SAFER STAFFING REPORT

PERIOD OF REVIEW NOVEMBER 2017 – APRIL 2018

1.0 INTRODUCTION

The National Quality Board (NQB) sets out the expectation that a Safer Staffing report is submitted bi-annually to an organisation's Executive Board. Implicit in this is that the Executive Board holds ultimate responsibility in guaranteeing that organisationally there is 'capacity and capability to provide high quality care'[1]. The aims that the NQB require to be addressed are

- that processes are in place to enable staffing establishments to be met on a shift-to-shift basis
- evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability
- that clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns
- that a multi-professional approach is taken when setting nursing, midwifery and care staffing establishments
- that nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties
- that Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review
- that NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift
- that providers of NHS services take an active role in securing staff in line with their workforce requirements.

This six month Safer Staffing review report to the Board concentrates on the above for the period November 2017 through to April 2018. The Trust Board are requested to note the contents of this report, and critically approve the recommendations.

[1] The National Quality Board (2013) How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

The findings and recommendations have been derived from appraisal of data (Appendix 1), staff views (clinical and managerial) as well as receiving specific project updates including the Hurst In-Patient Safer Staffing Tool. No one method enabled a qualitative overview and thus analysis using all domains was critical in evaluating the current position around safer staffing to ensure an accessible, responsive and quality health care provision.

Overall the identified findings demonstrated a staffing establishment that was sufficient to meet the Safer Staffing requirements. The reduced maintenance of staffing establishments were owing to unplanned absences such as sickness, human resource factors and the intensity of clinical care demands such as increased numbers of therapeutic observations. Increased demands were addressed by mainly using existing ward staff and temporary (Bank) staffing; on the whole staff shortages were filled via Bank rather than Agency. This was considered positive as it permitted greater staff familiarity with CWP systems and processes.

The reflective discussions also highlighted that clinical and management teams jointly strived to maintain care standards at times of intense staffing pressures and proactively tried to come up with creative solutions in the absence of any flexibility within establishments such as increased use of twilight shifts and the involvement of the broader MDT to support care delivery.

There were some variations in resources; included in this was the distribution and role responsibility of Resource Managers across the CWP in-patient footprint. There were recruitment contrasts for Registered Nurses (RN) and the composition of MDTs resulting in a need to formulate care and prescribe treatments based on resources available; the lack of adult in-patient psychology has relied on broader MDT treatment formulation. There was an emerging theme of increased hospital detentions in mental health that reflected a rising national trend[2]. There was also consideration around increased physical health needs of those accessing CWP services. This is a developing agenda for CWP to ensure rounded care delivery to meet the needs of people with mental health conditions and co-morbid physical health issues.

As an employer CWP has a diverse workforce and who are generally able to actively recruit. There was a perception that this is proving more challenging within East Cheshire and further exploration and understanding of this is needed. Additionally the development of new care models and redesign across CWP in-patient service may also provide an opportunity to examine and address this. There is a

[2] Care Quality Commission (January 2018) Mental Health Act The Rise in the use of the MHA to detain people in England http://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf

dedicated recruitment team around staffing processes (including temporary staffing). The Safer Staffing review highlighted that there is a positive opportunity for nursing personnel to be further involved in job fairs and the Consultant Nurses will support this as active recruitment drives to encourage nursing engagement from other areas will contribute to CWP sustainability and development of staff. This proposal, the new methods of developing a nursing workforce (MSc Nursing Degree, Advanced Nurse Practitioners and Trainee Nursing Associates) and Professional Advisors has been undertaken in the past 6 months to maintain a responsive workforce. Developments have also included planned working with CWP Education around recruiting 3rd Year student nurses via a CWP Nurse Recruitment event.

To facilitate in-depth understanding of these issues discussion has been presented under themed headings presented in the NQB (2013) report *How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability.*

2.0 PROCESSES AND PROCEDURES

2.1 PLANNED STAFFING VERSES ACTUAL STAFFING

Ward staffing was proactively planned through the use of the electronic roster system and mainly completed by Resource Managers. The majority of the Resource Manager posts are a cost pressure as they are, in the main, not established funded posts but they enable ward managers' to focus on their individual wards providing visible clinical leadership. There are occasional exceptions where Ward Managers complete the duty rotas, for example Crook Lane where there is no allocated Resource Manager.

The annual leave for ward staff was advance planned for the year however given capacity and the build-up of annual leave (such as from sickness), led to an accumulation of leave needing to be taken in month 11 and month 12 of the financial year which can have a knock on effect on staff availability. Ward Managers and Resource Managers monitor this across the full annual period to decrease this risk and any subsequent impact this may have.

Staffing establishments per shifts (days and nights) were predetermined and implicitly clear for each clinical area; with respect to establishments per shift, most areas meeting any deficits in daily establishment through utilising their own staff to cover. This was mainly through Bank use or on other occasions the use of temporary staff; on the whole Overtime and Agency was only used to ensure the safety of the clinical area through safe staffing numbers as a last resort. From reports Agency use was not disproportionate and although Eastway detailed that they

used Agency more often this was because the staff team seemed to have facilitated a staff group of Bank and Agency staff that were familiar with the client group's needs.

There has been no universal review of establishments across the in-patient areas in this 6 month period however the formation of the new care groups across CWP will consider this moving forward.

There was discussion and clarification with Resource Managers in terms of where planned staffing becomes actual staffing. The consensus was that 'actual' was the time at which staff arrived for the start of the duty period. However, it was only as discussions progressed that it was highlighted that a ward's actual staffing may not necessarily be static. This was due to the need for cross cover on other wards to redress unplanned staffing deficits or an increased level of care needs/acuity. If staff are moved for only a proportionate number of hours this is not immediately or consistently reflected in the actual data as part of shifts are not recorded in the safer staffing return nor are periods of cover from the ward manager or the wider MDT. In addition to base line establishments ward managers will also use a professional judgement approach in relation to ensuring safer staffing requirements are met. The approach to safer staffing is considered as a unit wide response and resource allows flexibility and response to ensure wards are safely staffed.

2.2 E ROSTERING

E Rostering is actively used and classifies completed rosters within one of three domains (Stormy, Cloudy or Clear) on the basis of Safety, Effectiveness, Budget, Fairness and Unavailability to reflect a rota's staffing capability. Strength of the E Rostering process is the capability of audit. Currently Version 10 of E Roster is in use and has been subject to MIAA internal audit and the audit recommendations will be considered and actioned as necessary.

