Skill Mix Review Inpatient Mental Health Settings and Neighbourhoods
Update July 2017

1. Introduction

The January 2017 the Skill Mix review document submitted to the Quality Committee identified the need, in line with the National Quality Board (NQB) document 'Safe Sustainable and Productive Staffing', to have the right staff with the right skills in the right place at the right time across the mental health services provided by the Trust.

This document will provide the 6 monthly update the committee on the current situation regarding staffing across the campus and neighbourhood services, progress on the recommendations made in the January document and propose further areas for change and growth. It forms part of the ongoing cyclical review of mental health Safer Staffing within the organisation.

2. Background

Poor staffing levels and clinical skill deficits in staff lead to adverse outcomes and poor care experiences. This information is not new and we need to establish ongoing data review of relevant metrics around skill mix to track the impact on the whole care pathway and patient experience. The Trust Safer Staffing and skill mix information has been reported in different styles, with varying degrees of narrative reviews and quantitative data analysis. It is important to establish a content model for reporting and reviewing so that comparisons can be made easily and to allow for early trend identification.

This document will provide a mixture of narrative update with some data provision to support this, with a proposal for an ongoing structure to allow for direct six monthly comparisons of the staffing skill mix and safer staffing positions across neighbourhood and campus services.

Whilst NHSE recommends the use of evidence based tools to calculate staffing requirements, the current national recruitment situation requires greater flexibility and creative thinking around clinical staffing solutions. As an organisation we also need

to think about how we approach succession planning, retirement of some of our most skilled and experienced clinical staff, promote talent management and develop emergent leaders to secure our future high quality workforce and support them to work at the top of their license. These topics have been explored in the Trust Workforce Strategy and Plan 2017 – 2022 and this document aims to look at the progress and challenges identified during the application of skill mix issues and safe staffing challenges.

Campus Services

Right Staff

There continues to be a national shortage of nurses as identified in the January paper. As an organisation we have struggled to recruit registered mental health nurses (RMNs) despite assertive recruitment both at home and overseas. It is widely recognised that the post Brexit referendum era of recruitment has had a significant current and predicted impact on staff coming from the EU with news agencies reporting that there has been a 96% reduction in EU nurses. (The Guardian, 2017)

The introduction and ongoing use of e-rostering has meant that prediction of staffing concerns can be highlighted earlier and mitigated against. There have been issues in maintaining safe staffing levels in both the Radbourne and Hartington sites over the summer months, but early identification of this issue, systematic planning and collaborative working across service lines has enabled the services to continue to function safely and respond to increasing acuity levels.

Ensuring adequate staffing has meant ongoing use of bank staff and substantive staff taking on additional shifts, which in turn has led to issues with following process around the Working Time Directive. Work is underway to ensure compliance with requirements around this and to support staff wellbeing and patient safety.

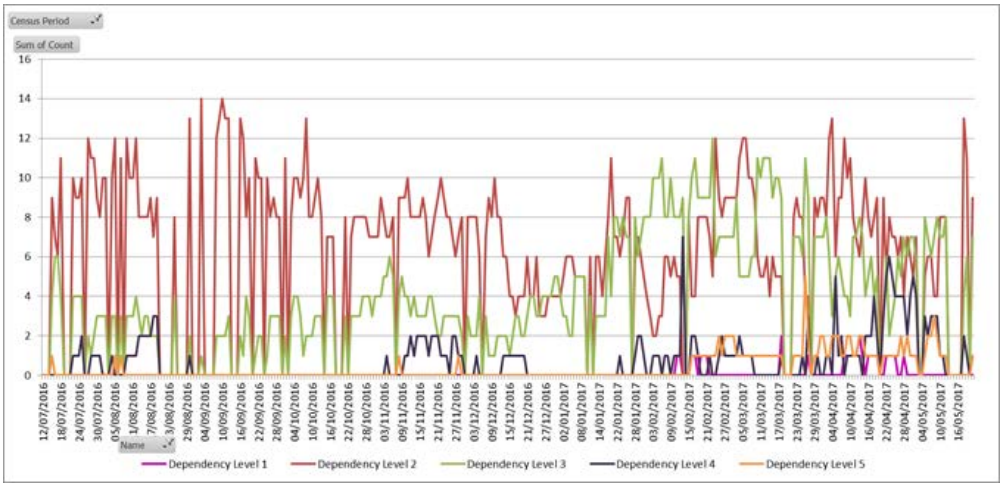


Fig 1. Example of increasing Acuity trend - Ward 1 London road

As part of a longer term resolution to the campus staffing difficulties, we have also reviewed if staff can reasonably be recruited from other professions and have projects ongoing to recruit occupational therapists (OTs) and medicine optimisation technicians (MOTs).

In addition, we have looked the grade of staff we are employing and filled posts with higher grade staff where this has meant that we can recruit with the correct skill set. We are continuing to explore the role of advanced clinical practitioner.

Right Skills

We need to consider the overall patient care pathway given that there will be a change to the Campus skill mix over the next year as we recruit from non-nursing disciplines. Clinicians with core skills in certain areas will need to focus on particular parts of the campus care pathway to ensure patient safety, clinical quality and adherence to professional standards. Meaningful activity whilst admitted, facilitating timely discharges and patient flow issues due the retraction of social care services and alterations to their threshold criteria are key concerns along the care pathway. By re-examining the skill mix across the campus services we can systematically plan to address these concerns.

