TRUST BOARD MEETING - PUBLIC

Meeting details

Date of Meeting:	30th May 2024
Title of Paper:	Safer Staffing – MHOST Annual Establishment Review
Author:	Portia Aveling, Interim Deputy Director of Nursing and Practice
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Discussion
Submission to Committee:	Regulatory Requirement

Overview of Paper

The aim of the paper is to provide a summary of the annual establishment review for all KMPT's Acute inpatient wards, forensic and specialist wards and community inpatient rehabilitation services. The review aims to support skill mixing, workforce planning and demonstrate any initiatives supporting safer staffing as well as meeting statutory requirements.

Issues to bring to the Committee's attention

The Mental Health Optimal Staffing Tool (MHOST) data collection occurred between 8th and 28th January 2024.

Some data accuracy concerns were identified which have highlighted the need for greater familiarity and fidelity with the use of MHOST. The process will be more regular through 24/25 once some additional training and systems work and training is complete.

Interpretation of Results:

The overall staffing picture is safe with continued improvements in key areas of missing charge cover (number of registrants on duty), and additional duties (covering observations and/or unplanned absence) through the roster review process. There are areas that require improvement to support consistency and efficiency but these do not pose safety concerns. These are:

1) Inpatient rehabilitation units and some older adult wards that are standalone geographically, are challenged with acuity and ensuring staffing is safe. New Ruby ward will resolve this for one older adult ward. It also creates opportunities for the Directorates to work differently to ensure a more efficient and patient focussed team-based way of working across hospital sites – which will need to consider patterns of activity such as patient leave, group activities and ways of working with distress and risk that are not wholly reliant on observations.
2) Clinically ready for discharge patients and wards functioning below optimal bed occupancy impact acuity and efficiency. This is anomalous in the current climate of high demand for beds

but is better understood when the swing in demand for male or female beds is taken into account over the data collection period.

3) The current staffing model includes the changed shift pattern and roster reviews. Further work is needed to improve the organisations understanding of safer staffing and the rigour of local reviews of staffing demand and patterns of work in teams.

Please note that all detailed data is available on request.

Governance

Implications/Impact:	Patient Safety: High numbers of vacancies and use of temporary staff can impact on patient care and safety.
Assurance:	Reasonable
Oversight:	Workforce and Organisational Development/Board

Background and context:

The annual inpatient establishment review is a statutory responsibility for the Chief Nursing Officer to complete on behalf of the Board. The review must comply with requirements set within the National Quality Board report (NQB) (2016) and updated (2018); Supporting NHS providers to deliver right staff, with the right skills in the right place at the right time.

Demonstrating sufficient staffing is one of the fundamental quality and safety standards required to comply with the Care Quality Commission (CQC) regulation. CQC Regulation 18; "To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times".

Findings of the Independent review of Greater Manchester Mental Health NHS Foundation Trust identified workforce challenges as an area of learning linked to planning and managing risk. Low staffing particularly for nursing and support for newly qualified nurses were found to be significant areas of concern that Trusts should consider.

This MHOST establishment review collected data over a 21-day period from 8th January to 28th January 2024.

The review has fully considered multi professional contributions to inpatient care settings across all the directorates with exclusions for social workers, administration and matrons.

1. Methodology and data collection

The development of the MHOST was commissioned and funded by Health Education England (HEE). The tool is applicable in the following settings: Working age adult admissions wards; old age functional and dementia ward; forensic (High and Medium secure) wards; Perinatal Mother and Baby Units and Low Secure and Rehabilitation wards.

The collection of the data was supervised by the ward manager and matron of each unit/ward. Wards were provided with the guidance and the data collection tool. The Heads of Nursing and Quality along with the Matrons monitored application of the tool and the collection of the data.

The guidance set out the criteria for acuity levels 1-5 specifically designated for their service, with 1 being the lowest level of dependency and 5 the highest. The staff could use professional judgment in deciding the most appropriate level of acuity. Staff collecting acuity and dependency data must have had an insight into the patient's current care needs and clinical presentation within the last 24 hours and not just how the patient presented at the point of collection at 3pm.

Data was collected over a period of 21 days from 8th January to 28th January 2024. The MHOST was moved from December to January as the 2022 audit data was impacted by the festive period. Patients on extended leave more than 4 hours were not included. If they were on overnight leave, they were discounted. Long periods of escorted leave are already included in MHOST tool, they were not added separately.

The MHOST required that Full Time Equivalents (FTE) hours worked by substantive staff, NHSP and agency were included. Two sets of staffing data were used in the analysis and were supplied by Finance department and Eroster for the January 2024 period. This is the second time the Eroster data was used to look at the hours confirmed as being work on the wards through the roster as well as the finance actual worked hours. The use of the two data sets enables a more accurate picture and cross-

referencing role for inclusion or exclusion. This data excluded roster information for Covid-19 isolations, maternity leave and career breaks as this skews results. Absences such as annual leave and study leave are accounted for in the headroom which is used in the MHOST tool. Administrative and senior managerial roles such as matrons, ward administrators, service managers and related apprentices were excluded.

The headroom in the Trust varies, in Acute Care Group is 23% and the other are groups have 21%. The recommended headroom in the MHOST tool is not less than 22%. As the Trust moves to more frailty and needs led wards the headroom percentage will need to be reconsidered.

The Ready for Action (RfA) time is the percentage of time allocated to a staff member for their breaks. Time is set in the MHOST for the particular ward type, ranges between 8.6%-9.1% depending on the type of ward being analysed. This has been set at 8.3% for this review however this may need to be reconsidered as the long day shift patterns embed.

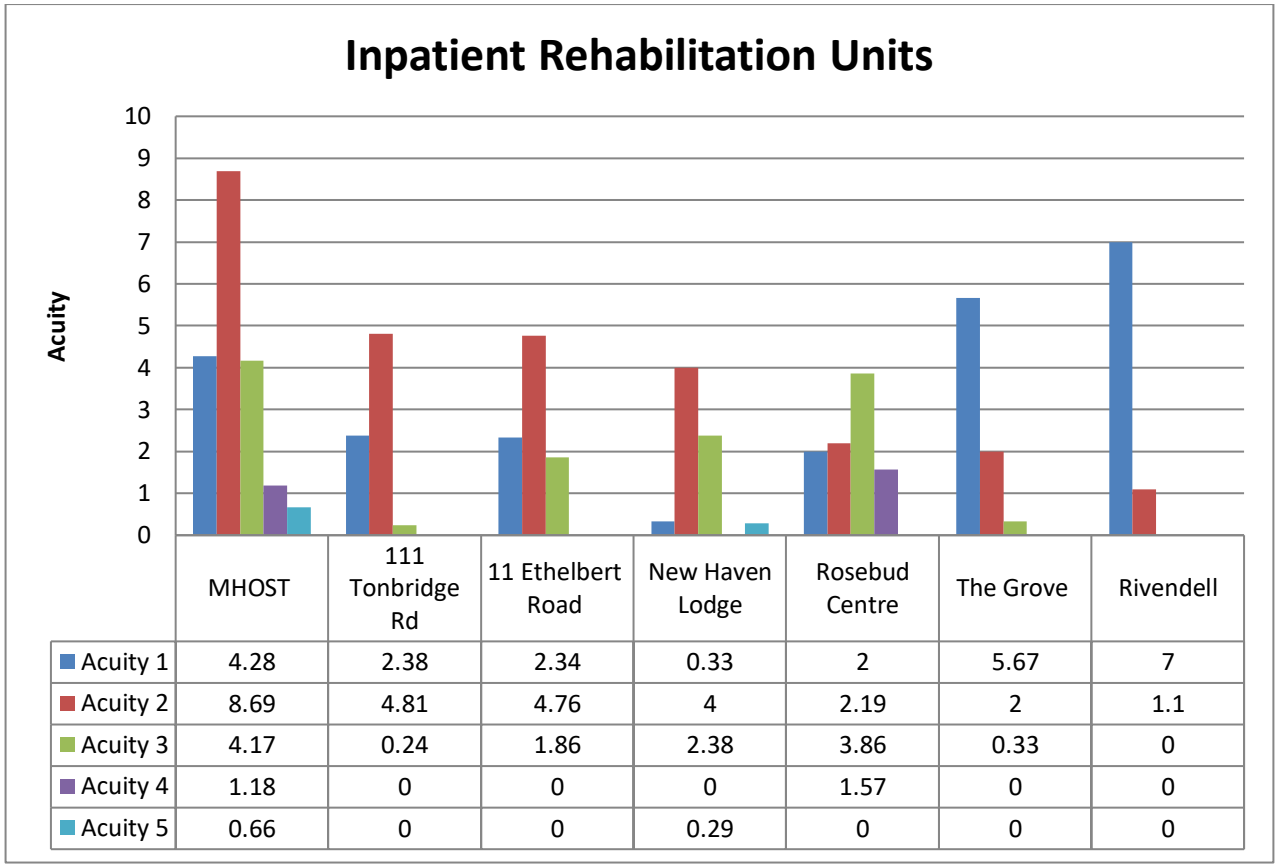
2. Results:

The results were collected in specialism or directorate and benchmarked against the corresponding MHOST specialist service.