2.3 TEMPORARY STAFFING

Reports indicated that much of the shift cover to address any staffing establishment shortfalls arose from wards using their own staff to work extra hours. Additionally, it was reported this process was a result of team commitment and flexibility and having client familiarity and maintaining a ward skill set. There were reports of generally being able to access staff from the nurse Bank and additionally highlighted that this had led to recruitment from the Bank into permanent posts. There was a reliance on temporary staff usage to maintain establishments

and to ensure adequate cover as a result of unplanned absence (for example sickness, emergency leave). There were periods where fill rates for Clinical Support Workers (CSW) were covered by Registered Nurses (RN) and although a cost pressure the principle held was the need to balance this and maintaining safe clinical care. This was a priority for all teams and there was awareness of how to escalate concerns via the bleep holder, Head of Clinical Services and on call system(s).

When unexpected deficits occurred across units there was a consequential need for staff to be relocated elsewhere for safety across the clinical area rather than having a singular ward view as previously highlighted.

Nevertheless, risk assessment processes were employed to weigh unit needs, specific ward commitments and unplanned absences. This, therefore, resulted in a planned safe fill rate deficit in one area to maintain a critical safety level in another. It was identified that staff highlighted that they understood the rationale for establishments to be balanced so as to maintain safe and effective staffing but conversely this impacted on the broader therapeutic interventions leading to prioritisation of high risk, high need treatments and interventions. This is not unreasonable when the overriding principle has had to be safety and effectiveness of care. Where possible members of the MDT were called upon to deliver care reinforcing a team based approach.

2.4 UNIFY

Monthly reports are generated per area to facilitate regular oversight by Ward Managers and Heads of Clinical Service of fill rates for RNs and CSW's across the day and night period. In the main fill rates were mainly over 95% as demonstrated below.

3.0 EVIDENCE BASED TOOLS

3.1 DASHBOARDS

To inform the safer staffing clinical discussions conversational focus was on throughput, occupancy, care and clinical demands. This assisted review of staffing establishment needs in consideration of individual ward profiles. It was noted from discussions that there was a perception of more complex length of stays, increased placement requests to enable safe discharge and increased levels of detention under the Mental Health Act (1983/20017). This is reflected in the changing trends nationally around hospital detentions. In January 2018 the CQC reported that there was a 40% increase in the use of the Mental Health Act with the act being applied to different groups than previously, including those with dementia and personality disorders.[3]

3.2 CARE HOURS PER PATIENT DAY (CHPPD)

The monitoring of staff to patient ratio by means of Care Hours per Patient Day was commenced in April 2018. This will facilitate staff-to-client ratio discussions and comparison at the next six monthly safer staffing discussions. At this juncture it is a process that has just been implemented and the Board is asked to note this with a view to a reported analysis in the next bi-annual report submission. In October 2017 CWP engaged in a national CHPPD pilot and provided feedback to the national programme that it would be beneficial if Allied Health Professionals (AHPs) be included within data capture. AHP staff are included in the CHPPD data and the data has started to be available within the Trust's Locality Data Packs.

3.3 IN-PATIENT QUALITY AUDIT TOOL

[3] CQC (2018) Mental Health Act The Rise in the use of the MHA to detain people in England http://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf

As the Board is aware some significant work on the quality of care, staff to client dependency and evaluations around direct to indirect care ratios has been completed using the In-patient Quality Audit Tool devised by Dr Keith Hurst (reported in the previous 6 month report). It has been discussed with the Trust's lead practitioner for this process that a repeat audit is completed within the CAMHS Wards. A summative decision was that this is feasible but ought to be considered towards the end of the year so as to enable the recommended changes and agreed actions to be realised. As part of the developments in this area the in-patient nurse consultants are taking forward quality audit improvement work.

The quality inspection component of the Hurst Tool has been completed on a staged approach the only two wards yet to be completed are Bollin and Eastway scheduled to be undertaken in August and September 2018. A recognised strength of having used this audit tool is that all the wards audited achieved the successful quality audit score of 70% or above; this is required by the national team to participate in the programme. Further analysis of the data and information obtained will be completed over the next six months. Eastway and Bollin will also have had their quality audits completed. Thereafter a rolling programme of re-audit will commence to measure and summarise changes.

There was consideration to whether the evidence based tool might be of use in measuring pharmacy provision but after wider consultation and consideration the tool was not adaptable for this use.

4.0 LEADERSHIP

4.1 RECRUITMENT & RETENTION

There were excellent examples of creative approaches to staffing being employed across the Trust, such as the recruitment of a housekeeper role and pharmacy technicians to facilitate care delivery and make best use of staff capabilities. Furthermore as the national picture for ensuring physical health within mental health is prioritised there has been the recruitment of Adult Registered Nurses within some in-patient wards thereby broadening the staffing establishment profile and expanding the skill base within the clinical team (Oaktrees, Cherry and latterly Meadowbank).

Recruitment has been fundamental to staffing sustainability and there is a dedicated CWP recruitment team. This six month review highlighted that it would be proactive for nursing cohorts to engage with and support the planned approach to recruitment of 3rd year students.

It was highlighted through the discursive parts of the safer staffing review that the ability to retain staff post qualifying and on completion of their preceptorship was a challenge with a proportion leaving for promotion or to other areas within CWP as part of career expansion. This led to further staffing pressures some of which has previously been discussed in terms of sustained recruitment within in-patients. However, staff moving on for these reasons and still remaining within CWP was perceived as positive overall.

4.2 SUPERVISION

Supervision is a crucial component in the delivery of quality care to enable reflective practice and it is a compliance measure within the safer staffing process; compliance targets are 85% or above. Compliance rates are reported and monitored at a service and ward level, moving forward the reports will be generated aligned to care groups. The six month data reflected variable rates of compliance however during the review meetings there was a clear commitment to try to achieve this target.

An area of good practice highlighted by some wards so as to achieve supervision compliance was identifying each week those staff that were due supervision. This was then included as part of the weekly objectives that could be diarised. It is, however, recognised that it is not only about compliance in the supervision process but ensuring a staff group who experience quality supervision 'to support and enhance practice for the benefit of clients'[4] and thereafter enable self-evaluation of practice and areas of development. To address this it is planned to complete a reflective event around supervision at the July Service Improvement Forum for In-patients that will contribute to the next bi annual review.