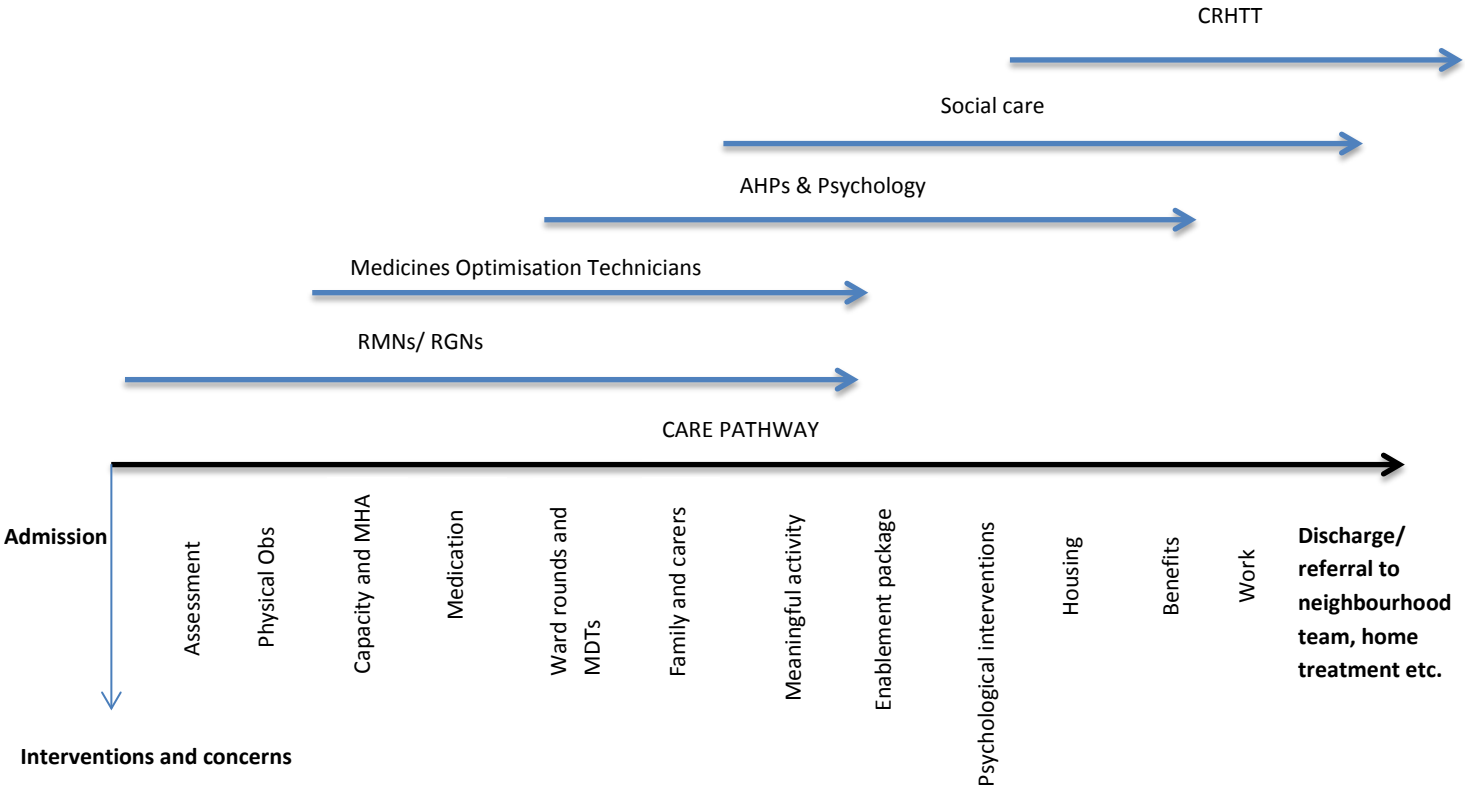


Fig 2. Campus care pathway and interventions

In order to establish and ensure proficiency, we will be holding sessions with existing campus staff to review and identify where the skills can be most usefully employed and what training is required to achieve safe and stable campus environments.

The role of the advanced clinical practitioner (ACP) is also being explored to support robust clinical practice and provide clinical leadership and career structure within specific clinical settings across the organisation. These roles, in the correct situations, will also support gaps in medical cover.

Staff across all campus services now have access to Paris and are fully trained and are in the process of embedding electronic recording into their practice. Staff have embraced the implementation and, whilst there are low level issues and concerns, the staff continue to have the ongoing support of the Clinical Lead for the Full Service Record (FSR) Project for support. Issues are reviewed on a fortnightly basis at the FSR clinical reference group to ensure rapid solutions and responses. This is a significant patient safety and quality improvement that is already showing significant benefits. However, we need to maintain oversight of the impact of

implementation on clinical time and interventions and be mindful of resolving issues as soon as possible to limit the effects on face to face contact time.

Right place and time

The committee will be aware that there is currently no standardised method to determine safe staffing levels in inpatient mental health settings. Staffing levels are set dependent on the clinical need presented by each shift. The trust has opted not to use the Hurst tool to base its staffing numbers on, but to allow staff the autonomy to assess clinical need as required, to ensure safe practice and support for clinicians. Staff achieve this by triangulating professional judgement local knowledge of staffing requirements and identified out comes for patients.

Fig 3 Staffing needs

Staffing numbers and levels of cover are reviewed by the Area Service Managers (ASMs) for the campus services on a daily basis to ensure that staffing levels enable safe care to be provided. It continues to be recognised that there is no single evidence based formula or ratio that will accurately calculate requirements and sites have generally worked on a care hours: staff hours formula. By introducing a standardised structure for reporting on the Skill Mix review this will allow for the analysis of the existing metrics over time and give an additional layer of assurance around the topic.

Work has also been undertaken around shift alignment. An investigation into the inequity of shift times has been completed and recommended the alignment of shifts cross the organisation into an agreed time schedule. This shift alignment has now

been approved by the Director of Nursing and Quality and its introduction across services improves the well-being of staff through the introduction of breaks, will ensure that shift patterns across all inpatient services are equitable and is supportive of the working time directive.

Neighbourhood Services

Neighbourhood services are under considerable strain at the moment with demand over a 12 month period increasing by 16% in the period 2016/17. Caseloads exceed the national guidance by an average of 18% with the average care coordinator caseload size being 48.9 per wte.

This shortfall has been communicated to commissioners and they have acknowledged the concerns but have not funded additional resource to close the gap further to the posts agreed in 2015/16.

In March 2017 a paper was submitted to the Trust board outlining the concerns around the neighbourhood services and identifying the ongoing risks and pressures. These included increasing waiting lists for care coordination, difficulties in manging transitions from Early Intervention and CAMHS services, the impact on patient flow between services, concerns regarding the impact of the STP proposals acuity levels. All these issues impact on and are impacted by skills mix and staffing levels.