3. Community Directorates Inpatient Rehabilitation Units

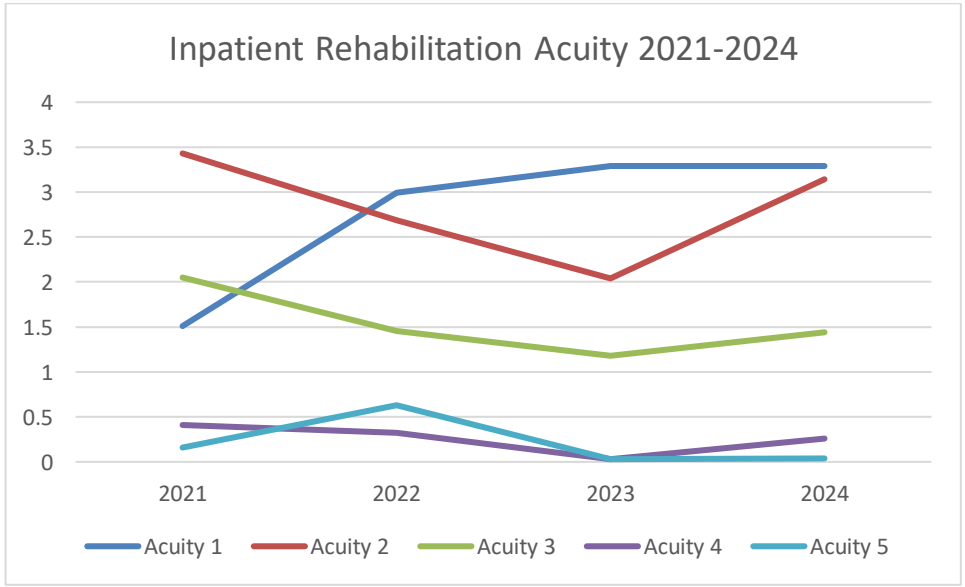
There is mixed support around the validity of the MHOST being used for inpatient rehabilitation units such as those that operate within KMPT. However, this is were the importance of using professional judgement and other data to review alongside the MHOST. In was noted during the collection period that there were no reported COVID or infection outbreaks or Inphase reports recorded linked to insufficient staffing.

Lower occupancy in these units has the effect of increasing the Care Hours Per Patient Day (CHPPD) but this can result in the establishments appearing inefficient. This can be good for patient experience but costly in relative terms. The requirements to meet safer staffing levels and safe acuity levels mean that there is not much room to flex staffing to accommodate this variation in need. The pace of discharge is slower, the units are standalone and the remote geographical areas impacts the ability to have higher acuity patients. Therefore, KMPT's units appear over staffed and costly. This will likely be a continued MHOST reporting pattern unless the rehabilitation delivery model changes.



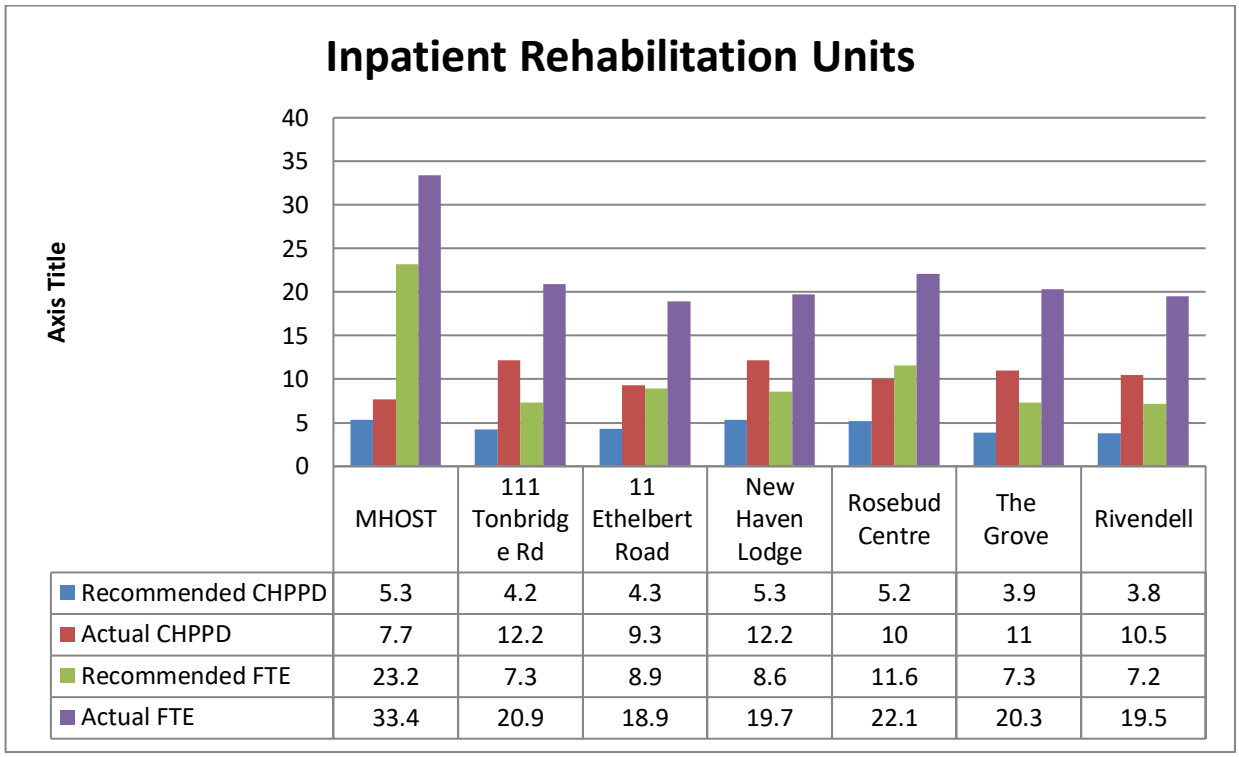
	MHOST	111 Tonbridge Rd	11 Ethelbert Road	New Haven Lodge	Rosebud Centre	The Grove	Rivendell
Acuity 1	4.28	2.38	2.34	0.33	2	5.67	7
Acuity 2	8.69	4.81	4.76	4	2.19	2	1.1
Acuity 3	4.17	0.24	1.86	2.38	3.86	0.33	0
Acuity 4	1.18	0	0	0	1.57	0	0
Acuity 5	0.66	0	0	0.29	0	0	0

All 6 inpatient rehabilitation units have reported lower acuity for the for the application of the tool in comparison to benchmark wards. Previous reports have identified contributing factors as delayed transfers of care (DTOC) now known as clinically ready for discharge (CRFD) along with the units running with vacant beds. However, on this analysis, low bed occupancy appears to be the biggest contributor to the lower acuity and this therefore increases the care hours per patient day (CHPPD). Rivendell reported all 7 patients at acuity level 1 which would be reflective of patients nearing discharge but also goes against the suggested acuity for rehabilitation units.



The standalone style of these units means that they cannot vary staffing to reflect a reduction of occupancy or acuity due safety requirements. It however notable, that the staffing is lower in terms

of FTE for these units. This suggests that the nature of the model is the issue here with lower acuity and underoccupancy being the primary factors.



	MHOST	111 Tonbridge Rd	11 Ethelbert Road	New Haven Lodge	Rosebud Centre	The Grove	Rivendell
Recommended CHPPD	5.3	4.2	4.3	5.3	5.2	3.9	3.8
Actual CHPPD	7.7	12.2	9.3	12.2	10	11	10.5
Recommended FTE	23.2	7.3	8.9	8.6	11.6	7.3	7.2
Actual FTE	33.4	20.9	18.9	19.7	22.1	20.3	19.5

