unwarranted clinical variation in service provision.
Technology is available to staff to allow them 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 the use of 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).

Clinical leaders have a critical role to play in the delivery of the NQB expectations.

Expectations of clinical and managerial leaders:

Right staff
Use professional judgement, local quality dashboard data and evidence-based workforce tools (see Appendix 2) when deploying staff.
Ensure the team has plans to use the workforce flexibly to respond to temporary, unknown and unplanned variations in service need.
Regularly review the quality metrics and budget statements with a line manager to understand how unplanned need impacts 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 the involvement/employment of people with lived experience 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 (in line with the evidence base for effective team working).
Support clinical staff to embed and evaluate quality improvements and innovations to improve service delivery.
Acknowledge and celebrate team members' achievements.
Be aware of and respond to indicators of reduced staff resilience and increased stress.
Ensure access to and uptake of supervision and reflective practice, and check that they are facilitated and monitored.
Involve experts by experience in the selection of staff.
Right place and time
Review local systems and processes to ensure they are lean and responsive to the needs of people who use mental health services.
Identify and prevent 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 and national procedural guidance.
Ensure bank and agency staff have the 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.
Ensure enhanced observations have the right checks and balances to ensure the resource being used is appropriate and efficiently and effectively deployed with minimum restriction for the service user.

We recommend further research into safe and sustainable staffing in mental health settings linked to outcomes.

1. Introduction

We developed this resource for community and inpatient mental health services across all specialties and for people of all ages. It takes a multiprofessional approach, recognising the importance of all members of 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 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 (NQB) 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

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

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 staffing levels and taking action if these fall short of what is required to meet people's care 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 a commissioned programme of empirical research on mental health staffing in multidisciplinary settings, particularly on linking staffing requirements to outcomes for people with mental ill health. Priority areas include:

- impact of skill mix and staffing in the multidisciplinary team on service user outcomes
- system-level longitudinal studies (changes to staffing and the impacts of other settings)
- research into the validity and reliability of dependency tools
- research into the applicability of dependency tools as deployment aids.

[1] NQB (2016) *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*.

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

We involved service users and carers in the development of this resource, 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 is intended to help commissioners develop their own assurance framework for safe and sustainable staffing. The 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.

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 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*, and to the other setting-specific guides in this series, particularly those for learning disability, community (district nursing) and children and young people.

This work aligns with *Leading change, adding value: a framework for nursing, midwifery and care staff* (NHS England 2016), which outlines the triple aim of achieving measures of better outcomes, better experiences and better use of resources. Users of this resource will also need to consider any specific guidance that may apply to specialised services, professional groups and service user groups – for example, AIMS accreditation or QNIC guidance which includes staffing requirements in CAMHS from the Royal College of Psychiatrists. Unions and professional bodies are also useful sources of support for this work.

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 staff.[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. Not restricting access to meaningful occupations/activities should be considered for service users as they may find these motivating at a time of acute distress.

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 may use the Deprivation of liberty safeguards or Mental Health Act (as amended 2007) to compulsorily treat those who pose a risk to

[3] NHS Benchmarking Network, 2016 report.

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.

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 as discussed later in this resource.

[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*.

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." **– A quote 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 with 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

[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.

same data shows the turnover rate reduced slightly from 13% in 2015 to 12% in 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. This is a wider issue than nursing. For example, an investigation into the occupational therapy workforce in London in December 2016[6] identified a 14.9% vacancy rate for mental health occupational therapy posts in London and concluded this was in part the result of removing the occupation from the priority immigration list.

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

When planning for a sustainable workforce for the future, organisations should consider the changing trends in people's career choices. Career expectations, motivations and choices differ between generations, as outlined in HEE's *Mind the gap: Exploring the needs of early career nurses and midwives in the workforce*. An age profiling tool available from NHS Employers can help organisations support individuals working beyond retirement age. There are opportunities to bring retired professionals back into the workforce in roles different from the ones they retired from.

[6] An investigation into the occupational therapy workforce in London, December 2016. London South Bank University, HEE and COT.

Indicative best practice supports the broader development of workforce planning

When undertaking staffing reviews for both inpatient and community mental health services, 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 vary, enabling effective response to unplanned care
- you use a range of quality measures to inform and monitor your plan
- you evaluate identified measures and changes made in terms of their impact on quality of care. This will include ensuring that service demands are considered and can be delivered – for example, caseload and complexity of need.