5.0 MULTI-DISCIPLINARY TEAM (MDT)

5.1 ROLES AND RESPONSIBILITY

The composition of each MDT across the Trust varies not only in terms of each team but also between local areas. There is access to broader psychological provision with the acute in-patient

[4] CWP (2017) HR22 Supervision Policy
http://nww.cwp.nhs.uk/Documents/PoliciesandProcedure/HR22%20Supervision%20policy%20Issue%206.pdf

wards in East Cheshire with access to an Art Therapist that is not available within other areas. All wards had Occupational Therapy (OT) provision and there was consensus that this role was well integrated in wards not only in establishment but in that OT staff contribute to areas of care delivery at times of high levels of clinical need e.g. therapeutic observations.

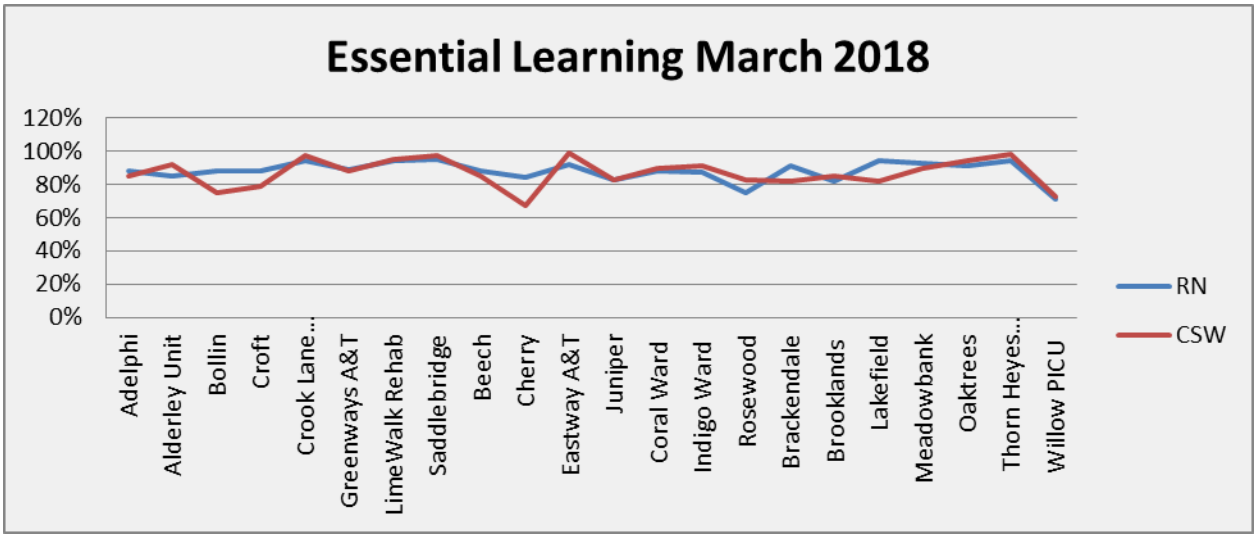
There was agreement on the need to maintain differing responsibilities of MDT members with a presiding sense of needing to work together. It was aspirational for areas that did not have access to a dedicated psychologist that they would wish access to this to assist in the delivery of comprehensive MDT reflective practice and formulation.

It was highlighted in discussions that ward managers on occasions had been required to be included in the staffing numbers to maintain daily establishment. The data did not reflect this as data is only captured when it is a full shift that someone is working in the daily establishment; this means that direct care by the ward managers is not submitted to Unify and therefore not included in fill rates.

6.0 TIME FACTORS

6.1 TRAINING

The data reflected that compliance with training was generally good as illustrated in the March 2018 chart below.



There are occasions however that at times of increased clinical need staff were withdrawn from mandatory training. However, an area of flexibility in attaining training compliance was where staff completed their e-learning in addition to rostered shifts whereupon this time could be

claimed back as it was able to be evidenced. It was recognised during the discussions that this would need robust oversight to minimise the risk of disproportionate amounts of time owing building up. There are also education facilities in the 3 localities where staff can access computers and attend sessions.

6.2 ENVIRONMENTAL

On review there were environmental challenges in terms of ensuring that staff were able to ensure gender requirements were met in relation to mixed sex accommodation. Some wards had greater capacity to achieve this than others. The clinical areas were all able to ensure maintenance of an individual's safety, privacy & dignity. Needs were met through increased observations and a short stay in the area until another bed could be allocated. Where there are incidents of potential breach these are datixed and reviewed by Matrons, Service Managers and reported to the Associate Director of Nursing for Mental Health and Learning Disability to determine whether the breach was justified or not.

7.0 OPENNESS AND TRANSPARENCY

Staffing levels are detailed per day on the ward entrance. Ongoing reviews of establishments were completed based on acuity and therapeutic observations to ensure safe and effective high quality care and any changes were aligned to clinical demand. An area of focus has been in relation to physical health care (led by the Consultant Nurse for Infection Prevention and Control) reviewing physical health in mental health. Appraisal of this and any subsequent recommendations and its finding will be reflected into the In-patient bed based care review. A summary of the work is outlined in appendix 2.

Ward staff openly discussed their views around safer staffing. There was no specific or formal request for increased staff but there was a sense that staff would welcome a review of establishments, the opportunity to have a broader MDT on all wards, including psychological therapies to assist in clinical formulation. This work has already commenced through the inpatient redesign project to explore whether the current configuration of inpatient wards is right to assist staff delivery of the best care. This piece of work continues to progress with the aim that it will be completed in September 2018.

Whilst there were some variations in the way Resource Managers carried out their role there was positive feedback that the role enabled ward managers to focus on the components of clinical care, staff proficiencies and MDT functioning.

7.1 Escalating concerns

Where wards have concerns around staffing levels these are raised direct to the modern matrons and heads of clinical services to provide a co-ordinated response to resolve; relocating resource from another ward for example.

Where it is not possible to resolve locally, capacity within the wider system can also be utilised; relocating resource from another locality for example.

Where there are ongoing concerns that are not resolvable these can be further escalated and a co-ordinated Trust response to support mitigation of concerns will be enacted. For example this has included a temporary reduction in beds on Adelphi ward to ensure safe staffing levels could be achieved. This was a temporary period from October 2017 during which time staffing levels were able to be addressed and the ward was able to return to full bed numbers in April 2018.

8.0 FUTURE PLANNING

8.1 An ongoing focus on the functionality of staffing establishments to ensure safe effective care is essential. It would be pragmatic to wait until, work that is being scoped around service redesign is completed given it is appraising acute in-patient pathways. This includes options around clusters, simulation modelling and capability in order to be responsive in care delivery, maintaining staff proficiency and taking into account physical health needs within the mental health in-patient settings.