Right Staff

Recruitment and retention in stressed services is difficult and further exacerbates the existing issues. However, recent recruitment rounds in neighbourhoods have been successful and staffing numbers have risen. The ‘let’s try again’ model of recruitment has also proved successful where good candidates that have struggled at interview have been given support and structured feedback and then offered a second opportunity for interview.

However, it has continually proved difficult to recruit band 5 nurses so the skill mix has been reviewed and reconfigured to take on band 6 staff. This solution is helpful

in meeting clinical demand but limits the career progression and structure in the longer term.

Teams have benefited from the temporary use of agency social workers and have identified that this would be a useful addition to the team skill mix at some point. This issue was also identified in the paper in January 2017 along with the issues of professional development and support for Social workers that the trust cannot currently meet. The situation remains the same and work needs to be undertaken to see if this option to add social workers to the neighbourhood skill mix can be resolved.

Support staff contribute a significant proportion of the face to face contacts within neighbourhood services and could form part of the solution to the capacity difficulties experienced in the teams. The tasks that can be undertaken by support staff are reflected by their banding and an options appraisal of employing specialist non registered staff to carry out specific tasks such as physical health monitoring needs consideration.

We also need to review our commitment to the use of peer supporters and volunteers, as, if we are to truly become a Recovery focused organisation, we need to commit to the employment and support of people with lived experience as part of our workforce. The benefits of having peer supporters have been recognised in the Five Year Plan for Mental Health' (Mental Health Taskforce to the NHS in England, (2016). Where our services have a more recovery focussed culture, they have reconfigured posts from one profession to another to support their recovery activities.

Right Skills

Recovery – staff need to be comfortable in their understanding of what it means to be a recovery focussed organisation. Our job descriptions and recruitment process need to reflect this and we need to clearly demonstrate the value of lived experience within our workforce. Our staff need to be supported to understand and embed Recovery principles in their practice and be trained in relevant evidenced based practice.

Behavioural activation – this is a formal therapy for depression that focuses on activity scheduling. It encourages patients to approach activities that they are avoiding and refocus their goals. Basic training would assist in formalised intervention planning.

Re-ablement, Vocation and self-management - we need to shift the focus of our intervention from containment and monitoring to those of re-ablement, vocation and self-management. We need to be confident that staff have the skill set to approach this shift in practice.

Non-medical prescriber (NMP) – the role of the NMP is one that can support practice and release capacity, particularly medical capacity. There are pilot projects underway in teams and, following review, the roll out and expansion of NMP practice should be developed. There are also roles for different AHPs to undertake this training and this useful of this needs quantifying.

Psychological therapies - the demand for psychological therapies continues to outstrip the capacity for provision. A review of this has been reported separately, but there is an additional issue in that we need to skill up neighbourhood staff to enable them to provide evidenced based interventions which are often psychological in nature and in addition to the existing psychology provision. There is also a pattern of supporting staff to attend additional training only for them to leave for higher banded posts in neighbouring organisations. Teams and service receivers do not see the benefit of the training investment. We need to review how this is addressed as we could make it a stipulation of the training that staff remain with the team hosting the training for 12- 24 months post-graduation. Alternatively or in addition, we need to review the skill mix of the teams to identify if there is capacity through re-engineering of posts to create posts at a higher band for higher qualified clinicians.

Physical health and well-being monitoring – the physical health care monitoring of people within the neighbourhood teams is not consistent. Staff need to have the skills and confidence to complete this work and this should be reviewed. Work also needs to be done to ensure the collaboration with primary care around this.

Work flow – workflow skills are essential to enabling a team to work well and safely. We do not routinely train managers in these skills and this need review. Suitable training would form part of the quality activities of the organisation and support staff well-being.

Management Skills – A proportion of the neighbourhood team managers are in interim posts. Whilst there is recruitment under way to resolve this, we need to ensure that there is formal coaching and mentoring available to these staff in addition to the support they are being given through their line management structures. The band 7 role is also under review to clarify the key responsibilities around managerial responsibilities and clinical leadership.

Right place and time

Neighbourhood review – the changes to the structures within neighbourhood services are being reviewed to determine what the next steps should be. There have been advantages to co-locating teams but the ongoing collaboration of services and longer term benefits need definition and review. The role of the neighbourhood service manager also needs clarification with specific recognition of the clinical leadership element of their duties.

Workflow management – Considerable work has been done to quantify and mitigate the flow of work through neighbourhood teams. By investing in training for staff to better manage the workflow through services we can ensure that the resources that we have are placed at the best points of the care pathway to have the most impact, whilst recognising the shortfall in provision.

Caseload weighting tools - we need to ensure that we recognise the acuity and complexity of people using our neighbourhood services and we can do this not only be examining the trends in PBR clusters, but also by using caseload weighting tools. Work is already underway with this and dependent on the tool used, the data could be included in the skill mix dashboard.

4. Review

This paper provides a review of the actions and interventions completed as part of the ongoing work around staffing and skill mix from the January narrative paper.

However, it is essential that we build on existing data to provide benchmarking against both campus and neighborhood provision that will allow for ongoing trend analysis and support our requirements under schedule 6. Data is already gathered by the trust to provide relevant metrics so I suggest a new dashboard, collating the relevant information for systematic and regular review by the committee:- see appendix A

The criteria against which the dashboard will report are drawn from the NHSE Mental Health Staffing framework with specific additions that add local detail. The data will be top line data only, as each metric is reported on in detail elsewhere. The skill mix dashboard is to facilitate trend analysis and respond accordingly.

The dashboard will be reportable by the next six monthly report in January and will have retrospective data for Qs1,2 & 3 for 2017/18.

4.1. Findings by Area

The information below responds to the actions and issues raised in the January paper for the campus services and includes additional detail or the neighbourhoods as requested by the committee.