Headroom (uplift) considerations

Workforce plans should include a ‘headroom’ uplift allocation for inpatient and community-based services. This is defined as the additional allocation/budget required to cover leave and regular activities that reduce time to care. The board needs to review and agree this at least annually so it reflects the organisation’s needs, is deliverable and takes account of:

- annual leave

- study leave (including mandatory training)
- maternity and parenting leave
- sickness and absence/carers and compassionate leave
- clinical supervision according to organisational policy (NB: this should be evaluated for quality)
- continuing professional development
- professional revalidation
- leadership capacity
- shift patterns.

In establishment setting, other time commitment factors should be considered:

- staff appraisal
- additional duties – for example, reservists, union duties.

It is important that the level of uplift is realistic and reviewed at least annually.

Team leaders have a key leadership role and 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 – for example, supernumerary status for ward managers and team leaders.

The key components of establishment reviews are:

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

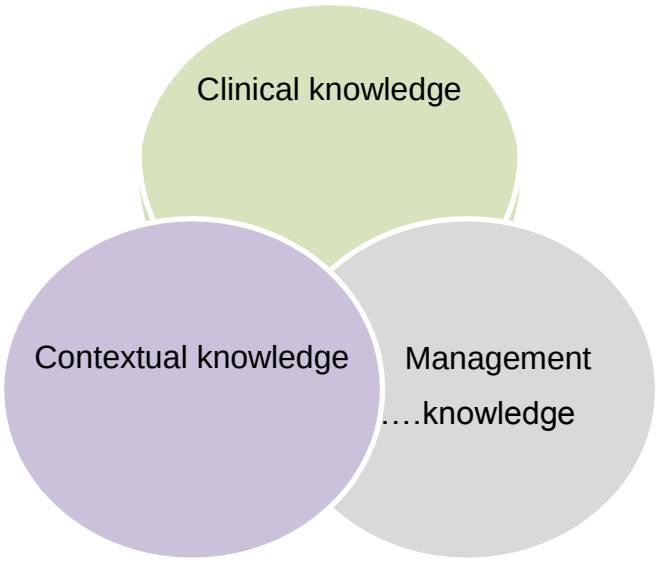
Professional judgement in reviewing establishments

Professional judgement is the use of accumulated knowledge and experience to make an informed decision, and is an integral part of making safe decisions on staffing. 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: Components of professional judgement



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

- therapeutic environment and space for meaningful activities and therapeutic time
- 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 dependency, acuity and gender mix of service users
- 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 not completed[7]). While flexible rostering should be considered when introducing shift patterns, organisations must consider potential impact on safety and quality, and monitor to ensure effective mitigation measures are put in place
- staff group's competence, capability and experience, including numbers on preceptorship, trainees and students, age range, physical health restrictions
- impact of temporary staffing (bank and agency) on consistency (and familiarity with the service users).

Professional judgement requires and involves the capacity to process this combination of information and make balanced, ethical and justifiable decisions.

Comparing staffing with peers

Organisations should use internal and external peer review 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 the published literature. While some caution is needed, comparison of staffing with peers can act as a 'sense check', particularly for assumptions and professional judgments, and help to share good practice.

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[7] http://journals.lww.com/lww-medicalcare/Fulltext/2014/11000/NursesShift_Length_and_Overtime_Working_in_12.7.aspx

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 2018) 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 lists expectations of boards and team leaders for getting the 'right staff'.

Table 1: Right staff – board assurance and accountability

The board will seek assurance that:
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 contextual factors which affect safe delivery of services.
4. The annually agreed uplift (headroom) percentage reflects organisational needs, is practical and is achieved.
5. Clinical leaders and managers have allocated sufficient time to supervise and lead effectively.
6. The annual review of safe sustainable staffing references benchmarking data available to the organisation (both internal and external).

Expectations of clinical and managerial leaders:

1. Use professional judgement, local quality dashboard data and evidence-based workforce tools (see Appendix 2) when deploying staff.
2. Ensure the team has plans to use the workforce flexibly to respond to temporary, unknown and unplanned variations in service need.
3. Regularly review the quality metrics and budget statements with a line manager to understand how unplanned need impacts sustainable, safe, effective, caring, responsive and well-led care.
4. Consider how the team reflects and responds to the diversity of the people who use its service.
5. Consider the involvement/employment of people with lived experience 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." – **A quote from the service user engagement process highlighting the key skills that make users feel safe and cared for.**

To use the workforce efficiently and effectively, you need to identify the necessary skills 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 (that is, 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
- 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 for specific roles and settings should be analysed 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, care co-ordinator roles, and crisis assessment and recovery.