8.2 A review of the Community (Physical Health) nursing workload is being completed to identify areas of quality improvement work that can be agreed. The Associate Director for Nursing for Physical Health will oversee the safer staffing response to NQB guidance which will be reported in the next safer staffing 6 monthly report.

8.3 The in-patient quality audit tool by Dr Keith Hurst will continue with the two wards (Eastway and Bollin) having their quality audit completed with the potential for a full re-audit of both CAMHS wards to review the impact and progress of recommendations made in the initial review.

8.4 The Trainee Nurse Associate and Nurse First Masters programme is continuing and the ongoing management and evaluation of this can continue to inform workforce planning. In January 2018 the Trust also employed 5 Trainee Advanced Clinical Practitioners and are looking ahead to recruiting a further 8 for commencement in September 2018.

8.5 As part of the 24/7 project there is a Band 6 Bleep Holder to hold supernumerary status. There will need to be further consideration of how this might be achieved in terms of staffing establishments.

8.6 CHPPD has commenced and will inform safer staffing for the next bi-annual report. This will include allied health professionals.

8.7 As part of the Specialist Mental Health Care Group the Mental Health Placed Based services are in the process of appraising and strengthening clinical services within the community (a summary of which is outlined in Appendix 3).

8.8 A pilot project is being considered using the Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS)[5] workforce tool within CAMHS (scoping meeting to take place in July 2018).

9.0 SUMMATIVE FINDINGS

9.1 RIGHT STAFF

The presiding theme is that we have the right clinical staff and maintain ward establishments for the delivery of safe care. A thorough review and development of the MDT is considered to have improved psychological input within the acute in patient areas.

The resource manager role is a non-clinical role and this review found that this role was vital in the rostering process, the timeliness around fill rates and staffing in the short, medium and long term. There were, however, variations in roles and responsibilities of Resource Managers across the services and this will be taken forward.

[5] National Collaborating Centre for Mental Health (2018) **National Collaborating Centre for Mental Health. Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS) for Mental Health Guide** London: National Collaborating Centre for Mental Health

There was consensus that having the ability to recruit in a timely manner was essential and that there was no disconnect with corporate teams such as Finance and People Services. Staffing in a timely manner was critical to safe and responsive care needs. Additionally proactive recruitment, flexible work patterns such as twilight shifts and the use of the MDT at times of acute clinical activity was fundamental in the safe maintenance of care.

The ability to have the Band 6 nurses maintaining supernumerary status when rostered as a Bleep Holder has proved challenging and further review to achieve this is underway.

9.2 RIGHT SKILLS

In general staffing establishments are maintaining levels of proficiency through mandatory training and there is a mechanism in place for new staff to be skilled up with pre-booked training dates being allocated. Newly qualified staff have preceptorship and this is essential to embedding skills. Furthermore, supervision and retaining experienced staff is central to safer staffing and is seen as a priority.

The development of a wider staffing skill set has commenced. This has included the recruitment of Adult Registered Nurses in Physical Care into mental health wards and there is a programme of work taking place to ensure quality care in the mental health settings around physical health (as set out in Appendix 2).

9.3 RIGHT PLACE AND TIME

The ability to meet staffing requirements is planned by way of e-rostering, the use of temporary staffing and at times agency staff. Short term and unplanned absences have proved challenging in terms of capability to cover shifts and appraisal of the data and narrative discussions reflect this. All areas rely on their permanent staff working Bank and some of the areas that this has been critical where familiarity with clients' early warning signs and positive behaviour plans is critical to safe care.

On occasion staff do not always work on the ward where they were originally identified to work having to be transferred out to wards where there was a greater clinical need. The discussions indicated that this was understood and appreciated to deliver priority care. What was highlighted was that in addressing absences at short notice there was a limited ability to deliver

some of the planned therapeutic treatments with clients and this had also led to MDT involvement in the day to day care management at times of high need.

BOARD ARE ASKED TO CONSIDER AND AGREE THE FOLLOWING RECOMMENDATIONS

10.0 RECOMMENDATIONS

10.1 Develop a mechanism to capture the degree to which ward managers work as part of the daily staffing establishment.

10.2 To undertake a review of the Resource Manager role to strengthen it and reduce variations.

10.3 During the introduction of the Band 6 Supernumerary Bleep Holder to assess any impact on ward staffing.

10.4 To enhance active recruitment drives as a recurrent feature of the safer staffing process.

10.5 Ongoing review of establishments and the monitoring of fill rates and the maintenance of narrative dialogue with staff and managers to gain insight into local and specific staffing influences.