4.1.1 Campus North and South Services (Hartington Unit and Radbourne Unit)

Radbourne Campus

Issue	Update
Clinical Area: Radbourne Unit	
1. Vacancy management.	There have been a number of drives and recruitment events to improve the staffing position and this has ensured that we have maintained a neutral positron. There are band 5 staff expected to come into post in September and we have some staff recruited to start in January. There are efforts being made to recruit band 5 OT staff into some of the vacant posts (8 in total) Over recruitment of HCA's earlier in the year has been of significant benefit and this has given a buffer when

Issue	Update
	band 5 staffing numbers are low or sickness / training demands have reduced available staffing.
2. Safer staffing management update plus issues relating to the use of bank staff	The unit has been utilising bank shifts and approval was given to recruit some agency staff in light of band 5 deficit.
3. Impact of E-rostering on staffing - trends	Whilst the e-roster has improved the reporting and trust wide view of roster management there are still issues being ironed out in the day to day management of the roster and there is a significant time pressure for the band 7 staff to manage and oversee the roster.
4. Analysis of KPI data for last 6 months - trends	Supervision rates remain a challenge and appraisal compliance has been a challenge to maintain at an acceptable level. Sickness rates remain higher than the expected rate and this is largely attributable to short term sickness. Stress management remains a challenge and the team have been accessing support from the trust staff welling lead for support. In the last 12 weeks the unit has benefited from the additional support of a local staff wellbeing coordinator.
5. Analysis of workforce metrics for last 6 months	Appraisal, training and Bank usage are all over target. Sickness is higher than trajectory. Action plans and mitigations are in place and the KPI's will be discussed in detail at the deep dive meeting to ensure that all action are being delivered and any additional resources that can be identified are made available.,
6. Monitoring impact of staff on the working time directive – are we successfully collecting this information and what are the trends	The data shows that a small number of staff are doing a significant amount of additional hours. In addition the long established shift pattern in in-patient areas means that staff switching from late to early shifts are having a rest period away from work of less than 12 hours. However this is covered in the standard contract. Staff are encouraged through their line management to spread annual leave across the twelve month period in order to ensure they have regular rest periods to reduce the burden of work.
7. Serious incident data – trends including smoking related incidents	Reduction in smoking related incidents in Q4 and Q1 17/18. However incidents of violence and aggression related to smoking are still occurring and episodic incidents of New \psychoactive substance use are problematic. Overall the incidents of violence and aggression in the unit have reduced, particularly when compared to the

Issue	Update
	same time period in 2016.
8. Patient experience data - trends	The data from q1 and q4 has shown consistent reporting for the in-patient wards. The information from the Mental Health Alliance visits highlights some helpful observations and feedback from the ward areas. Clear communication, preserving confidentiality particularly where discussions can be overheard in offices and activities for those who are on level 3 engagements have been clear themes to date. The embedding of the weekly visits is a significant asset to the unit and the team have been very constructive in their feedback and provided regular and clear advice back to the lead nurses and unit management. This is developing area of collaborative working and gives a clear narrative to compliment the quarterly patient experience team data.
9. Skill mix – what work has been done on this in terms of both the ratio of preceptors to experienced staff and also in terms of broadening the professions included in the skill mix	There is ongoing work to ensure the preceptorship programme reflects the feedback from Preceptees and the needs of the clinical areas. The key focus areas are growing confidence in the role of qualified practitioner and also developing task specific knowledge so that newly qualified clinical staff can feel competent amongst their peers. Most importantly the preceptorship programme incorporates a strong supervision culture focussing upon compassion focussed supervision to support Preceptees as they adjust to their new roles within the organisation. Clinical teams tend to have three preceptees per area as a maximum at any time. They have a preceptor and an associate mentor for support during this time. There is often some cross over of Preceptees between January and March when the groups that started in September are nearing completion and the groups who started in January are just beginning, however this generally means that preceptorship programmes are completed by early July which reduces pressure over the summer period.
10. Update on the implementation of PiPA	PiPA developments have been incorporated into two newly formed task and finish groups, the 90 day cycle and bed optimisation project groups. These groups are looking at a number of initiatives which will be scheduled to start later in the year. Core to both is a systematised way of ensuring that clear admission goals and outcomes are established and tracked throughout the course of an admission. That is not to say that there is no plan present but the approaches

Issue	Update
	taken have variance between the in-patient areas and this needs to be more standardised.
11. Friends and family feedback – trends relating to staffing	Sickness is above average for the trust; however this is felt to be well managed and not at a significantly high level in the context of a busy acute environment which reflects national staffing pressure.
12. Medicines management	The earlier part of the year (Q4) saw a steady reduction in low level and significant medicines management issues. However there have been a small number of incidents in Q1 which have been noteworthy. The incidents appear to relate to staff being distracted or pre-occupied and not paying sufficient attention to prevent an incident from occurring. The outcome of these incidents has not been serious and the errors were realised quickly and dealt with swiftly. The in-patient teams are implementing a review of medicine cards and general prescribing trends for all patients once a week in the in-patient areas. This is a check of rapid tranquilisation use, PRN, TTO medication etc. to ensure that there is oversight of medicines administration, transcription and prescribing by senior nurse, pharmacist and Medical team representative. This initiative is dependent on available staff as not all areas have the same level of cover so it remains a work in progress and is being monitored by Drugs and therapeutics Committee as art of the rapid tranquilisation work plan.
13. Implementation of PARIS – impact on staffing	PARIS has been successfully rolled out across all in-patent areas. The clinical teams have been well supported by IM&T to understand the new system and adapt to the change. Having successfully completed the roll out the next phase of work will be to rationalise the system and exploit the opportunities that a full EPR provides in reducing duplication, enabling more streamlined and jointly owned /authored documents to improve the quality of patient records and reduce the time burden upon clinical staff. The EPR is taking some time longer to complete than the existing clinical record and there are some key areas for review, namely recording of patient engagements as the system has the potential to distract the person monitoring from the individual they are monitoring. This is currently under review. Future work will see a review of assessment and