Where there is a proposal to introduce new roles, the board must be satisfied (through the staffing report) that the individuals in these roles have the appropriate level of assessed skills, competence and values to maintain or improve outcomes.

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 literature review summary 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 multiprofessional teams have the time to undertake mandatory training and continuing professional development.

Organisations 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 and 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.[8] Teams with clear objectives are associated with higher levels of staff and patient satisfaction.[9]

[8] 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, pp. 331–372.
[9] 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.

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. Flexible working options may suit staff and are important in their retention. Options include:

- part-time working
- compressed hours
- flexi time
- annualised hours
- term-time contracts
- flexible retirement schemes.

NHS Employers guidance should be followed in developing opportunities for flexible working.

Targeted recruitment campaigns should consider the training requirements associated with ensuring competence. Such campaigns may include return to practice and overseas recruitment.

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.[10]

Organisational culture influences turnover rates and staff satisfaction and wellbeing. Organisations should monitor their employee feedback and develop a culture where staff are treated with dignity and respect, have a work–life balance, and are in well-designed jobs with development opportunities to ensure a safe

[10] www.leadershipacademy.nhs.uk/programmes/the-ready-now-programme

environment for patients.[11] Staffing levels will influence employee satisfaction and wellbeing.

Organisations should focus on staff, encouraging their workforce to be emotionally resilient, compassionate and person-centred at all times. In their provision of occupational health services, organisations should ensure sufficient provision for mental wellbeing.[12]

Table 2 below lists the expectations of boards and service leaders in ensuring availability of the right skills.

[11] RCN Healthy workplace, healthy you campaign www.rcn.org.uk/get-involved/campaigns
[12] www.nice.org.uk/guidance/ng13

Table 2: Right skills – board assurance and accountability

The board will seek assurance that:
1. Processes are in place to identify, analyse and implement evidence-based practice across services. 2. Where new care models are developed, a clear plan exists for organisational development support to enable such change to take place safely and affordably and these plans are evaluated (see the national leadership framework for system leadership competencies *Developing people – improving care*). 3. An evidence-based approach in the organisation supports effective team working. 4. Systems and processes are in place to promote staff wellbeing and prevent fatigue and burnout. 5. The organisation has a clear strategy for staff retention, which clearly states learning and development opportunities for all staff groups, and plans for attracting, recruiting and retaining staff that are aligned with the workforce plan
Expectations of clinical and managerial leaders:
1. 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. 2. Develop the team using clear objectives and outcomes agreed by the multidisciplinary team (in line with the evidence base for effective team working). 3. Support clinical staff to embed and evaluate quality improvements and innovations to improve service delivery. 4. Acknowledge and celebrate team members' achievements. 5. Be aware of and respond to indicators of reduced staff resilience and increased stress. 6. Ensure access to and uptake of supervision and reflective practice, and check that they are facilitated and monitored. 7. Involve experts by experience in the selection of staff.

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." – **A quote from the service user engagement process.**

Efficiency is integral to quality improvement. It is not only about how the available resource is deployed, but also about ensuring the right model of care is in place so the right care and treatment are 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.[13]

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, 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. Unwarranted variation can be a sign of waste, missed opportunity and poor quality, and can adversely affect outcomes, experience and resources (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

[13] 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.

review) recommends the use of electronic rostering (e-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 in the Carter team's *Good practice guide: Rostering*.

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.[14] 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 measure to count the mental health clinical workforce.

4.3. Observation

High staffing costs in mental health services can arise from high observation[15] levels. Evidence about what is appropriate is lacking and there is no national policy.

[14] Foster C, Bowers L, Nijman H (2007) Aggressive behaviour on acute psychiatric wards: prevalence, severity and management. *J Adv Nursing* 58(2):140–149.
[15] www.kcl.ac.uk/ioppn/depts/hspr/research/ciemh/mhn/projects/litreview/LitRevSpecObs.pdf

Organisations should ensure that staff have the appropriate skills and competence to engage with service users when undertaking observation. They should be 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. Organisations should review levels of concern and include clear reporting steps for teams to confidently escalate concerns.

Appendix 5 shows 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 health services should have a good experience if organisations ensure availability of staff and continuity in relationships.

Table 3 below summarises expectations for boards and team leaders to deliver against right place, right time expectations.