APPENDIX 1

Month and Year of Data	Locality	Ward	Day				Night				Fill Rate			
			Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night	
			Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Nov-17	East	Adelphi	1233	1164	1119	1070.5	701.5	701.5	1150	1085.5	94.40%	95.67%	100.00%	94.39%
Dec-17	East	Adelphi	1245.5	1069	1289	1154	727.5	705.5	1253	1077.5	85.83%	89.53%	96.98%	85.99%
Jan-18	East	Adelphi	1503.5	1289	1266	1156	809.5	775	1453.5	1208	85.73%	91.31%	95.74%	83.11%
Feb-18	East	Adelphi	1202	1107.5	1222	1084.5	690	690	1046.5	977.5	92.14%	88.75%	100.00%	93.41%
Mar-18	East	Adelphi	1361.5	1246.5	1487	1268.5	784	726.5	1270.5	1190	91.55%	85.31%	92.67%	93.66%
Apr-18	East	Adelphi	1465.5	1256	1296	1207	694.5	660	1261.5	1204	85.70%	93.13%	95.03%	95.44%
Nov-17	East	Alderley Unit	1055	985	1369	1352.5	690	632.5	690	706	93.36%	98.79%	91.67%	102.32%
Dec-17	East	Alderley Unit	1128.5	1094.8	1397.5	1286.5	713	609.5	713	770.5	97.01%	92.06%	85.48%	108.06%
Jan-18	East	Alderley Unit	1080	1112.5	1361	1204.5	713	575	713	801.5	103.01%	88.50%	80.65%	112.41%
Feb-18	East	Alderley Unit	920	890	1307.5	1221.5	644	552	655.5	736	96.74%	93.42%	85.71%	112.28%
Mar-18	East	Alderley Unit	1032	975.5	1451	1373	713	621	713	805	94.53%	94.62%	87.10%	112.90%
Apr-18	East	Alderley Unit	1070	965.5	1543.5	1494.5	713	690	770.5	782	90.23%	96.83%	96.77%	101.49%
Nov-17	West	Beech	1267	1289	1150	1121.5	701.5	697.5	681	654.5	101.74%	97.52%	99.43%	96.11%
Dec-17	West	Beech	1326	1314.5	1007.5	936.5	713	704.5	701.5	701.5	99.13%	92.95%	98.81%	100.00%
Jan-18	West	Beech	1359	1303.5	1113	1113	697.5	697.5	722.5	678.5	95.92%	100.00%	100.00%	93.91%
Feb-18	West	Beech	1227	1202.5	1034.9	1007.4	656	644.5	644	639	98.00%	97.34%	98.25%	99.22%
Mar-18	West	Beech	1401.65	1352.65	1003.5	955.5	713	713	743	731.5	96.50%	95.22%	100.00%	98.45%
Apr-18	West	Beech	1483	1469.5	854	844	747.5	747.5	649	632.5	99.09%	98.83%	100.00%	97.46%
Nov-17	East	Bollin	1272	1170	1323	1230.5	655.5	664.5	1368.5	1204	91.98%	93.01%	101.37%	87.98%
Dec-17	East	Bollin	1269.04	1174	1268	1176.25	730.5	712	1426	1292.5	92.51%	92.76%	97.47%	90.64%
Jan-18	East	Bollin	1297	1270	1421	1366.5	701.5	671	1280.5	1185	97.92%	96.16%	95.65%	92.54%
Feb-18	East	Bollin	1127.5	1088	1292.5	1190.5	669	636.5	1056.5	1022	96.50%	92.11%	95.14%	96.73%
Mar-18	East	Bollin	1308.5	1202	1517.5	1358	733.5	726	1315	1211.5	91.86%	89.49%	98.98%	92.13%
Apr-18	East	Bollin	1393.5	1316.5	1391.5	1293	732	674.5	1334	1307	94.47%	92.92%	92.14%	97.98%
Nov-17	Wirral	Brackendale	1105	1116	933.5	933.5	678.5	667	678.5	690	101.00%	100.00%	98.31%	101.69%
Dec-17	Wirral	Brackendale	987.5	966	1045	1033	713	713	713	701.5	97.82%	98.85%	100.00%	98.39%
Jan-18	Wirral	Brackendale	880	884	1139	1139	729.5	706.5	713	678.5	100.45%	100.00%	96.85%	95.16%

Feb-18	Wirral	Brackendale	900	896.5	1011	1012	644	644	632.5	632.5	99.61%	100.10%	100.00%	100.00%
Mar-18	Wirral	Brackendale	1080.5	1058.5	1063	1028	713	713	713	713	97.96%	96.71%	100.00%	100.00%
Apr-18	Wirral	Brackendale	1065.5	1066.5	971	910.5	678.5	678.5	701.5	690	100.09%	93.77%	100.00%	98.36%
Nov-17	Wirral	Brooklands	1026.5	1026.5	1114.5	1114.5	621	621	1104	1104	100.00%	100.00%	100.00%	100.00%
Dec-17	Wirral	Brooklands	898.5	852.5	1207.5	1207.5	644	609.5	1092.5	1069	94.88%	100.00%	94.64%	97.85%
Jan-18	Wirral	Brooklands	1030	1007	1278.5	1278.5	770.5	713	1006.5	983.5	97.77%	100.00%	92.54%	97.71%
Feb-18	Wirral	Brooklands	788	765.04	1230.5	1219	632.5	563.5	920	920	97.09%	99.07%	89.09%	100.00%
Mar-18	Wirral	Brooklands	949.15	945.15	1233.5	1176	675.5	675.5	912	912	99.58%	95.34%	100.00%	100.00%
Apr-18	Wirral	Brooklands	949	888.5	1118.5	1118.5	688	607	719.5	707.5	93.62%	100.00%	88.23%	98.33%
Nov-17	West	Cherry	1168.75	1105.25	1239.5	1210.5	644	632	1068.5	1057	94.57%	97.66%	98.14%	98.92%
Dec-17	West	Cherry	1362.25	1311.29	1288.5	1232	684	666	1101	1090.5	96.26%	95.62%	97.37%	99.05%
Jan-18	West	Cherry	1207.75	1177.75	1454.5	1446.5	670.5	628	1230.5	1223	97.52%	99.45%	93.66%	99.39%
Feb-18	West	Cherry	903	903	1483.5	1483.5	531.5	531.5	1173	1173	100.00%	100.00%	100.00%	100.00%
Mar-18	West	Cherry	1148.5	1148.5	1280	1314.5	575.5	575.5	1104	1104	100.00%	102.70%	100.00%	100.00%
Apr-18	West	Cherry	1016.25	1016.25	1445	1433.5	717.5	717.5	1162	1162	100.00%	99.20%	100.00%	100.00%
Nov-17	West	Coral	989.5	936.5	1317.5	1317.5	632.8	632.8	770.5	770.5	94.64%	100.00%	100.00%	100.00%
Dec-17	West	Coral	905.5	894	1358	1358	586.5	586.5	901.5	901.5	98.73%	100.00%	100.00%	100.00%
Jan-18	West	Coral	1032.3	1020.8	1364.5	1364.5	669	669	874	874	98.89%	100.00%	100.00%	100.00%
Feb-18	West	Coral	740	739	1321.5	1321.5	598.5	577.5	949	949	99.86%	100.00%	96.49%	100.00%
Mar-18	West	Coral	1276.5	1276.5	1150	1150	586.5	586.5	954.5	954.5	100.00%	100.00%	100.00%	100.00%
Apr-18	West	Coral	1389	1375	951.5	951.5	563.4	563.5	1012	1012	98.99%	100.00%	100.02%	100.00%
Nov-17	East	Croft	1200	1114.95	1860	1468.5	690	560.5	1380	1266.5	92.91%	78.95%	81.23%	91.78%
Dec-17	East	Croft	1227	1194.65	1922	1267.5	713	529	1426	1393.5	97.36%	65.95%	74.19%	97.72%
Jan-18	East	Croft	1242	1143	1565.5	1487.5	713	607	1426	1388	92.03%	95.02%	85.13%	97.34%
Feb-18	East	Croft	1093.5	980	1414	1411	644	575	1288	1259.5	89.62%	99.79%	89.29%	97.79%
Mar-18	East	Croft	1227	1028.5	1531	1610	713	691.5	1380	1340.5	83.82%	105.16%	96.98%	97.14%
Apr-18	East	Croft	1177.5	1160.5	1448	1514.5	690	667	1322.5	1329.5	98.56%	104.59%	96.67%	100.53%
Nov-17	West	Eastway A&T	1041	1041	1082.5	1058	609.5	609.5	806	806	100.00%	97.74%	100.00%	100.00%
Dec-17	West	Eastway A&T	835	812	1136	1136	616.5	605	786	774.5	97.25%	100.00%	98.13%	98.54%
Jan-18	West	Eastway A&T	712.75	689.75	1344.5	1328.5	598	598	855.5	855.5	96.77%	98.81%	100.00%	100.00%
Feb-18	West	Eastway A&T	929.5	923.5	1046.5	1046.5	479.5	479.5	830	830	99.35%	100.00%	100.00%	100.00%