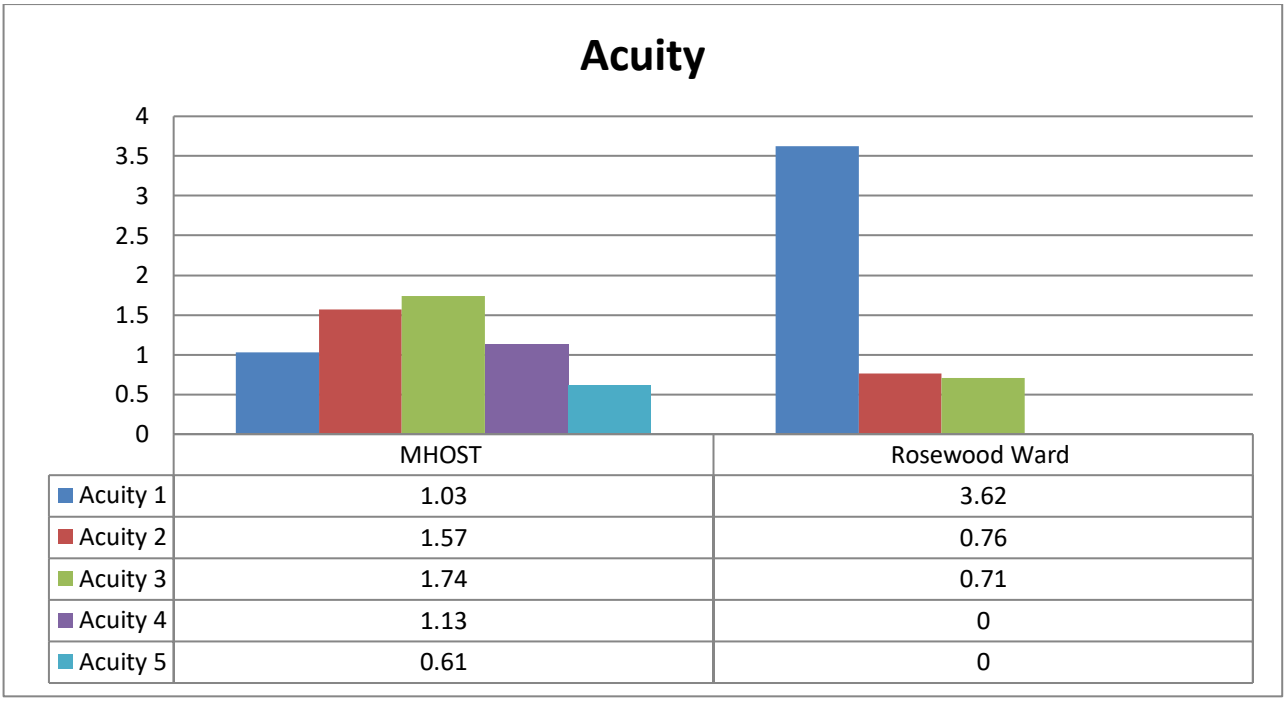
4. Forensics and Specialist Directorate:

The forensic and specialist directorate (FSD) services are mapped against their identified MHOST with the exception of Bridge House. Bridge House is a substance misuse rehabilitation specialist unit which is a setting the MHOST is not validated for. During the MHOST collection period there was one reported COVID outbreak on Walmer Ward resulting in the ward closure and one InPhase recorded for Emmetts Ward in relation to insufficient numbers of healthcare professionals. This obviously impacts the results of data collection for those teams.

Data accuracy issues were identified within the FSD collection as patients on extended leave were recorded under acuity 1. Where possible these were amended.

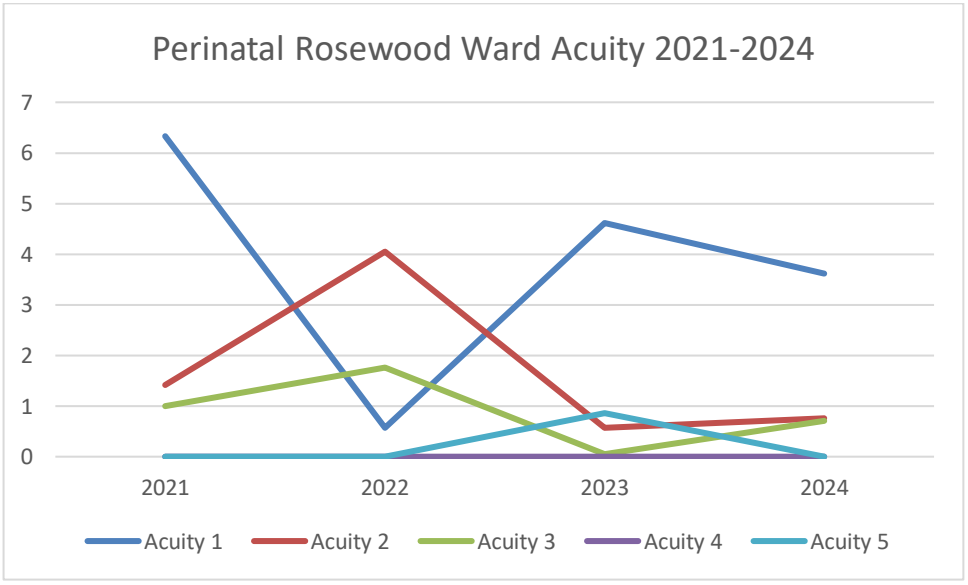
Rosewood Mother and Baby Unit (MBU)

Mother and Baby Unit staffing levels are predetermined by Royal College of Psychiatry: Service Standards for Mother and Baby Units (2014) and NHSE/I. The multi-disciplinary team (MDT) staffing levels are not varied according to acuity, as they are set standards and include specialist roles. Other needs such as enhanced observations are met by increased staffing levels. Rosewood is operating within this guidance. During the data collection period the MBU did not record any covid or infection outbreaks requiring ward closure and there were no InPhase reports linked to insufficient staffing. However, the unit didn't run at full bed occupancy with an average bed occupancy of 5 out of 8 beds occupied. This will impact acuity and CHPPD figures when comparing with the MHOST averages.

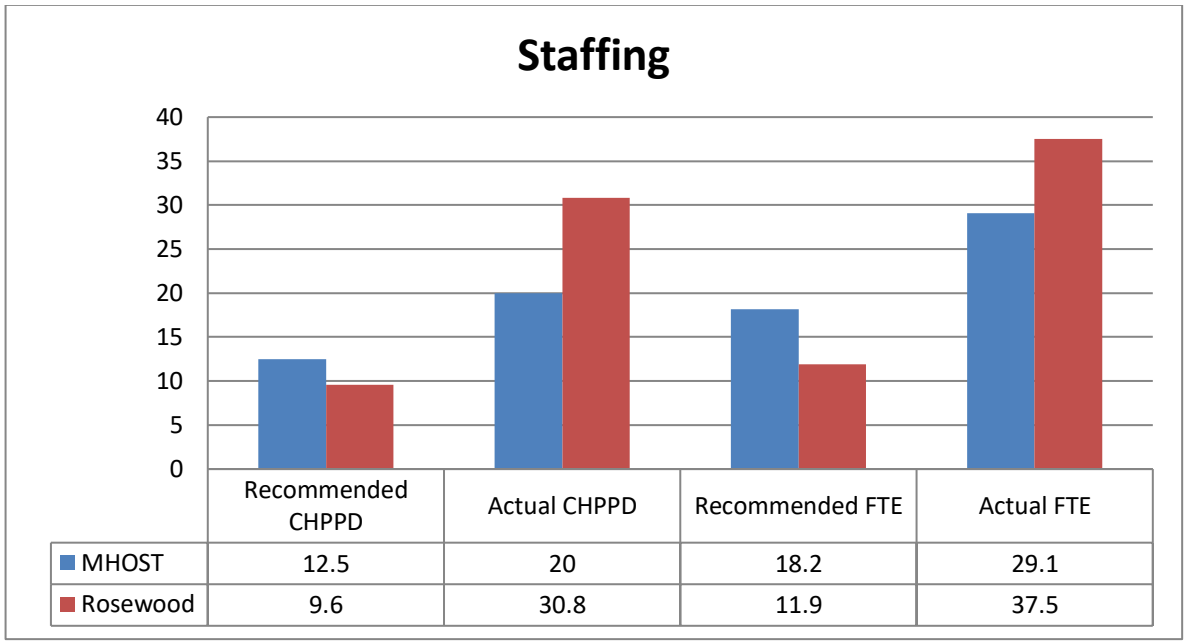


	MHOST	Rosewood Ward
Acuity 1	1.03	3.62
Acuity 2	1.57	0.76
Acuity 3	1.74	0.71
Acuity 4	1.13	0
Acuity 5	0.61	0

Acuity continues to remain slightly lower that the MHOST wards with no Acuity 4 or 5 listed. This is consistent with previous MHOST reports with only 1 Acuity 5 mother being recorded for the first time in December 2022. Most patients were recorded as acuity 1, with no recorded level 4 patients. It is important to consider that although the mother may be recorded at acuity 1 the babies may require more intense support and resource.