Issue	Update
	admission documentation, streamlining of MDT process and better links to 1 to 1 sessions with key staff and improved communication templates with GP's etc. the safety plan which was rolled out earlier in the year is also being reviewed in line with feedback from clinical staff to ensure that it is providing the correct levels of information at key points in a person's clinical journey.
14. Ward level life quality dashboard	The ward dashboards are being improved and are not currently live presently. The performance team and IM&T team are working together to develop a dashboard system. A version was piloted hover data anomalies and system irregularities have necessitated future development work a revised version is being worked on currently. The team regular review their performance reports at the Unit business meetings and performance review groups. The board trust Management Team has also begun regular reviews of the performance within the divisions to improve communication and understanding between the wards and the board and vice versa. This is also part of the GIAP recommendations to have a more formal structure of review in place to ensure that areas are performing optimally and that any resource requirements are understood and where possible met by the wider organisation.
15. Specific issues relating to the impact on staffing from having to cover the 136 suite	The Section 136 suite has been undergoing a series of upgrades following a serious incident last year. The revised suite is due to open at the beginning of August. This has seen the area being made more comfortable for people awaiting assessment and a reduction in 'blue vinyl' which has a lot of association with custodial settings. In addition the staff egress has been built, the observation arrangements have been revised to improve the privacy and dignity of people whilst ensuring staff can be vigilant in regards to people safety. Staffing of the suite remains unchanged and there are ongoing discussions with Commissioners and internally within the organisation in regards to staffing the suite at times of high clinical demand.
16. Flow coordinators – pilot posts	The unit employed two flow coordinators in March 2017. These posts have been developed to provide administrative support to the bleep holders when it comes to the management of beds within tie unit or if an out of area or specialist placement adult bed (i.e.

Issue	Update
	PICU) is being sought. The flow coordinators provide cover across the core hours 9 – 5, five days a week however they work flexibly and extend these hours where possible to 7 – 7. The flow coordinators have made accessing a bed a more efficient process and have enabled the bleep holders to be able to release time back to overseeing clinical activity within the unit and responding to areas at times of high demand.
17. NMP pilot in campus services	The NMP pilot is at the recruitment stage and the development of roles which would have been traditionally the Specialist registrar posts is underway. Within Radbourne Campus we have two existing NMP qualified staff who are being supported with supplementary prescribing currently.
18. Meaningful activity	The ward areas have been developing the availability of meaningful activities on the wars within the unit. The Big lottery application in conjunction with the QUAD has been submitted. There was an even and workshop coordinated between DEDA a local dance academy and the in-patient unit at Radbourne whereby some of the people in hospital went to a performance at DEA and the dance company then performed a workshop at the Unit the following day. this was extremely well received. Access to activity remains a high priority and limited places at the hub and capacity demands upon the ward can often limit the access to supportive activity. There is a correlation between this and smoking incidents as service receivers often identify that smoking and the time off the ward are a way of relieving boredom. It is anticipated that the addition of OT staff (2 per ward, 8 staff in total) working on the acute in-patient wards will see a greater focus placed on therapeutic activity and coordinated and tailored programmes for individuals in addition the occupying activities provided by the wider ward team and unit recreational staff.
19. Impact of ward social workers	The social worker who is regularly based at the Radbourne unit continues to be a source of significant support and has been key in identifying support packages for people in Derbyshire. There is ongoing negotiation as to whether the same resource can be provided by Derby City Council as this would be invaluable to improve pathways toward discharge.

Issue	Update
20. Impact of ward psychologists	The recently recruited Psychologists are due to start at Radbourne unit in August.
21. Impact of transforming care/ CTR admissions	There has been some significant work on the admission pathway for those who require CTR. This has initially begun by clarifying the identification and monitoring of these people flagged by the Winterbourne review. The CTR process has been updated by the CCG and additional monitoring is in place currently at the request of NHSE as they believe that Derbyshire are currently above trajectory for admissions. The data would suggest that we have been over reporting and that our data cleansing process and clinical scrutiny over the submitted reports requires improvement. In addition to this a regular review forum to understand what trends and learning can be identified from the CTR review documentation. This will be regularly feedback to the CCG within a revised framework as it is important that we are able to demonstrate the learning and service improvements to ensure that we are not necessarily admitting people or developing our services in the absence of referencing our local intelligence.
22. Impact of staffing issues on leadership within campus services	The pull on senior clinicians to be involved in direct clinical work which would usually be undertaken by band 5 clinical staff is having an effect upon the capacity to fulfil wider functions within the unit. The team are struggling to provide regular structured supervision or where ad hoc supervision is being offered that this is not being uploaded and captured. The response to investigation deadlines, engagement in clinical development tasks and availability to attend training.
23. Bed occupancy data over the last 6 months	The Bed optimisation group are monitoring bed occupancy. There is variance between areas and this relates to staffing and the development of more structured and standardised review and monitoring processes. This work will begin again in September / October once we have overcome some short term staffing and capacity issues. NHSI are supporting the development of some service improvement work based upon evidence of work nationally, for example the red 2 green initiate undertaken by Worcestershire services.

Issue	Update
Clinical Area: Hartington Unit	
1. Vacancy management – six month back view of vacancy statistics plus action taken on recruitment. Particularly interested in Band 5 vacancy.	We have a number of staff starting in band 5 posts in Sept & Oct. 17. These staff were interviewed earlier in the year even last year for the vacant posts. So posts were filled but the nurses were not in them physically and the shifts have had to be covered by bank staff
2. Safer staffing management update plus issues relating to the use of bank staff	Not always meeting safer staffing levels particularly at night as there should be 2 qualified staff but mostly the wards have 1 qualified and on a number of shifts over the last 6 months the bleep holder had had to also be in the numbers on one of the wards as the qualified nurse
3. Impact of E-rostering on staffing - trends	Not all senior nurses are consistently using the e-roster to full capacity or at times ensuring it is updated. 2 out of 3 wards use the roster. Discussions are taking place within the unit to look at role for an e-roster admin
4. Analysis of KPI data for last 6 months - trends	
5. Analysis of workforce metrics for last 6 months	Vacancy 2.4% Turnover 12% Sickness 5.9% Appraisals 79.7% Mandatory Training 88.1% Agency use 0.83% Bank staff Use 13.7% Clinical Supervision 42% Management supervision 52%
6. Monitoring impact of staff on the working time directive	Staff are aware of this as an issue but it is not recorded as we would like.
7. Serious incident data – trends including smoking related incidents	Increase in fire which are smoking related. Staff recording incidents of smoking more Q1 17/18 Medication 46 Abuse aggression 39 Absconsion 38