Mar-18	West	Eastway A&T	892.5	892.5	1127	1127	590.5	590.5	870.5	870.5	100.00%	100.00%	100.00%	100.00%
Apr-18	West	Eastway A&T	812.8	801.3	1512.5	1512.5	661.5	661.5	890.5	890.5	98.59%	100.00%	100.00%	100.00%
Nov-17	East	Greenways A&T	1132.5	958.35	1725	1607.5	690	667	1035	1012	84.62%	93.19%	96.67%	97.78%
Dec-17	East	Greenways A&T	1197	1084	2001	1666	713	736	1288	1184.5	90.56%	83.26%	103.23%	91.96%
Jan-18	East	Greenways A&T	1272	1042.5	2139	1746	713	736	1426	1207.5	81.96%	81.63%	103.23%	84.68%
Feb-18	East	Greenways A&T	1057	986	1932	1519.5	644	667	1288	1092.5	93.28%	78.65%	103.57%	84.82%
Mar-18	East	Greenways A&T	1217	998.5	2139	1828.5	713	632.5	1426	1449	82.05%	85.48%	88.71%	101.61%
Apr-18	East	Greenways A&T	1170	974.5	1817	1805.5	690	563.5	1380	1403	83.29%	99.37%	81.67%	101.67%
Nov-17	West	Indigo	1088.5	1040.5	897	897	542.5	531	874	845	95.59%	100.00%	97.88%	96.68%
Dec-17	West	Indigo	900.5	854.5	1086.5	1086.5	598	586.5	897.5	895.5	94.89%	100.00%	98.08%	99.78%
Jan-18	West	Indigo	1063	1051.5	1068	1010.5	648	647	843	796	98.92%	94.62%	99.85%	94.42%
Feb-18	West	Indigo	950.5	919	1010	992	492	469	792	784.5	96.69%	98.22%	95.33%	99.05%
Mar-18	West	Indigo	1134.5	1116	908.5	903.5	658	646.5	830.5	766	98.37%	99.45%	98.25%	92.23%
Apr-18	West	Indigo	1233.95	1191.45	739.5	696.5	542	542	874.5	828.5	96.56%	94.19%	100.00%	94.74%
Nov-17	West	Juniper	1396.5	1379.5	967	932.5	685.5	685.5	724.5	724.5	98.78%	96.43%	100.00%	100.00%
Dec-17	West	Juniper	1392	1398	1034.5	977	663.5	652	951.1	933.6	100.43%	94.44%	98.27%	98.16%
Jan-18	West	Juniper	1306	1294.5	1186	1151.5	724	724	955	909	99.12%	97.09%	100.00%	95.18%
Feb-18	West	Juniper	1168.5	1136	1242	1230.5	713.5	710.5	906	896	97.22%	99.07%	99.58%	98.90%
Mar-18	West	Juniper	1164.5	1134	1122.5	1112	713	713	862.5	832	97.38%	99.06%	100.00%	96.46%
Apr-18	West	Juniper	1368.2	1322.2	1007	987.5	701.5	701.5	689.8	683.8	96.64%	98.06%	100.00%	99.13%
Nov-17	Wirral	Lakefield	1034	1034	1012	977.5	667	667	701.5	667	100.00%	96.59%	100.00%	95.08%
Dec-17	Wirral	Lakefield	1105.5	1105	1049	1025.5	690	690	908.5	885.5	99.95%	97.76%	100.00%	97.47%
Jan-18	Wirral	Lakefield	1151	1135.5	874.5	874.5	724.5	724.5	1012	1012	98.65%	100.00%	100.00%	100.00%
Feb-18	Wirral	Lakefield	996	996	897.5	897.5	632.5	632.5	862.5	862.5	100.00%	100.00%	100.00%	100.00%
Mar-18	Wirral	Lakefield	1204.5	1193	1012	1000.5	747.5	713	897	874	99.05%	98.86%	95.38%	97.44%
Apr-18	Wirral	Lakefield	1098.5	1098.5	1023.5	1023.5	736	657.5	793.5	782	100.00%	100.00%	89.33%	98.55%
Nov-17	East	LimeWalk Rehab	1104.5	1087.5	1035	1077.5	690	540.5	690	774.5	98.46%	104.11%	78.33%	112.25%
Dec-17	East	LimeWalk Rehab	1051	911	1069.5	1006.5	713	568	713	711	86.68%	94.11%	79.66%	99.72%
Jan-18	East	LimeWalk Rehab	1154	920.5	1069.5	1047.5	713	621	713	656.5	79.77%	97.94%	87.10%	92.08%
Feb-18	East	LimeWalk Rehab	1024	947.5	963	922	644	540.5	644	694.5	92.53%	95.74%	83.93%	107.84%
Mar-18	East	LimeWalk Rehab	1093.5	1035.5	1023.5	1008.5	713	671	713	731	94.70%	98.53%	94.11%	102.52%