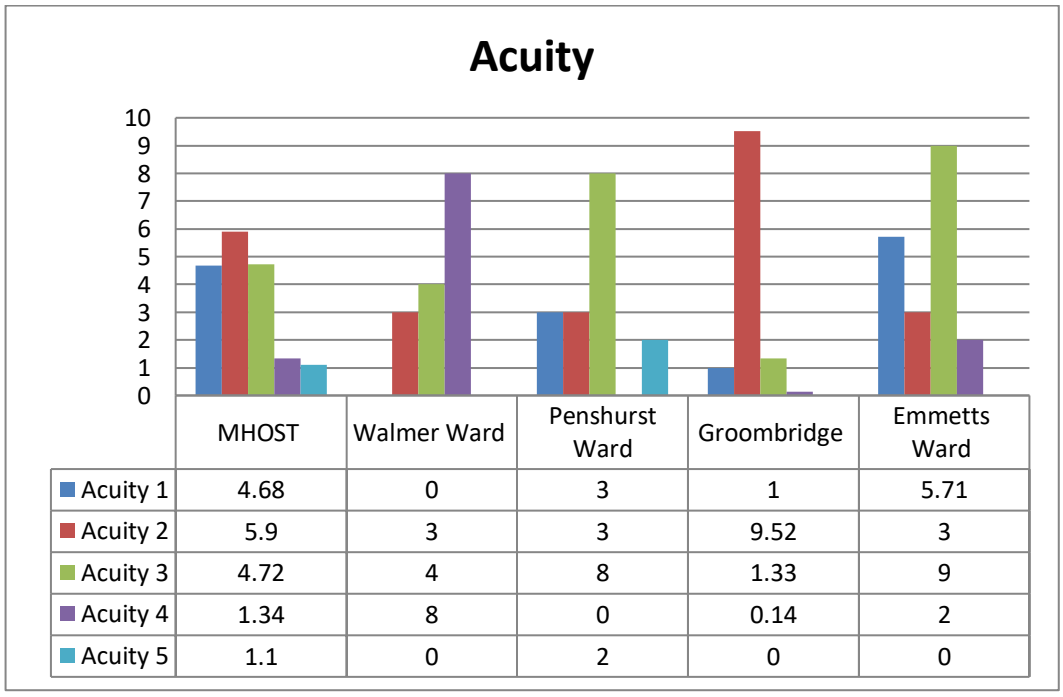
Rosewood FTE and CHPPD figures are consistent with the previous MHOST results and continue to run higher than the recommended figures although this MHOST are more inline than last year's FTE calculations. This higher running pattern is seen in the benchmarking wards and is reflective of how the care for the mother and the baby are individually assessed with staff increasing as required to support the baby's needs. This often results in the service being perceived as expensive, however there may be opportunities to look at staff being utilised differently or using short notice annual leave options when the unit is running under occupancy. Some initiatives are already in place with the team to find some workable solutions to this.



	Recommended CHPPD	Actual CHPPD	Recommended FTE	Actual FTE
MHOST	12.5	20	18.2	29.1
Rosewood	9.6	30.8	11.9	37.5

Medium Secure Unit (MSU)

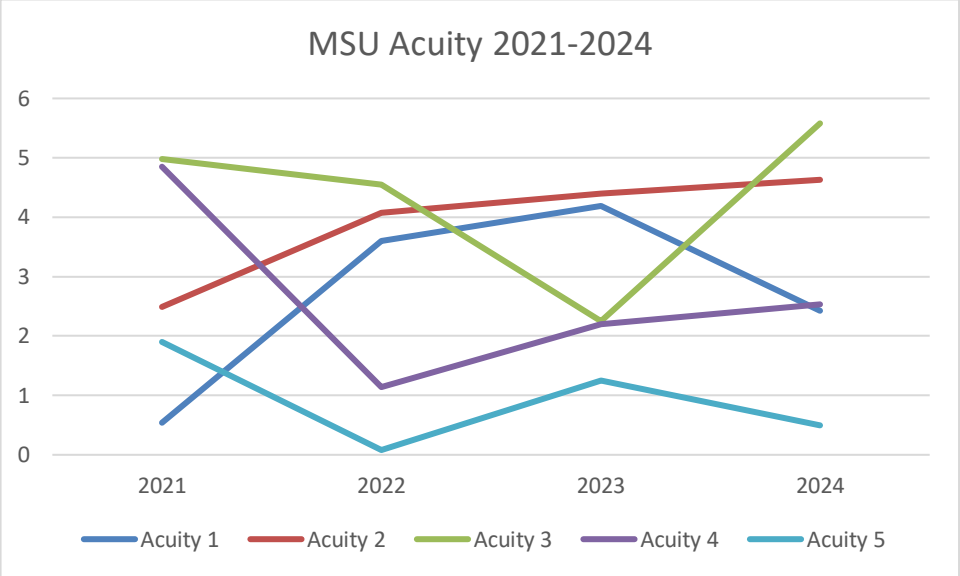
KMPT's medium secure wards host patients under Ministry and Justice restrictions which by their nature means that the pace of progress is cautious before patients can move on or be discharged. Often this results in longer term inpatient stays, that could be seen in with the recording of low or repetitive acuity scores. During the data analysis for these wards it was noted that Walmer had a COVID outbreak, patients had been included when on leave and one InPhase was recorded for Emmetts ward related to insufficient numbers of healthcare professionals.



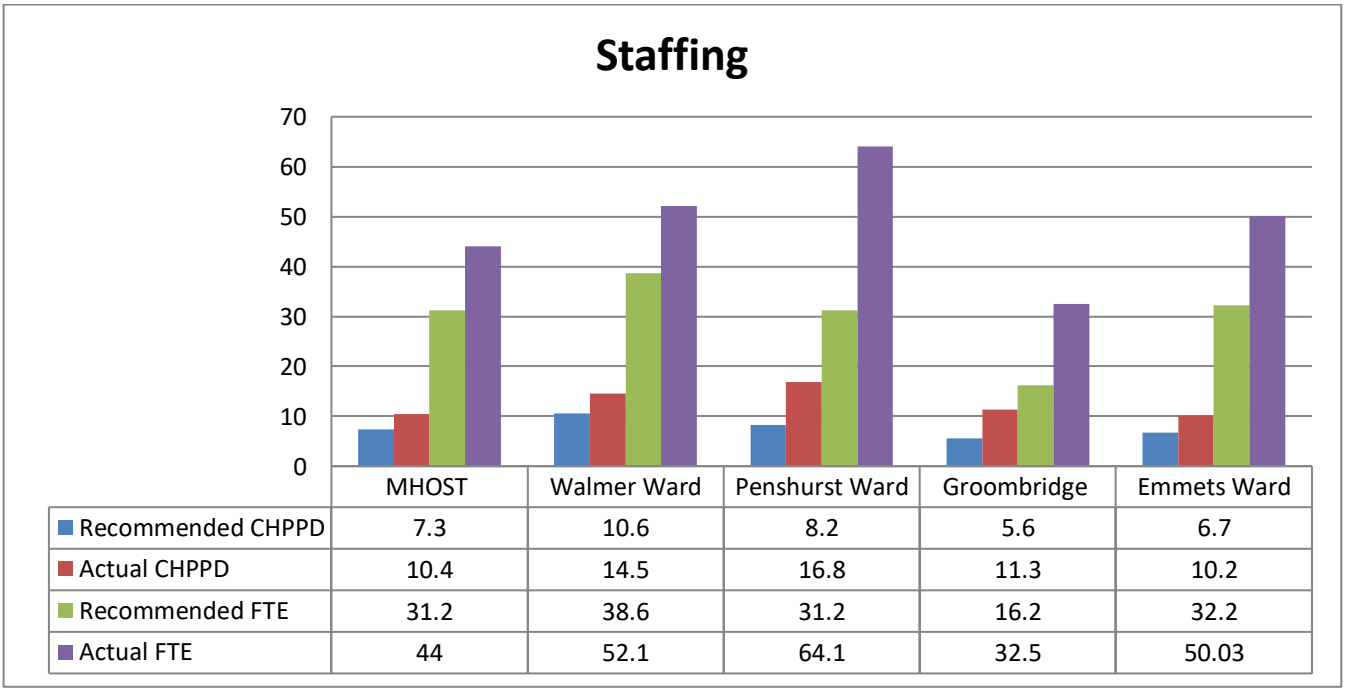
	MHOST	Walmer Ward	Penshurst Ward	Groombridge	Emmetts Ward
Acuity 1	4.68	0	3	1	5.71
Acuity 2	5.9	3	3	9.52	3
Acuity 3	4.72	4	8	1.33	9
Acuity 4	1.34	8	0	0.14	2
Acuity 5	1.1	0	2	0	0

The acuity in the MSU did not follow previous or expected trends with only Penhurst having acuity 5 patients. This results in the overall higher patient acuity levels (4&5) coming down whilst the number of acuity 3 patients have increased. This is not the expected acuity pattern for these types

of ward when comparing to the MHOST benchmark wards and is an area for the directorate to review as this will impact the CHPPD and FTE recommendations.



The MSU wards are awaiting refurbishment or maintenance updates which were highlighted in the annual ligature audit. This means professional judgement around staff staffing and admissions is essential to mitigate against the environmental challenges. The recommended and actual CHPPD hours are more consistent with MHOST benchmark wards expectations although due to the lower acuity there is a bigger gap between the recommended and actual CHPPD. This is particular notable for Penshurst and is link to having no acuity 4 patients recorded.