Issue	Update
	Self-harm/ fire 30
8. Patient experience data - trends	The unit staff are trying to gain more feedback from patients and carers. Both patients and staff have found the value of having the Mental Health Alliance peer reps visit the wards however these are due to stop at the end of Aug and we are awaiting next steps from Healthwatch Need to look at how the feedback is added to concern and compliment on Datix - look at admin role ?
9. Skill mix	3 Medicines Optimisation technicians 3 occupational therapists
10. Update on the implementation of PiPA	PiPA in its true sense is not fully implemented across any of the services in the Trust. The Hartington Unit calls their morning meetings which are multi-disciplinary PiPA meetings. These are successful and from these short /brief meetings actions are recorded and followed up at the next morning meeting. This log has been implemented to support completion of actions and recommendations from meeting which need to be achieved quickly from one day to the next to aid discharge
11. Friends and family feedback – trends relating to staffing	As recorded in the PEC report Teams have been reminded to ensure these are completed and recorded.
12. Medicines management	Our MOT pharmacy technician has commenced Tansley Ward in July 17. Prior to commencement of this role the staff team and pharmacy (KWH) have been collating the amount and costs of medicines that are wasted on this ward alone. This is one of the outcome measures to reduce the waste and cost and optimise.
13. Implementation of PARIS – impact on staffing	Despite the ability and safety of having all clinical records from all teams accessible in one place presently we have received a lot of feedback from patients regarding staff always being at nurses station behind laptops or always busy on laptops /computers. The teams however have embraced the move despite initial fears. One ward in particular who struggled have turned out to be our champion area to support others. The monthly meetings with the Paris team even now following the implementation has been value and a number of issues have been discussed and changes made to support clinical teams. On Tansley ward 2012 the direct care time of a registered nurse was recorded

Issue	Update
	as 37% with record in 2017 being 32%. For HCA the recorded direct care time 2012 was 65% with little admin to 2017 being 21% with increase of admin and motion. These results need further review by Senior nurse to see areas which have had most impact.
14. Ward level life quality dashboard	No information
15. Specific issues relating to the impact on staffing from having to cover the 136 suite	At Hartington the responsibility for 136 suite has been for the bleep holder to facilitate. This takes them away from the clinical Leadership across the service when they are needed to remain with the person in 136 suite so can only respond by telephone (when possible) depending on the needs of the person. Where possible the other Senior Nurses /Clinical Leads if on duty will support. Numbers of individuals seen have been 44 with 3 being under the age of 18 years. Of these individuals 30 were discharged, 13 admitted (7 Informal-6 sectioned) and 1 not stated. MHA office in Trust keep spread sheet of 136 however are recorded by address not by which 136 attended. Also not recorded reason for discharge etc . However the hard copies of the 136 records are sent on to appropriate AMHPS service
16. Flow coordinators	These sit within the Radbourne Unit. No real impact noted from clinical teams at Hartington Unit.
17. NMP pilot in campus services	No staff within the wards have completed NMP. However this would be of value in the future.
18. Meaningful activity	Recreational workers are now linked to certain wards. Feedback from Mental Health Alliance slowly demonstrates activities increasing or available. Individual weekly times tables are being introduced at unit from Aug
19. Impact of ward social workers	The Social worker we have working in the in-reach team has been invaluable. He liaises with other social workers and has enhanced the ward team's knowledge regarding enablement packages which has supported discharges. He also co- chairs the safer discharge meeting at the Hartington Unit.
20. Impact of ward psychologists	Psychologist has again been invaluable and not only supports the individual patients but has set up training sessions for the staff, team huddles (pilot on Tansley,)and supporting the staff with work with

Issue	Update
	individual patients and groups on the wards. He also facilitates the formal debrief sessions and Schwartz rounds.
21. Impact of transforming care/ CTR admissions	Helped with personalised management plans
22. Impact of staffing issue on Leadership within campus services	2 newly appointed Clinical Leads and 3 acting Clinical Leads on unit out of 9. Competency booklet developed and coaching for these staff arranged with Senior Nurse/ professional practice development. Registered nurse (Band 5) we presently have 3 (p) under preceptorship with 2 (p) to commence Sept 17, with further recruits following later in the year.
23. Bed occupancy data for last 6 months	Bed occupancy including leave 102% Bed occupancy excluding leave 88% Length of Stay 49%

4.12 Kingsway Campus Older peoples, Rehab and Forensics

Issue	Update
Clinical Area: Kingsway Campus	
24. Vacancy management	Cubley court have 3 RN vacancies each, however all are recruited to for Cubley Court Male and 2 for Cubley Court Female, commencing for September 2017. Cubley Court Female has a career break and maternity leave but has not been able to recruit into those posts temporarily. Ward 1 has no vacancies. Audrey House has no vacancies, Cherry Tree Close have 2 vacancies with both being recruited into. The Kedleston Unit has 5- 8 RN vacancies but this is due to the uplift in establishment , vacancies won't necessarily be filled by RN'S Unfortunately as we recruit for newly qualified RN's so far ahead of them qualifying there are a number that do not take up the posts, this has recently happened on Cubley Court Female.
25. Safer staffing management update plus issues relating to the use of bank staff	The majority of bank shifts continue to be filled by our own staff; however Cubley's demand continues to outstrip capacity.