Apr-18	East	LimeWalk Rehab	1062.5	1057.5	1000.5	1039.5	690	621	690	695	99.53%	103.90%	90.00%	100.72%
Nov-17	Wirral	Meadowbank	1141	1140.5	1520	1497	747.5	782	1107	1061	99.96%	98.49%	104.62%	95.84%
Dec-17	Wirral	Meadowbank	1098.5	1086.5	1387.5	1355.5	724.5	724.5	1138.5	1127	98.91%	97.69%	100.00%	98.99%
Jan-18	Wirral	Meadowbank	1081	1069.5	1771	1770.5	805	782	1334	1334	98.94%	99.97%	97.14%	100.00%
Feb-18	Wirral	Meadowbank	780.5	757.5	1403	1403	655.5	575	1311	1244	97.05%	100.00%	87.72%	94.89%
Mar-18	Wirral	Meadowbank	917.5	906	1644.5	1621.5	586.5	574.5	1391.5	1368.5	98.75%	98.60%	97.95%	98.35%
Apr-18	Wirral	Meadowbank	1175.5	1095.5	1524	1520	621	540.5	1434	1184.5	93.19%	99.74%	87.04%	82.60%
Nov-17	Wirral	Oaktrees	1256	1213	724.5	724.5	540.5	540.5	753.5	753.5	96.58%	100.00%	100.00%	100.00%
Dec-17	Wirral	Oaktrees	1174.5	1170.5	1323.5	1307	724.5	724.5	397.5	352.5	99.66%	98.75%	100.00%	88.68%
Jan-18	Wirral	Oaktrees	1228	1203	1275	1252.5	839.5	851	425.5	391	97.96%	98.24%	101.37%	91.89%
Feb-18	Wirral	Oaktrees	1160	1150	977	977	690	690	307.5	307.5	99.14%	100.00%	100.00%	100.00%
Mar-18	Wirral	Oaktrees	1179	1124	1198	1187.5	713	713	346.5	276	95.34%	99.12%	100.00%	79.65%
Apr-18	Wirral	Oaktrees	1361	1377	1215.5	1207	690	655.5	345	310.5	101.18%	99.30%	95.00%	90.00%
Nov-17	West	Rosewood	1028.5	1024.35	1523	1523	517.5	517.5	816.5	816.5	99.60%	100.00%	100.00%	100.00%
Dec-17	West	Rosewood	958.3	945.3	1389	1389	542	520.5	827.5	804.5	98.64%	100.00%	96.03%	97.22%
Jan-18	West	Rosewood	915.25	914.75	1401.5	1390	609.5	609.5	837	837	99.95%	99.18%	100.00%	100.00%
Feb-18	West	Rosewood	868.5	868.5	1372	1372	522.75	522.75	744.5	744.5	100.00%	100.00%	100.00%	100.00%
Mar-18	West	Rosewood	960.5	960.5	1322.5	1322.5	506	506	897	897	100.00%	100.00%	100.00%	100.00%
Apr-18	West	Rosewood	861.25	872.75	1421.5	1421.5	593.5	616.5	616.5	616.5	101.34%	100.00%	103.88%	100.00%
Nov-17	East	Saddlebridge	1039	994	1345.5	1265	690.5	587	678.5	778	95.67%	94.02%	85.01%	114.66%
Dec-17	East	Saddlebridge	998.5	914.5	1234.5	1173	678.5	544.5	747	745.5	91.59%	95.02%	80.25%	99.80%
Jan-18	East	Saddlebridge	993	932.5	1293.5	1305.5	655.5	625	805	828	93.91%	100.93%	95.35%	102.86%
Feb-18	East	Saddlebridge	917.5	850	1196	1140	563.5	540.5	747.5	770.5	92.64%	95.32%	95.92%	103.08%
Mar-18	East	Saddlebridge	1098.5	987.5	1296	1281.5	724.5	678.5	713	708	89.90%	98.88%	93.65%	99.30%
Apr-18	East	Saddlebridge	1077.5	999	1357	1345.5	644	644	793.5	793.5	92.71%	99.15%	100.00%	100.00%

Nov-17	Wirral	Willow PICU	1056	989.5	877.5	866.5	724.5	701.5	678	666	93.70%	98.75%	96.83%	98.23%
Dec-17	Wirral	Willow PICU	918.5	907	943.5	909	667	655.5	770.5	747.5	98.75%	96.34%	98.28%	97.01%
Jan-18	Wirral	Willow PICU	1028.5	973.5	991	935	724	724	713	701	94.65%	94.35%	100.00%	98.32%
Feb-18	Wirral	Willow PICU	931.5	913	901	900	644	644	655	655	98.01%	99.89%	100.00%	100.00%
Mar-18	Wirral	Willow PICU	1018	1006.5	845.5	822.5	724.5	712.5	655.5	632.5	98.87%	97.28%	98.34%	96.49%
Apr-18	Wirral	Willow PICU	806.5	783.5	908.5	920	759	759	724.5	724.5	97.15%	101.27%	100.00%	100.00%

APPENDIX 2

Physical Health in Mental Health – the right staff , the right skills in the right place and time

Physical health problems such as heart disease, respiratory disease, diabetes, swallowing difficulties, and malnutrition are under-recognised and sub-optimally treated among people with severe mental illnesses (Lawrence and Kisely 2010; McIntyre et al 2007). Delays in accessing care as a result of late identification by staff working in inpatient units can lead to poorer treatment outcomes contributing to the excess morbidity and mortality rates**.**

Patients and service users admitted to hospital with a mental health issue are becoming increasingly likely to also have complex physical health needs. Therefore, it is essential that staff in mental health settings meet patients' physical as well as mental health care needs.

Care Quality Commission (CQC 2017) recommend regular assessment of the physical health needs of patients with appropriate follow up including screening and intervention and monitoring of outcomes and the employment of medical, nursing and pharmacy staff and other healthcare professionals with the necessary skills and knowledge to oversee and deliver aspects of physical healthcare. This includes competent use of the equipment and correct interpretation of the results obtained.

One solution to consider is to develop new care models and building flexible teams across traditional boundaries, ensuring they have the full range of skills and expertise to respond to service user needs in different settings that can focus on improved outcomes for service users. This includes a range of mental health and physical health nurses, allied health professionals and advanced practitioners.

A mapping exercise has also taken place across all inpatient facilities looking at access to Allied Health Professional (AHP) services and its implications in timely care provision. There exists within care groups, an variation in accessibility to AHP and this impacts not only the physical health treatment received by our patients but can also increase length of stay.

A recommendation through the Safer Staffing Report would be a review of the inpatient workforce to prepare for the future, to develop new care models and flexible teams utilising a range of staff crossing all professions including nursing and therapies. Strong clinical leadership across all staff groups including AHPs can be used to drive improvements in service delivery and enhance the quality of care for patients using the service.

Current projects and recommendations

- Workforce Planning Group meeting in August to progress the inpatient redesign work and discuss planning future workforce skill mix and care modelling requirements
- Consideration of new roles and team structures on inpatient wards including associate nurses, advanced practitioners and a mix of registered general nurses and mental health or learning disability nurses.
- A mapping exercise has taken place across all inpatient facilities looking at access and variations to AHP services and its implications to care and treatment provision for our inpatients. This will be discussed at the workforce planning group.
- A review of patient physical health assessment forms to reduce duplication of work and appropriateness of forms, to help release time for care.
- Development of existing physical health improvement leads forum to promote physical health and share physical health innovation and expertise.