	MHOST	Walmer Ward	Penshurst Ward	Groombridge	Emmets Ward
Recommended CHPPD	7.3	10.6	8.2	5.6	6.7
Actual CHPPD	10.4	14.5	16.8	11.3	10.2
Recommended FTE	31.2	38.6	31.2	16.2	32.2
Actual FTE	44	52.1	64.1	32.5	50.03

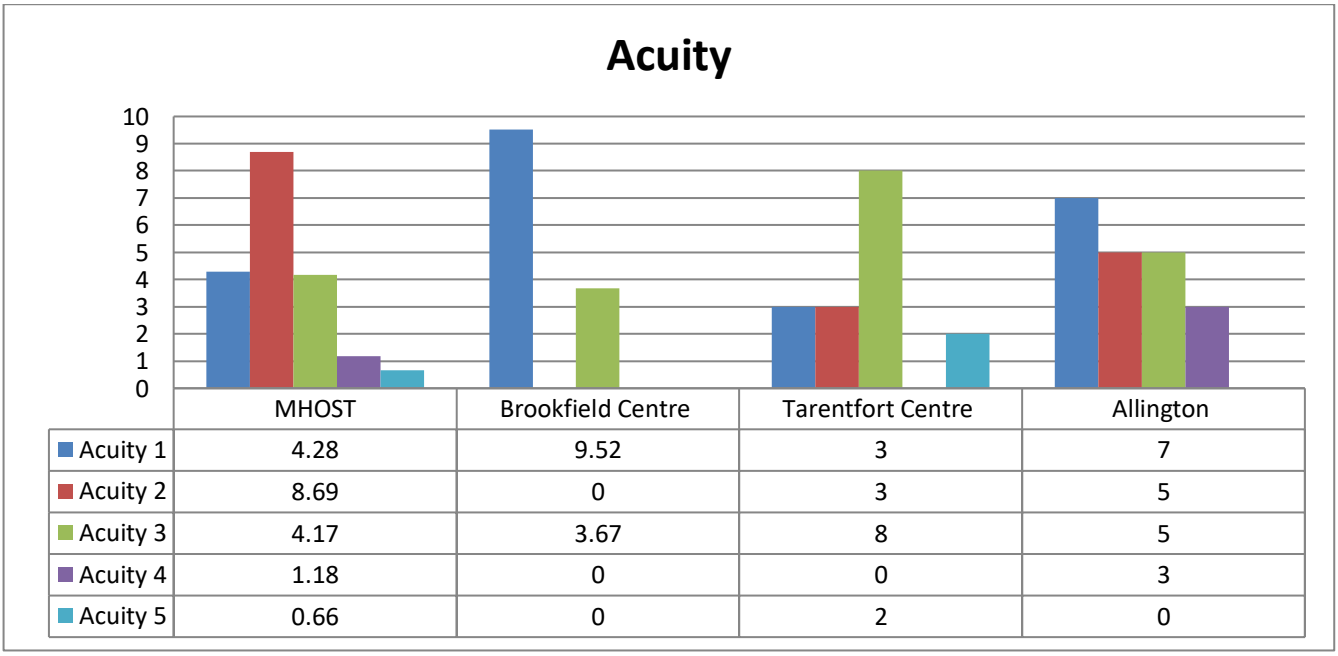
Previous MHOST reports identified the actual FTE for KMPT's MSU have been significantly high and an outlier. Although the data demonstrates an expected gap between the recommended and actual FTE, the MSU FTE gaps are significantly more that the recommended gap of no more than 10.8, with Penshurst (32.9) Groombridge (16.3) and Emmets (17.83). Emmet's ward is more

significant as during the MHOST collection period they recorded an actual FTE of 50.03, included leave patients in the acuity and recording an InPhase for insufficient numbers of healthcare professionals. This would indicate a deeper dive around roster management for this ward is required.

The Directorate meet daily to look at staffing resources and re-allocate staff based on the acuity along with the actual FTE on the day. This supports a more fluid approach to establishments but may not be picked up through the MHOST as this is unlikely to be recorded on KMPT's digital systems. In addition to this, the wards have a number of other roles assigned to them including social workers (not included in this MHOST), AHP, medics and psychology which are partially included in the calculations as MHOST recommends. However, these staff members may not be on the wards for the actual hours booked for each ward as they are not necessarily based on the ward. Therefore, this could be an opportunity for the daily staffing huddles to consider an MDT approach manage the acuity demand and redistribution of resource.

Forensic Rehabilitation: Low Secure Units

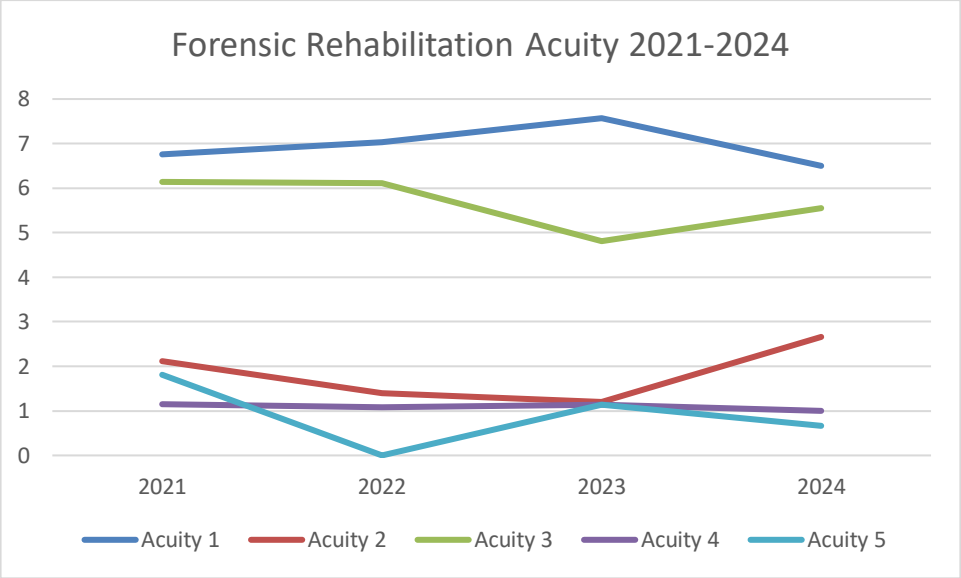
Similarly, to the MSU patient demographics LSU often support long term patients that have higher staff to ratio requirements and therefore the patients need specialist placements to support discharge that are challenging to find. During the MHOST collection period Tarentfort had individuals with commissioned extra care packages, which included increased staff to patient ratios. This impacts the FTE and CHPPD so is taken in to consideration in the reporting. The LSU didn't have any COVID or infection outbreaks or staff related InPhase reports recorded during the data period.



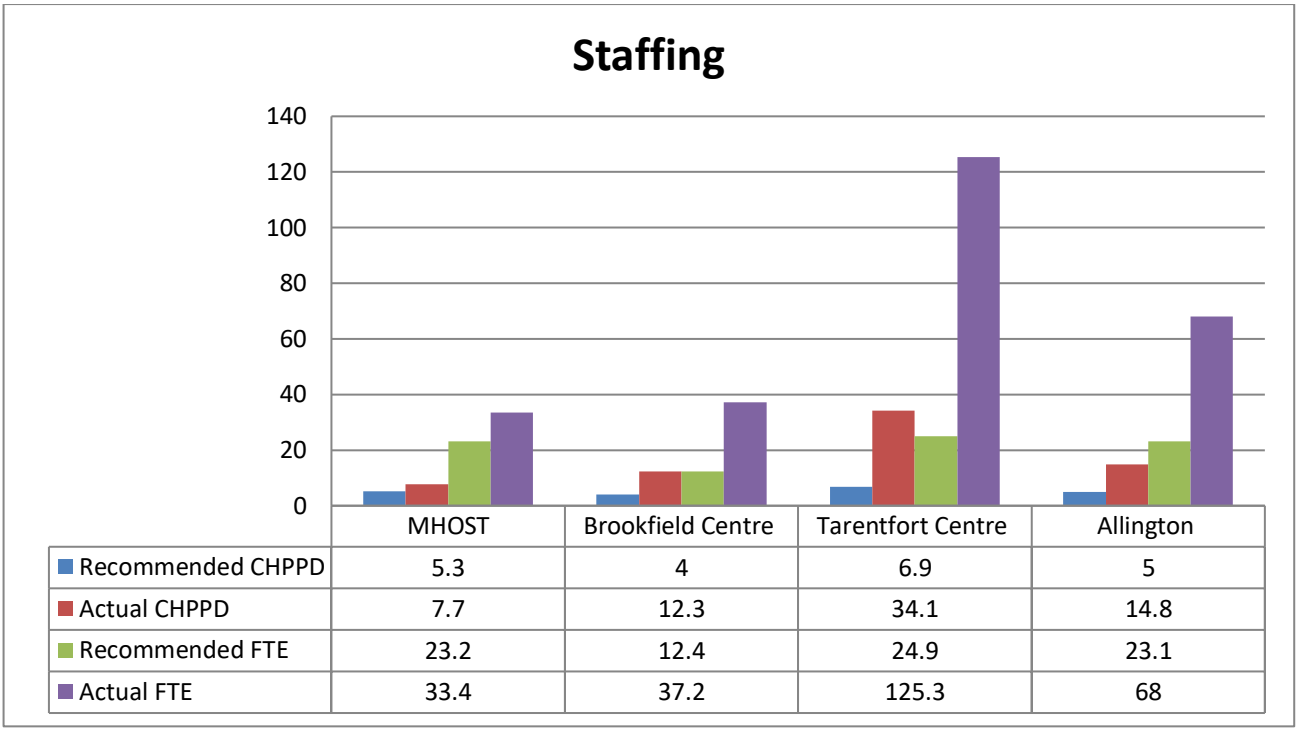
	MHOST	Brookfield Centre	Tarentfort Centre	Allington
Acuity 1	4.28	9.52	3	7
Acuity 2	8.69	0	3	5
Acuity 3	4.17	3.67	8	5
Acuity 4	1.18	0	0	3
Acuity 5	0.66	0	2	0