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

The board will seek assurance that:
1. Standard approaches across services identify and prevent unwarranted clinical variation in service provision. 2. Technology is available to allow 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 the use of 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:
1. Review local systems and processes to ensure they are lean and responsive to the needs of people who use mental health services. 2. Identify and prevent unwarranted variations in care and treatment and implement plans to eliminate them. 3. When planning staffing and caseloads, consider (and plan to minimise) community teams' travel time. 4. Review the use of technology to ensure it enables staff to work remotely, efficiently and safely. 5. Ensure staff rosters are used in line with local and national procedural guidance. 6. Ensure bank and agency staff have the appropriate clinical skills to meet the needs of people who use mental health services. 7. Ensure bank and agency staff receive an effective local induction. 8. Identify over-dependence on bank and agency staffing and reduce it. 9. Ensure enhanced observations have the right checks and balances to ensure the resource being used is appropriate and efficiently and effectively deployed with minimum restriction for 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.” – **A quote from the service user engagement process.**

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 and publish this at least monthly and report to the board regularly. 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 below in combination with NQB guidance.

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[16] (and other staff incidents); job satisfaction; burnout; missed breaks; overtime; actual expenditure against planned expenditure; CHPPD; 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, missed care. 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-reported outcomes measures; patient experience measures; falls; increased use of 'when required' medication; self-harm; unexpected death.
Potential process-related indicators	Complaints and compliments; DNA rates; waiting times; level of reporting of incidents; readmission rates; length of stay; delays in transfer; delayed discharge; occupancy levels; medication errors.

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

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. Incidents can involve several organisations; therefore robust information sharing arrangements must be agreed and in place.

The NQB guidance states “Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and serious incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers’ safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (http://www.sciencedirect.com/science/article/pii/S0965206X15000935) and case note review and the FallSafe under-reporting survey (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) for inpatient falls.”

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.

Organisations should ensure that staff, including students and junior doctors on placement, feel confident to raise concerns and are treated fairly. Concerns raised formally are considered and actioned as appropriate. They should also consider empowering service users and carers to report issues and incidents.

Appendix 3 includes references on developing a safety culture.

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. You should 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 co-production, 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?” – **A quote from the service user engagement process.**

6.1. Strategic staffing reviews

NQB expects boards to receive an annual strategic staffing review, or more frequently in the context of significant service change, 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 the Summary 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. This should be included 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:

- **team or ward level** – this provides clinical managers with a local view of staffing levels and indicators at single team or ward level
- **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 consideration of including a service user perspective
- **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. Working group members (including any declaration of interest)

Ray Walker	Chair of the working group Director of Nursing	Mersey Care NHS Foundation Trust
Kenny Laing	Deputy Chair of the working group Deputy Director of Nursing	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Lindsey Holman	Project Manager	
Tim McDougall	Deputy Director of Nursing	Greater Manchester Mental Health NHS Foundation Trust
Helena McCourt	Deputy Director of Nursing	Mersey Care NHS Foundation Trust
Jane Stone	Group Director of Nursing	Priory Group
Ian Hulatt	Professional Lead Mental Health	Royal College of Nursing
Professor Alan Simpson	Professor of Collaborative Mental Health Nursing	City, University of London
Professor John Baker	Professor of Mental Health Nursing Non-Executive Director	University of Leeds Leeds and York NHS Partnership NHS Foundation Trust
Steve Barrow	Deputy Director of Finance	Warrington and Halton Hospitals NHS Foundation Trust
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 of Quality and Safety	Hertfordshire Partnership University NHS Foundation Trust

Jamie Soden	Deputy Director Nursing	Coventry and Warwickshire Partnership NHS Trust
Amanda Pithouse	Deputy Director Nursing	South London and Maudsley NHS Foundation Trust
Emma Corlett	Mental Health Professional	UNISON representative
Shirley Baah-Mensah	Chief Nursing Officer, Black Minority Ethnic Strategic Advisor Operational Service Lead	North East London NHS Foundation Trust
Dr Maya Roberts	Member of the Royal College Psychiatrists Sustainability Committee	Royal College Psychiatrists

8. Stakeholder engagement

- Focus group of service users and carers facilitated by Liverpool John Moores University
- Providers and professional representatives at engagement events
- Multidisciplinary twitter chat
- Health Education England
- NHS England
- Department of Health & Social Care
- 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
- Royal College
- Service User and Carer Group Advising on Research (SUGAR), City, University of London
- HR Network
- Chief Executive Network
- British Psychological Society (BPS)

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
- Mersey Care 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

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