Issue	Update
26. Impact of E-rostering on staffing - trends	Senior Nurses report that it is easier to maintain a grip on TOIL and worked hours etc. ensuring that staff are working there rostered hours and not accumulating TOIL and not going over on AL, otherwise no impact reported.
27. Analysis of workforce metrics for last 6 months - trends	Headcount average 190 No outstanding RTW's Appraisal 91% target 90% Sickness 5.2 % target 5.04% Bank usage 14% target 4.98 % Training 93% target 90% No variation or trends.
28. Analysis of KPI data for last 6 months	All are green rated except CPA Settled Accommodation CPA Employment Status Data Completeness: Outcomes These are not unusual and are on average 3% below the 90% target for completion.
29. Monitoring impact of staff on the working time directive	Inpatient staff are not currently adherent to WTD; they do not sign a contract to state they are in agreement to work beyond contracted hours. Breaks and rest times are organisational responsibilities, these are provided within the older adult wards but neither rehab nor low secure services. There is currently a project running to look at consistency of shift patterns across the trust inpatient areas and the provision of break times. The trend is that the Trust does not adhere to WTD.
30. Serious incident data – trends including smoking related incidents	Smoking continues to take place on the Kingsway site. Staff buy in to the smoke free initiate has been variable with Kedleston relaunching and having a positive impact. Other areas have struggled. This has been followed up and advice and support sought via the Fresh Committee. Smoking related incidents have decreased and continued on a downward trajectory.
31. Patient experience data - trends	Friends and family responses remain low. Work has been done to improve this but the response rate has not improved. It is important to note that the populations

Issue	Update
	on these clinical areas are relatively static and so the opportunities to seek feedback are reduced. Complaints and compliments remain at similar levels with reporting of 4Cs embedded in practice. Safeguarding incidents remain high due to the older adult population on site and the need to be proactive around vulnerability of this group.
32. Skill mix – what work has been done on this in terms of both the ratio of preceptors to experienced staff and also in terms of broadening the professions included in the skill mix	Teams are being asked to look at incorporating OTs and pharmacy optimisation technicians into shift rosters, however apart from the Kedleston unit there appears little appetite. All area have voiced the desire to have an in house social worker. Older adults are identified for the first wave of Advanced Nurse Practitioners.
33. Update on the implementation of PiPA	PiPA daily meetings are happening on Ward 1 with the input of the Functional Rapid Response Team, the model does not fit for Audrey House/Cherry Tree Close and the Kedleston Unit. It is under discussion for the Cubley Wards alongside input from the DRRT.
34. Friends and family feedback – trends relating to staffing	Friends and family feedback does not highlight any trends relating to staffing.
35. Medicines management – impact of staffing n the number of medicines related incidents and also feedback on the recruitment of MOT if relevant	Although there has been 1 never event in relation to a medications incident there has been a decline in medicines related incidents. There has been no recruitment of MOT's
36. Implementation of PARIS – impact on staffing	PARIS has no direct impact on staffing, it a continual learning curve, both in staff's expertise with using and developments to ensure its fit for purpose. The biggest impact is in the recording of observation levels – as it requires a greater concentration to record on an electronic device than paper, patient engagement during this time has decreased.
37. Ward level life quality dashboard	N/A

Issue	Update
38. Specific issues relating to the impact on staffing from having to cover the 136 suite	N/A
39. Flow coordinators – pilot posts	N/A
40. NMP pilot in campus services	N/A
41. Meaningful activity	Ward 1 reported difficulties with OT provision and activities on the ward due to OT vacancy; they now have an agency OT and have recruited permanently, otherwise across campus no changes.
42. Impact of ward social workers	Kingsway campuses do not have ward social workers and submit a referral for each individual case. In older adults there are long delays in allocation resulting in extended hospital stays. The Cubleys will often have patients who have been looked after by social care from another county but placed in care in Derbyshire , there is are further delays then with arguments about responsibility.
43. Impact of ward psychologists	All wards except the Cubleys have psychology input although all feel that it is not adequate to meet need.
44. Impact of transforming care/ CTR admissions	Negligible for the Kingsway and London Road campus
45. Impact of staffing issue on Leadership within campus services	Kedleston now has a substantive Unit manager which has provided consistency and an improvement in standards. Cubley male has had many changes of Senior Nurse in the last 12 months and currently has non due to long term absence, this reflects in an increase in incidents and decline in the quality of the patient experience.
46. Bed occupancy data for the last 6 months	Audrey House 79% Cherry Tree Close 74% Kedleston 66% Cubley F 70% Cubley M 63% Ward 1 69% Ward 2 temporarily closed Kedleston bed occupancy has slowly been reduced to allow for the refurbishments to be completed safely,

Issue	Update
	they will be back to full capacity in 2018. Ward 1 has had over 100% capacity for the last 3 months after the temporary closure of Ward 2, this is being monitored through the working group for that action.
47. Band 4 assistant practitioners	Cherry Tree Close and Audrey House have 1 each
48. Dedicated discharge nurse on Cubley	No but is being readdressed now in line with the Ward 1 & 2 temporary closure planning and bed pressures
49. OA areas reported improved recruitment by using the generic advert	No, recruitment has slowed down in line with all areas , there are no applicants at times now.
50. What has been the impact of the introduction of the new shift pattern? (7 Week Roster)	Kingsway campus has worked this line for some time so it is not new.
51. Has the recruitment of general nurses been successful	No general RN's have been recruited

4.13 Neighbourhoods

Recruitment

Recruitment has continued in the neighbourhoods with ongoing success. Managers are prioritising posts for appointment as soon as they are aware that a vacancy occurs which reduces the time taken to recruit. The implementation of the TRAC system is being embedded and there should be an increase in efficiencies as staff become familiar with the system.

However, there are ongoing issues with the recruitment of band 5 posts which has led to posts being filled at band 6 to meet the need for staffing. In the longer term, this has a financial impact for the organisation and also erodes the career structure in the neighbourhoods. It is though indicative of the perception by staff that the neighbourhood role is complex and warrants a higher banded clinician.

Evidence based interventions

The provision of evidence based interventions within neighbourhoods requires a significant investment of time and training by the Trust at a point when the services are stretched as never before. This will need planning and support to succeed.

Caseload management

Teams do not uniformly use caseload management tools to examine the acuity and complexity of their clinician's caseloads. There is a piece of work underway to look at this and this will assist to divert resources and to support staff. The initiative will also provide additional data to support the work that has already been completed identifying the shortfall in staffing in the neighbourhoods.