The LSU wards have reported lower acuity than the MHOST recommended average with Brookfield and Allington as both have higher Acuity 1 levels than expected. For Brookfield this is the third MHOST report of low acuity with a higher number of acuity 1 patient levels although overall their acuity has increased slightly with more acuity 3 patients. Tarentfort's acuity 3 and 5 is slightly above the MHOST benchmark wards for the second MHOST. This is linked by a number of patients on 2:1 nursing care or extra care packages. The patients on extra care packages are considered

to be admitted outside the normal recommended service criteria and require specialist placements of which there is a National shortage. This was also identified in the previous two MHOST reports as a concern along with the challenges this presents when delivering safe quality care for all patients.



The LSU have consistently remained above the above the recommended FTE which is in line with the MHOST benchmarking pattern but the difference between the recommended and actual is significantly more than expected. The directorate has previously been impacted by admitting patients that are not within normal service criteria and require increased staffing support that impact FTE and CHPPD results. This level or type of care delivery may not be fully represented in the MHOST benchmarking wards and needs to be considered when reviewing the data. Tarentfort in particular is impacted as the actual FTE is 125.3 including all the additional commissioned extra care hours. If the extra care package staff are removed this figure reduces to would be 61.5 and is more inline, however the MHOST requires all substantive and temporary/additional staff to be counted within the process.



	MHOST	Brookfield Centre	Tarentfort Centre	Allington
Recommended CHPPD	5.3	4	6.9	5
Actual CHPPD	7.7	12.3	34.1	14.8
Recommended FTE	23.2	12.4	24.9	23.1
Actual FTE	33.4	37.2	125.3	68

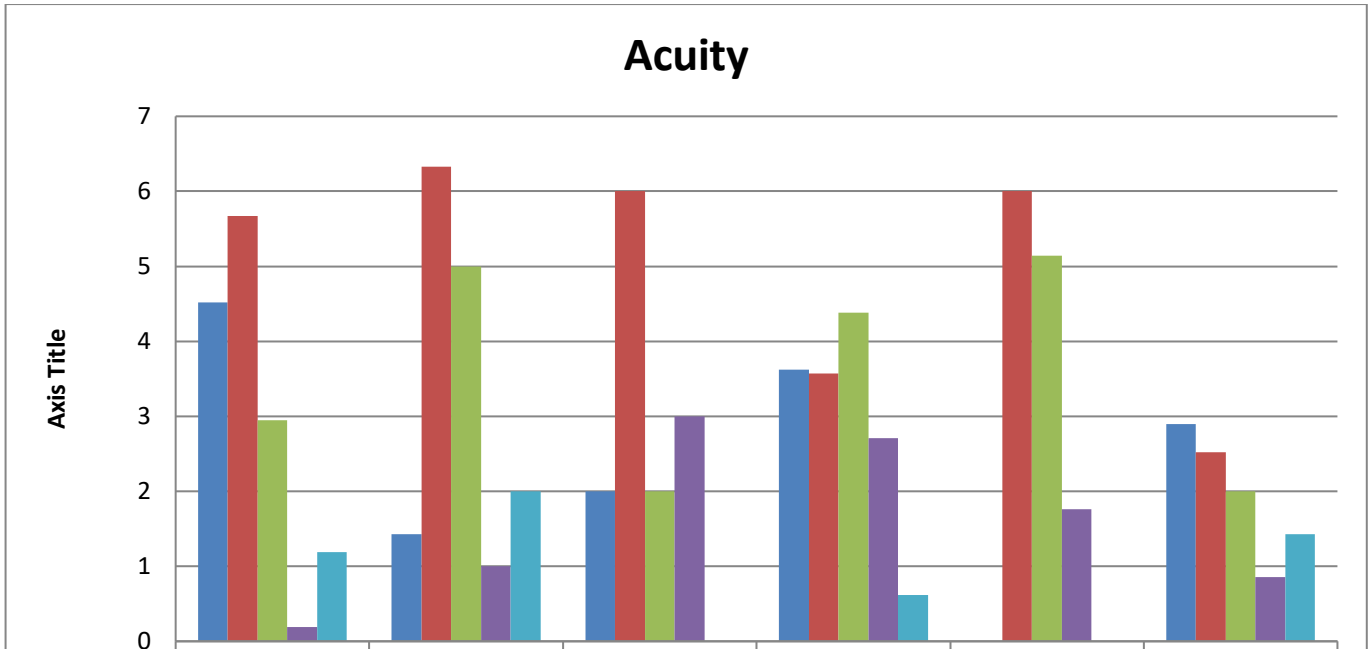
5. Acute Directorate:

Historically the Acute Directorate only included younger adult wards with older adult wards aligned to another care group. All older adult and younger adult acute wards are under the Acute directorate but with the MHOST criteria applied they will continue to be reviewed separately against the relevant tool. The Willow Suite continues have the Psychiatric Intensive Care Unit tool applied. This will be reviewed for future MHOST collections as the wards move to needs led admission criteria which will include a frailty pathway.

There were no COVID or infection covid outbreaks, one ward was decanted with a reduced bed occupancy, three InPhase reports recorded insufficient numbers of healthcare professional and one ward's gender was changed for the MHOST period. At the time of the MHOST there were between 50 to 55 clinically fit for discharge, 11 patients placed in out of area PICU beds and 18 patients on the PICU Liaison caseload. This is also the first MHOST when the wards all provided single sex accommodation.

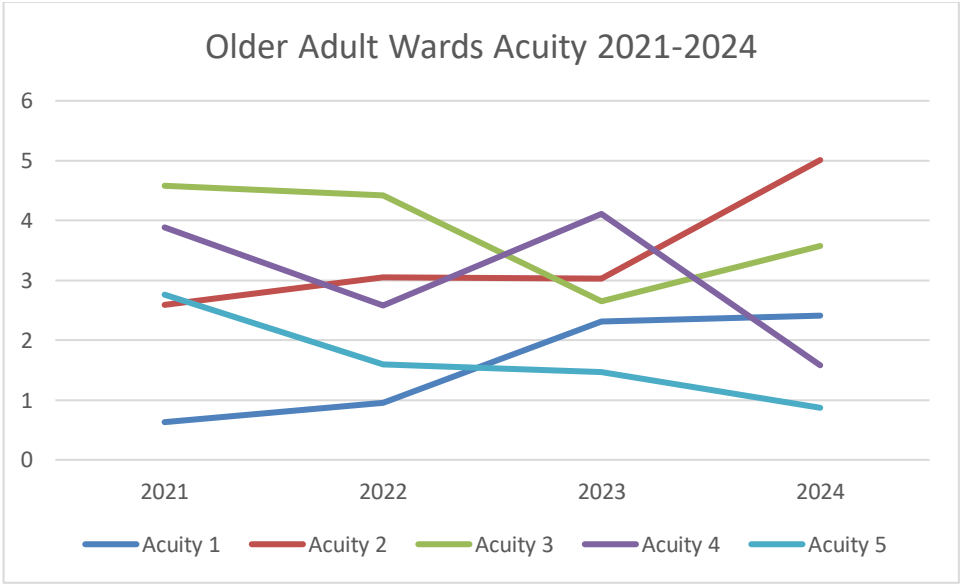
Older Adult Wards

Since the last MHOST the Older adult wards have evolved in the following areas admission criteria, single sex or gender wards, provide mixed models of care with organic and non-organic patient needs and have individual risk concerns linked to the estate. There were no covid outbreaks and Heather reported one InPhase for Insufficient numbers of healthcare professionals during the MHOST period.

