NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD PUBLIC
3 December 2020

Title	Safer Staffing 6 Monthly Review of In-patient staffing levels and Community Health Teams.
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Purpose of the Report

To present to the Board a report on in–patient mental health nurse staffing and community health safer caseload review levels. This is in line with the national expectations of NHS providers to providing safe staffing levels in all care settings, this is in line with a requirement to provide the Board with a report outlining the assurance and issues related to safe nurse staffing levels at six monthly intervals.

Summary of Key Issues

This report informs the Board on the steps taken to meet the expectations detailed in the guidance produced by the Chief Nursing Officer and the National Quality Board, '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 (2013).

This paper focuses on our approach to ensuring that levels of nurse staffing which includes registered and unregistered nursing staff match the dependency needs of patients during the period April 2020 –October 2020. The paper identifies causes and actions taken to address issues relating to safe staffing.

The report includes the staffing response to Covid 19 challenges for our clinical workforce and offers assurance of actions taken to mitigate challenges.

There is likely to be a change a model from NQB to "team around the patient" concept that takes into account the MDT model for mental health.

Strategic priorities this paper supports

Improved population health outcomes	☒	
Improved experience of care	☒	The right staffing numbers to meet the service user needs and respond accordingly.
Improved staff experience	☒	The right staff numbers creates an environment where staff can safely practice and deliver high quality care
Improved value	☒	The right staffing resources reduces the need for agency and promotes consistency of practice.

Committees/Meetings where this item has been considered

Date	**Committee/Meeting**

Implications

Equality Analysis	The Trust has a duty to promote equality in the recruitment of the nursing workforce.
Risk and Assurance	The following clinical risks are associated with inadequate nursing and care staffing capacity and capability: • Inadequate staffing numbers compromise safe and compassionate care. • Poor monitoring of staffing capacity and capability can give rise to unacceptable patterns of inadequate staffing • Not having the right skill mix in clinical environments can place unacceptable, additional demands upon staff and give rise to unsafe and ineffective care. • If staff feel unable to speak out, then potentially unsafe staffing levels go undetected and reported and steps to maintain patient safety not be taken as required.
Service User/Carer/Staff	Inadequate staffing numbers compromise safe and compassionate care.
Financial	Poor monitoring of staffing capacity and capability can give rise to unacceptable patterns of inadequate staffing
Quality	Not having the right skill mix in clinical environments can place unacceptable, additional demands upon staff and give rise to unsafe and ineffective care.

Supporting documents and research material

a. Reference: 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 (National Quality Board 2013)

b. Mental Health Staffing Frame work

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

c. Safe, sustainable and productive staffing in district nursing services (National Quality Board 2018)

   https://improvement.nhs.uk/resources/safe-staffing-district-nursing-services/

Glossary

Abbreviation	In full
CHPPD	Care Hours Per Patient Day
CAMHS	Child and Adolescent Mental Health Services
NQB	National Quality Board

1.0 Background

1.1 Further to the Robert Francis Report (2013), the National Quality Board (NQB) have published guidance that sets out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for service users.

1.2 In July 2016 the NQB issued a follow up paper "*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe sustainable and productive staffing"* which outlines an updated set of NQB expectations for Nurse staffing within Acute Trusts. We are awaiting further guidance in relation to Mental health staffing response to Covid 19 demand, outlining "care around the patient "concept.

1.3 This is the Eleventh report to the Board summarising the results of the Trust monitoring of staffing levels across all mental health and continuing care wards and covers the 6-month period from April 2020 to October 2020.

2.0 Covid – 19 Impact on safer staffing inpatient

2.1 In response to the pandemic the NQB are outlining a proposal for an amended safer staffing framework for mental health and learning difficulties. The proposal outlines the context of the pandemic waves, challenges around reduced staff availability alongside changing and unpredictable patient acuity and care needs, recognising that the ways in which we have mitigated these risks that may not be reflected in the safer staffing data:

2.2 There have been additional impacts resulting from the pandemic and restoration and recovery phase of COVID-19 which included: isolation of patients as part of IPC, use of PPE, alterations to visiting and leave, loss of formal and informal social support networks, changes to therapy delivery and absence of key staff due to social isolation and increase acuity and flow through our inpatient and community services.

2.3 The proposal outlines that staffing within MH utilises a MDT approach Restoration and Recovery, alongside a second wave pandemic presents an opportunity to deliver a 'team around the patient' concept. maximising the use of staff resource in the wider sense and ensuring that there are sufficient staff to meet the increased and changing patient demand.

2.4 Some of the ways in which we created flexibility within our workforce and "team around the patient" during the report period were;

- From June 2020 to September 2020 year 2 and year 3 student nurses were able to take up aspiring nurses role at band 4 providing front line care. (70 in London, 40 in Luton and Bedford).
- Increased use of flexible roles working across areas such as Occupational therapy assistants and Psychology assistance who assist with tempering the therapeutic environment.
- Additional flexible roles working across a system such as discharge co-ordinators, duty senior nurse support workers.
- Direct care Infection control roles such as housekeepers and local infection control champions.
- Senior staff providing direct patient care and support.

2.5 During wave one a peripatetic team was created primarily to staff a Covid 19 positive area within units, however it was also operationalised to provide support in the event of increased patient acuity / staffing deficits. This model can be re-established if variable

acuity and or staff deficits occur in the second wave. This enabled a team to work alongside colleagues who know the service users.

2.6 "Team around the patient" interventions are not captured through health roster therefore this report does not include a data highlight report as this data is meaning-less in relation to offering assurance.