References

Care Quality Commission (2017) Brief guide: Physical healthcare in mental health settings https://www.cqc.org.uk/sites/default/files/20170612_briefguide-physical_cal_healthcare_mental_health_settings.pdf accessed 21.05.18

Lawrence D, Kisely S (2010). 'Inequalities in healthcare provision for people with severe mental illness'. Journal of Psychopharmacology, vol 24, no 4, suppl, pp 61–8.

McIntyre RS, Soczynska JK, Beyer JL, Woldeyohannes HO, Law CWY, Miranda A, Konarski JZ, Kennedy SH (2007). 'Medical comorbidity in bipolar disorder: re-prioritizing unmet needs'. Current Opinion in Psychiatry, vol 20, no 4, pp 406–16.

APPENDIX 3

Appendix for Safer Staffing paper – Specialist Mental Health: Place Based services

Overview

This appendix to the safer staffing update will seek to provide a position statement with specific reference to the services that fall within the Specialist Mental Health: Place Based portfolio and particularly focusing upon Community Mental Health Teams (CMHT). It will detail the current position together with the steps currently being undertaken to ensure that services and the workforce are positioned to respond to the *safer staffing* agenda by ensuring *the right staff, the right skills* and *the right place.*

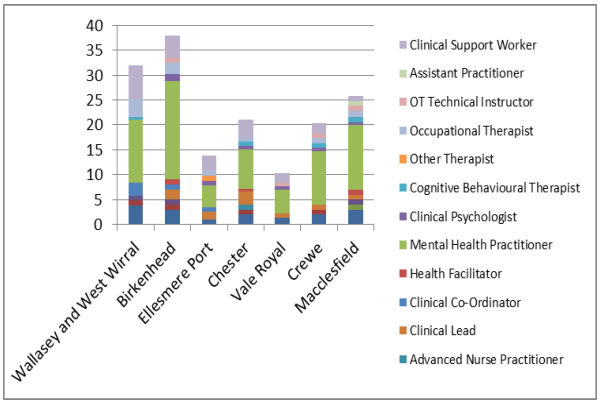
Background

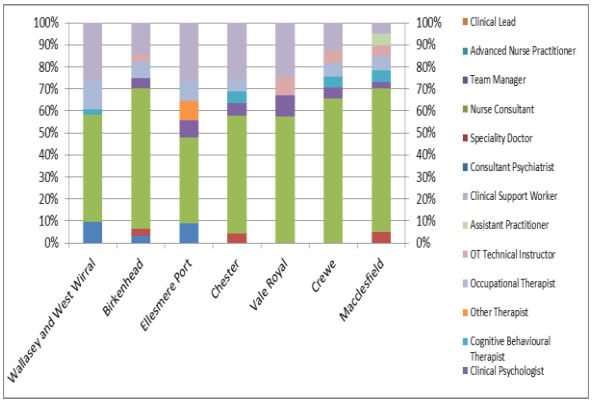
One of the Trust's key priorities is the Transformation of Mental Health Services with its signature quality initiative programme focusing upon the Responsive Care in Communities programme which seeks to ensure a Trust wide approach to the delivery of specialist mental health services that reduces unwarranted variation in practice, quality, experience and outcome of both physical and mental health and supports the delivery of place based care that uses the assets and skills of the local community to deliver integrated care. Taken in the context of an aging workforce and increasing difficulties in the recruitment of key roles it is imperative that this work programme takes an innovative approach to the development of new roles for both registered and non-registered staff that uses the assets and skills of the local community to integrate care delivery.

It should be noted that there are considerable interdependencies with the wider redesign of specialist mental health services, including the programme of work being done across Central and Eastern Cheshire to ensure that services are safe and sustainable; clinically effective and accessible whilst providing a good service user experience within the current financial envelope.

Current Position

CMHTs continue to operate as multidisciplinary teams, although the structure and composition of those teams varies significantly across the Trust's footprint. The table below illustrate the current composition of the teams for adults of working age – both in terms of the number of staff and proportionally.





It is evident that there is considerable variation across teams with regard to the types and mix of roles within teams without any agreed rationale for this. It is also worthy of note that those teams that are currently facing the greatest degree of challenge have the greatest proportion of qualified and least support staff. This variation is also evident within Older Peoples CMHTs with roles and functions having developed as a response to local demand, commissioning arrangements and clinical pathways.

The CMHT workforce is starting to routinely develop and utilise advanced skills and roles within clinical practice. Particular examples include the development of Non-Medical Prescribers, Advanced Practitioner roles, [although to date these positions are generally held by nurses], and the new Nursing Associate role. Historically, there has been little consistency across the organisation with regard to the development of these roles – particularly the Advanced Practitioner, and how the advanced skills are utilised to their optimum, Recent training positions have sought to address this and have been developed in a considered manner with the vision for services and the desire to address '*the right staff, the right skill, the right place*' agenda in mind.

<u>Right Staff</u>

An audit completed across CMHTs revealed a limited number of people who held advanced skills and a number of those lack current experience in their use – particularly the use of psychological interventions.

The current review of community services entails a clinically-led review of the current Care Clusters to ensure that they are NICE concordant together with the identification of the skills required to undertake each intervention and that it is delivered by the *right person, with the right skills in the right place* throughout the clinical journey. This will support services to identify an appropriate skill mix and optimise their capability, enabling recruitment and training and development to be considered planned way that maximises teams' capability through the use of innovative roles.

Evidence based approaches to caseload management, for example Choice and Partnership Approach (CAPA) are also being explored to ensure that workforce capability (capacity and skill) is available in right place to meet demand.

Right Skills

There is already a recognition (due to differing commissioning arrangements) that there are gaps in relation to the monitoring of peoples' physical health and wellbeing as well as access to psychological interventions [including interventions around personality disorder]. There is also recognition that there are training needs within the wider workforce resulting in the involvement of Education CWP and Organisational Development to support this.

Although very much in its infancy, progress is already being made towards addressing the clinical gaps utilising new roles with the Nursing Associate and new Advanced Practitioner roles being a clear example of how Specialist Mental Health: Place Based services are seeking to ensure that there is a robust approach to meeting the physical health needs of service users.

Right Time

It is important to recognise that the wider redesign of health and care systems impact upon the delivery of care within CMHTs too as the move to deliver Place Based care that addresses the needs of local populations' gains momentum.

Whilst the move towards integrated models of delivery is at different stages across the organisation, there is a unilateral acknowledgement of the need to develop increased links with Primary Care services – either through closer working practices or the development of new roles, to provide earlier intervention, reduce duplication and unnecessary consultations/ contacts and to address the mental health needs of people with other long term health conditions. Several 'pilot' programmes are in progress across the organisation trialling models with the aim of providing earlier support and intervention for the local populations.