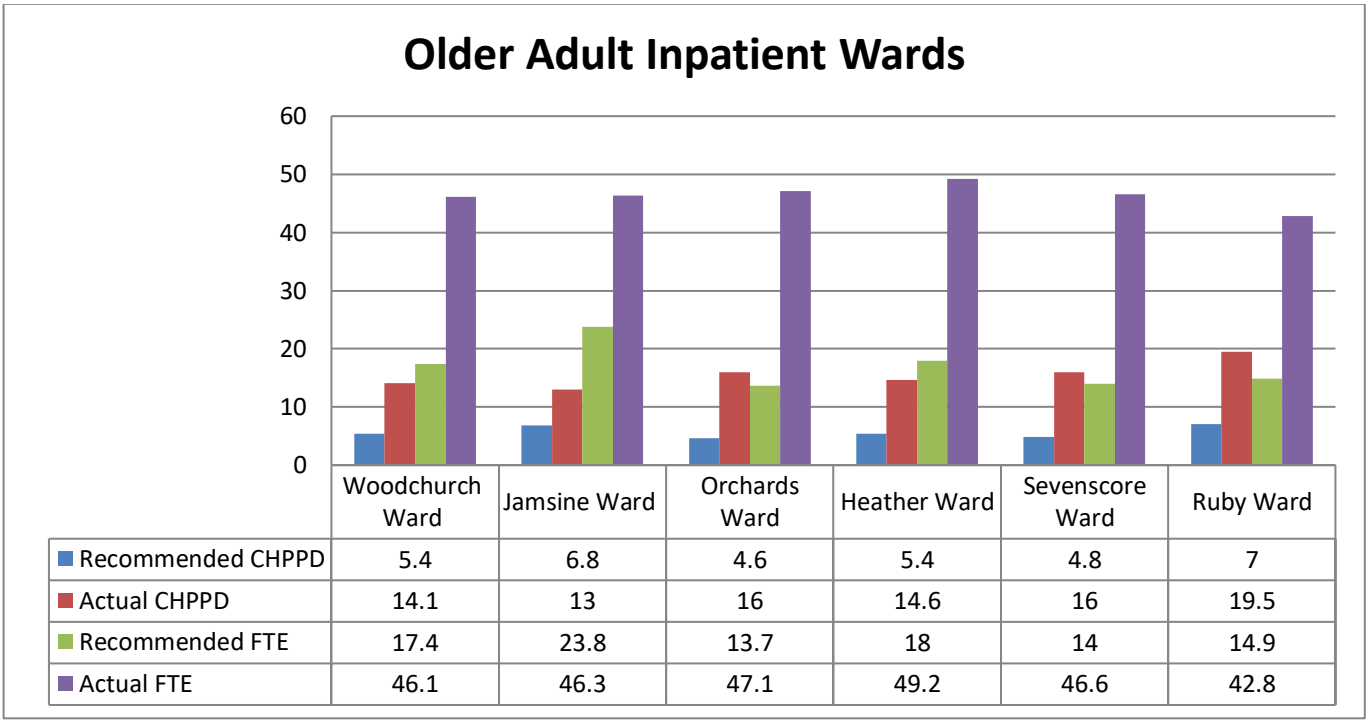


	Woodchurch	Jamsine Ward	Orchards Ward	Heather ward	Sevenscore Ward	Ruby Ward
Acuity 1	4.52	1.43	2	3.62	0	2.9
Acuity 2	5.67	6.33	6	3.57	6	2.52
Acuity 3	2.95	5	2	4.38	5.14	2
Acuity 4	0.19	1	3	2.71	1.76	0.86
Acuity 5	1.19	2	0	0.62	0	1.43

Professional judgement is required alongside the MHOST as Sevenscore and Woodchurch have a number of ligature risks identified by the annual ligature audit that will be addressed through the Trust Capital prioritisation process and the interim introduction of ligature free rooms. Jasmine ward sits as a standalone unit with no neighbouring mental health support. Ruby ward decanted from Medway Maritime Hospital and into Littlestone with reduced bed occupancy whilst the 'new Ruby ward' build was completed. Each of these wards' admission criteria reflects the environmental and patient safety risks resulting in lower acuity or bed occupancy results. Despite this, all wards continue to sit above the MHOST bench marking with more acuity 3 and above patients recorded.



The directorate continues to be affected by Clinically ready for discharge patients for the fourth consecutive MHOST report. These patients are ready for discharge but awaiting appropriate placement or care packages. However, their acuity varies due to the complexity of the physical and mental illnesses related to old age.

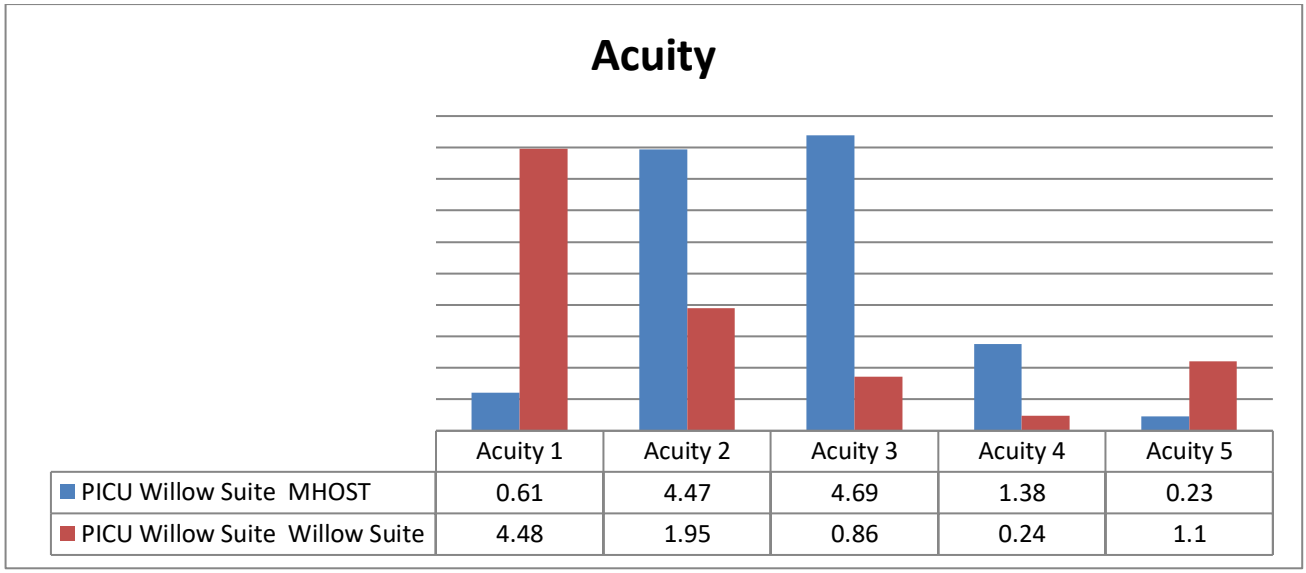


	Woodchurch Ward	Jamsine Ward	Orchards Ward	Heather Ward	Sevenscore Ward	Ruby Ward
Recommended CHPPD	5.4	6.8	4.6	5.4	4.8	7
Actual CHPPD	14.1	13	16	14.6	16	19.5
Recommended FTE	17.4	23.8	13.7	18	14	14.9
Actual FTE	46.1	46.3	47.1	49.2	46.6	42.8

The recommended FTE for the wards, except for Jasmine and Heather, sit below the MHOST benchmark which reflects the reduced bed occupancy and admission criteria. This is also reflected in the CHPPD. It is worth highlighting that Jasmine despite being a standalone unit with a restricted admission criterion continues to sit above the other wards and MHOST benchmarking which indicates they are taking patients that are not suitable for the environment. Similarly, to the MHOST benchmarking pattern, the actual FTE for all wards is higher than recommended and the gap between actual and recommended aligns. This is reflective of the physical and mental health complexities of the older or frail patient.