3.0 Management of Staffing Levels

3.1 From April to July staffing availability was significantly affected by Covid-19 related sickness staff sickness. As track and trace protocols were initiated staff attendance has also been affected by self-isolation following contact with an individual with Covid-19. These absences are often initiated with minimal notice and therefore have a significant effect on immediate staff availability and have the ability to negatively impact care. The trust initiated recording of COVID-19 absences and working from home arrangements supporting accurate reporting and tracking, which enabled early intelligent deployment of staff into teams.

3.2 To ensure appropriate staffing levels are maintained a number of actions continued: a review of staffing levels shift by shift by ward staff and immediate managers, during the daily safety huddle the duty senior nurse has an opportunity to move resources to meet staffing deficits and to address issues of risk or acuity. Overall staffing issues are subject to review in the weekly locality senior nurse meetings and two monthly rota reviews with the Director of Nursing, Service Lead Nurse and the Safecare Lead.

3.3 Professional judgement has been paramount in managing unplanned absences or increased demand, alongside the skill mix and competencies of the nursing staff. Within MH and Community Health Services wards, who is on duty can be as important as actual numbers. During restoration and recovery, professional judgement is particularly important and experienced staff have been available to support teams to make decisions to provide the safest care possible across the organisation.

3.4 Escalation processes through Gold, silver, and bronze structure are in place and staff have been encouraged to escalate and report staffing incidents and concerns. During the peak of wave 1 the framework of Gold, Silver and Bronze command monitored daily sickness/absence and any potential impact patient on safe care, enabling swift and agile response to any deficits. In wave 2 the structures remain but are less frequent staffing concerns can still be escalated through these structures

3.5 Where staffing deficits are identified with no mitigating action taken a datix is generated and reviewed by the manager for the service. During this period all incidents reported on datix have been reviewed by the Borough lead nurse to ensure patient care has not been impacted, and to review requirement for mitigation to reduce risk of reoccurrence.

4.0 Safer staffing and care hours metric

4.1 We continue to record safer staffing and use Care Hours per Patient Day metric.

4.2 The ward staffing information is published monthly on the NHS Choices and Trust Website.

4.3 Health roster are initiating a programme to include care hours into health roster. This will enable managers to more easily match staffing and acuity. We await further guidance on the assurance frame work for "care around the patient" model.

5.0 Community Health

5.1 Across Community Health Services there has been an impact of staff sickness / absence which has been monitored in daily safety huddles and team skill mix adjusted accordingly. There has been daily scrutiny of caseload to ensure our most dependent patients are prioritised with face to face visits and less dependent and those that can be educated to meet their own care needs are responded to by staff that are unable to visit the patient at home. A quality improvement project was undertaken across CHS Community Nursing teams to provide assurance of safe systems for monitoring and review of the patient caseload. The work was informed by the clinical response and ongoing review for meeting individual patient and family / carer needs experience during wave 1 of the pandemic.

5.2 The Nursing and Therapies teams has been responsive to the wider care sector to ensure people can remain out of hospital, where appropriate. Staff have worked to achieve swift, yet safe transfers of people as well as enabling increased community care capacity, by the following ways:

- Integrated Discharge Hubs to support redesigned patient discharge pathways.
- Care homes - providing training, advice and support
- Supporting local testing centres for Covid 19
- Creating dedicated Covid positive wards for the wider care sector both in Bedfordshire and East London (WEL).

The pandemic has also prompted teams to consider how we work with people to manage their health, bringing an opportunity to create alternative approaches that enable people to proactively manage aspects of their health condition and care eg self-administration of Insulin.

6.0 Safer Nursing Care Tool NHSE/I

ELFT CHS are members of the national Expert Working Group (EWG) for developing a Safer Nursing Care Tool for Community Nursing services. CHS have previously been part of the foundational work of the safer staffing caseload tool which is now being developed by NHSE/I to be validated as a national tool for Community Nursing. The project will review community nurse staffing decision support tools for establishment setting ensuring the right care, at the right time in the right place aligned with patient outcomes.

Data collection across participating community Nursing teams will take place during December, for submission and approval by the Clinical Reference Group and Shelford Group.

7.0 Care Hours Per Patient Day (CHPPD)

7.1 Each NHS Trust now reports CHPPD on each ward monthly via a report to NHS Improvement which is made available and benchmarked via the Model Hospital website.

7.2 CHPPD is calculated on each ward by totalling the number of Nursing and Healthcare Support Worker Hours in a 24hr hour period divided by the number of in-patients at midnight. We were unable to access this data for this report but will provide an analysis in the next quarters report

7.3 NHS Improvement have yet to issue guidance on appropriate ‘ranges’.

7.4 There are significant variations between Trusts based on shift patterns and the skill mix of nursing teams.

8.0 Community Health Services

8.1 It is essential that we have data to demonstrate the role of the District Nurse and inter related Community Nursing roles as well as to inform workforce planning; we need to ensure the right skills from the right level of professional is coordinated around a person's care needs.

8.2 In the previous report the Board received the first data set for the Community nursing teams using the safer caseloads tool (2017) with the intention to present subsequent reports on safer caseloads within District Nursing at six monthly intervals; this would align with inpatient unit reporting, enabling us to build a robust and more reliable data set for workforce planning and monitoring aligned to patient caseload.

8.3 On the first data collection staff skills and familiarity of data gathering was variable and despite data cleansing there were gaps in data quality. To address this training took place in January 2020 with a Coordinator for safer caseloads, locality team leads and Team leads in attendance. We had intended to do a 2nd data collection in March which has been delayed as a result of the Coronavirus pandemic; this will be rescheduled as soon as possible.

8.4 Health roster in Community – the implementation of Health roster across all three community health services has made steady progress which will accelerate with the appointment of a Project Manager to continue the programme; community teams have been identified as a priority within the programme and will recommence from the end of June 2020.