Exploring Options to Improve Capacity and Work on Demand

In the paper delivered to the Trust board in March 2017 on Community Mental Health Team Capacity and Risk Mitigation the following options were put forward as ways to deal with the issues of caseload capacity and service demand. Each has an impact on Staff skill mix and clinical skill, but I have highlighted the areas with the highest level of need.

a) Links with Outpatients and Psychological Therapy Service Development

Work is being undertaken to review clinical variation in outpatients and to review the provision of psychological therapies. The emerging models tend to rely upon the specialist supervising a nurse to take on a role in providing service currently provided by the specialist. This development would require additional skills training and supervision of advanced clinicians.

b) Increased recovery-focused solutions

This work is ongoing within Neighbourhoods and offers the most realistic opportunity to improve service user experience, whilst assisting with flow and capacity. Staff

would need additional training to fully embed their knowledge and understanding of recover focused interventions as well as psychosocial interventions training to support this development.

c) Increased use of Peer Support

This work is more established in some areas than others and is small scale. However the benefits in outcomes for service users means that we would strive to enable more peer support within services, and embedded particularly within the recovery strategy. The peer supporters will need training and supervision to enable this development to operate successfully.

d) Increased nurse clinic models

This work is already in place across Neighbourhoods and there is potential for some growth which will be explored. Practitioners using this model need to be supported by our organisational systems and policies to maintain this way of working.

There is much to do within the neighbourhoods that moves practice along but also looks at the next phase of the neighbourhood model implementation. A robust working group is in place and meets readily to progress this work.

5. Conclusion and Recommendations

As an organisation we need to be able to measure the impact of the strategies we have for delivering on our staffing skill mix issues and demands. We need to ensure that these processes are reasonable and have the desired effect of giving us the right staff with the right skills in the right place and time. We need to skill up our workforce and enable those skilled practitioners to collaborate with the people using our services on interventions that facilitate recovery.

Future staffing models in the organisation need to maintain a focus on outcomes rather than numbers. Central to this is clarifying patient benefit by the routine administration of PROMs (Patient reported outcome measures) and CROMs

(Clinician reported outcome measures) so that we can clearly see the impact of staffing on the recovery and discharge of those people using our services.

We also need to be mindfully recruiting and retaining high calibre staff who are enthusiastic and passionate about their work and report satisfaction with their roles. Their wellbeing is good and they have a desire to excel and develop as they identify their future ambitions, through meaningful conversations and appraisal with their managers.

We should move towards core job descriptions that focus on recovery and enablement rather than monitoring and containment and review restrictive recruitment practices around essential criteria on job descriptions that may exclude suitable candidates. We will do this by building in time limited expectations for completion of qualifications to enable suitable candidates to be included in the recruitment process.

The Skill mix dashboard will enable us to see the impact of the existing strategies and actions on our workforce and identify the impact of new initiatives and practices.

Specific recommendations

1. Produce a roll out plan for the recruitment of OTs and MOTs to the campus sites and implement.
2. Ensure staff wanting to exceed the WTD do so according to policy and procedure and that this is reported and monitored through operational systems.
3. Embed agreed alterations to shift alignment across campus services.
4. Review and support the continued embedding of the use of Paris EPR in Campus services.
5. Review and implement an improved Therapeutic activity offer across all campus services
6. Review the need for and complete substance misuse training across all clinical areas.
7. Complete an options appraisal for the recruitment of substance misuse workers on Campus sites.
8. Support Succession planning and Talent management activities.

9. Explore the viability and practicality of expand the recruitment of social workers within the organisation.
10. Review the viability of expanding the role of support staff in neighbourhoods.
11. Ensure a regular and sustained increase in the numbers of volunteers and peer supporters employed by the organisation.
12. Develop and roll out a 3 year neighbourhood training plan for evidence based interventions as part of the neighbourhood development plan.
13. Support the development of recovery focused job descriptions.

9. Conclusion

Our staff are our largest resource and require support and investment to provide the high quality service that we aspire to provide. All this takes place against a backdrop of staffing shortages and uncertainty around availability.

We need creative solutions and clear measurable evidence that these solutions will give us the right staff with the right skills in the right place at the right time.

Bibliography

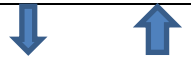
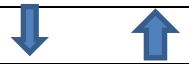
https://www.theguardian.com/society/2017/jun/12/96-drop-in-eu-nurses-registering-to-work-in-britain-since-brexit-vote

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

Five Year Forward View - Plan for Mental Health (Mental Health Taskforce to the NHS in England, (2016)

Appendix A

Skill Mix Dashboard

Date	**2017/ 18 Q1**	**2017/ 18 Q2**	**2017/ 18 Q3**	**2017/ 18 Q4**	**2018/19 Q1**	**2018/19 Q2**	**2018/19 Q3**	**2018/19 Q4**
Clinical Quality								
Acuity/ PbR								
Total incidents								
SIs								
Restraint								
Medicines incidents								
Seclusion								
Self-harm incidents								
Patient and carers								
Proms								
Complaints								
Compliments								
Friends and family								
Staff								
Vacancies								
Average on shift *								
Bank & agency rates								

Date	**2017/ 18 Q1**	**2017/ 18 Q2**	**2017/ 18 Q3**	**2017/ 18 Q4**	**2018/19 Q1**	**2018/19 Q2**	**2018/19 Q3**	**2018/19 Q4**
Training								
Supervision								
Nos of volunteers								
Nos of peer supporters								
Throughput								
Length of stay								
Admissions								
Discharges								
Readmission								
Bed occupancy rate								
Finance								
Cost per person								
Recruitment costs								
Training costs								

This version of the dash board does not differentiate between campus and neighbourhood services. Dependent on what can be produced by IM&T we may be able to have neighbourhood and campus data together on the dashboard or alternatively have 2 versions to cover the different areas.

The criteria are taken directly from the NHSE Mental health staffing framework with the addition of peer supporters and volunteers.

*The average on shift can vary and requires definition dependent on the clinical area and shift. For example min 5 registered nurses over 24 hrs or numbers per shift.