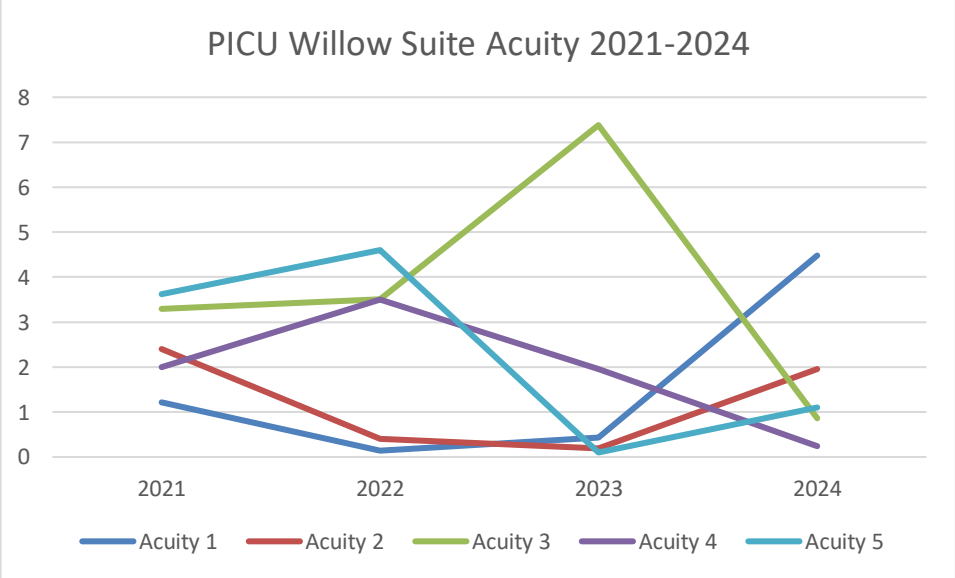
Psychiatric Intensive Care Unit (PICU): Willow Suite

Willow Suite is the male only PICU ward however for the first two annual MHOST data collections the ward had out of scope admissions requiring extra care packages with higher nursing ratios and a temporary bed reduction to support this. This needs to be considered when comparing annual data sets. Female PICU is sourced outside of KMPT bed stock. At the time of the MHOST data collection there were 11 patients in out of area PICU's beds and 18 patients on the PICU Liaison caseload. There were no COVID or infection outbreaks, no InPhase reports for insufficient healthcare staff or any other notable areas that would impact acuity or staffing levels.

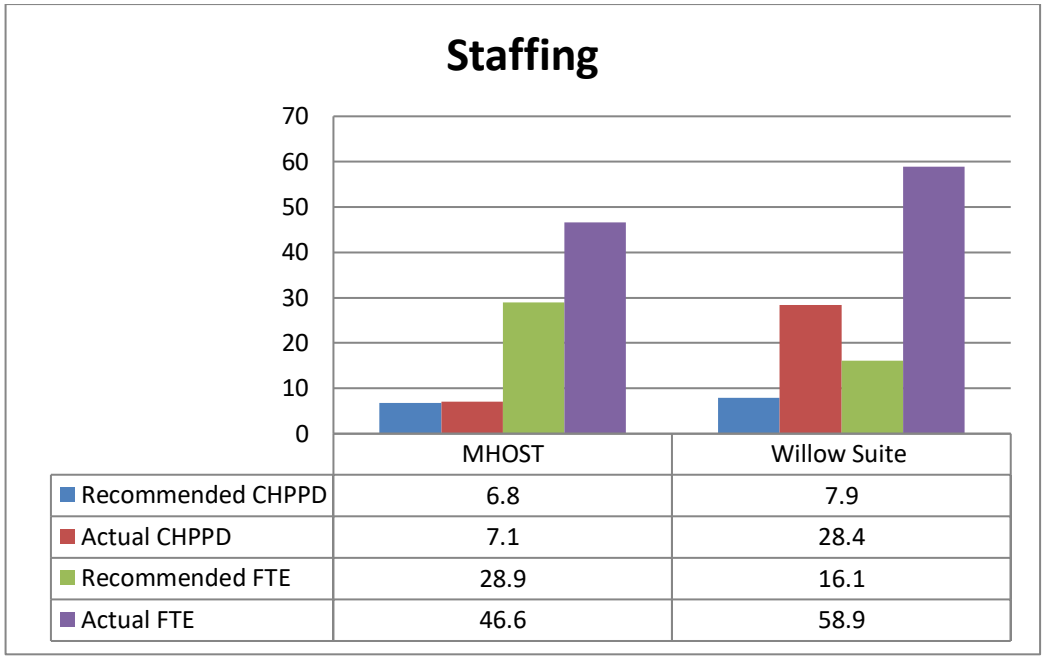


	Acuity 1	Acuity 2	Acuity 3	Acuity 4	Acuity 5
PICU Willow Suite MHOST	0.61	4.47	4.69	1.38	0.23
PICU Willow Suite Willow Suite	4.48	1.95	0.86	0.24	1.1

Willow Suite operated under bed occupancy throughout the MHOST period with the exception of 1 day. The lowest bed occupancy of 7 or 8 was recorded for 16 of the 21 days. This will impact the overall acuity and staffing data as not operating at an optimum capacity level. This can be seen when comparing the MHOST averages with Willow's acuity which is lower than expected. When comparing Willows MHOST data year on year the overall acuity level has reduced.



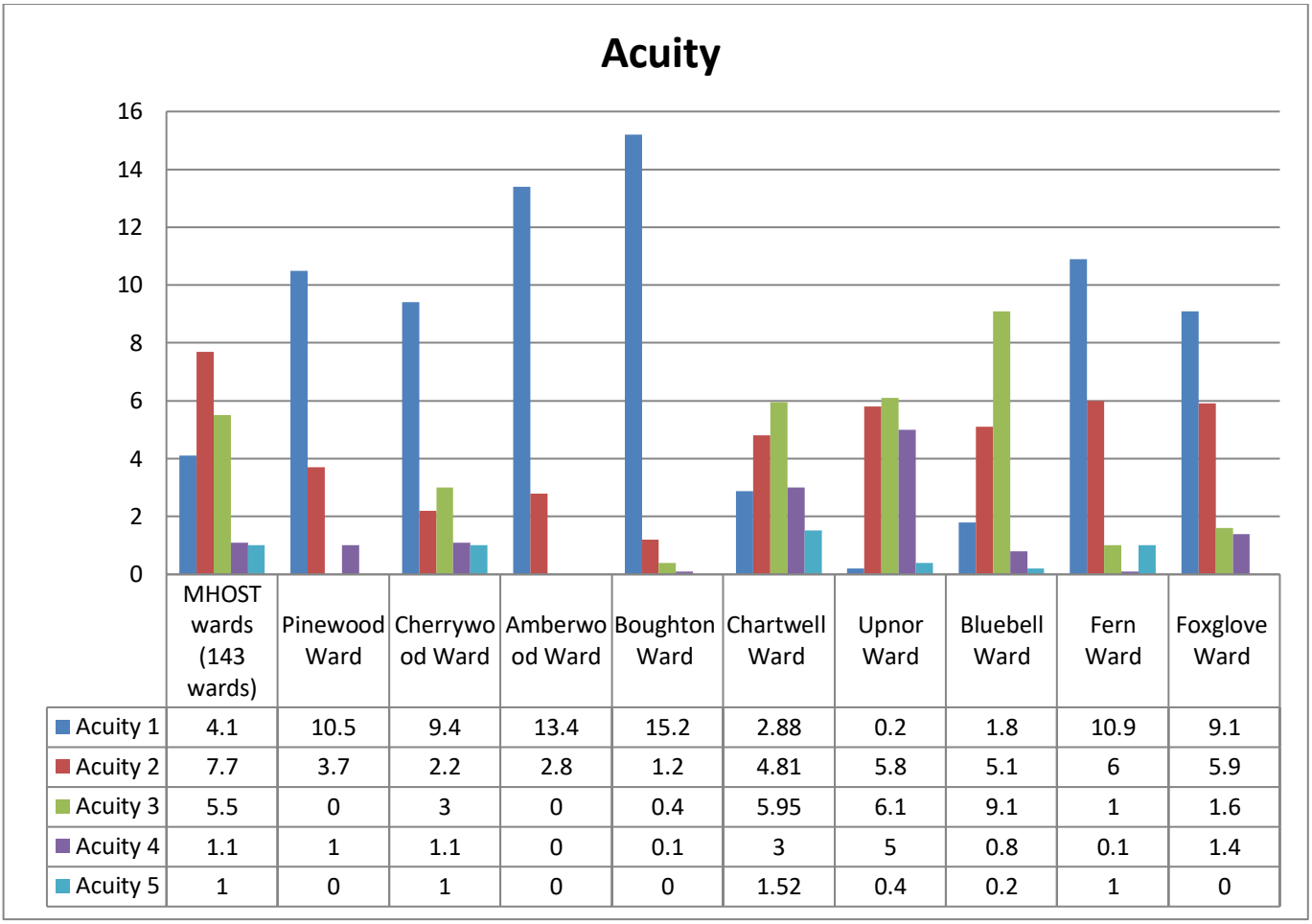
Willow suite's actual CHPPD and FTE run above the MHOST benchmarking expectation and reflects the acuity and bed occupancy position. This can also be seen in the gap between actual and recommended for CHPPD and FTE. The recommended FTE sits at 58.9 (MHOST 46.6) with the recommended being at 16.1 (MHOST 28.9). A PICU ward requires a minimal level of staffing to provide a safe environment for patients and staff with the ability to adjust to unpredictable demand. However, reviewing the MHOST data from all annual reviews, it suggests an opportunity to review how different disciplines support the care on the wards across the site.



	MHOST	Willow Suite
Recommended CHPPD	6.8	7.9
Actual CHPPD	7.1	28.4
Recommended FTE	28.9	16.1
Actual FTE	46.6	58.9

Acute (Younger adult) wards

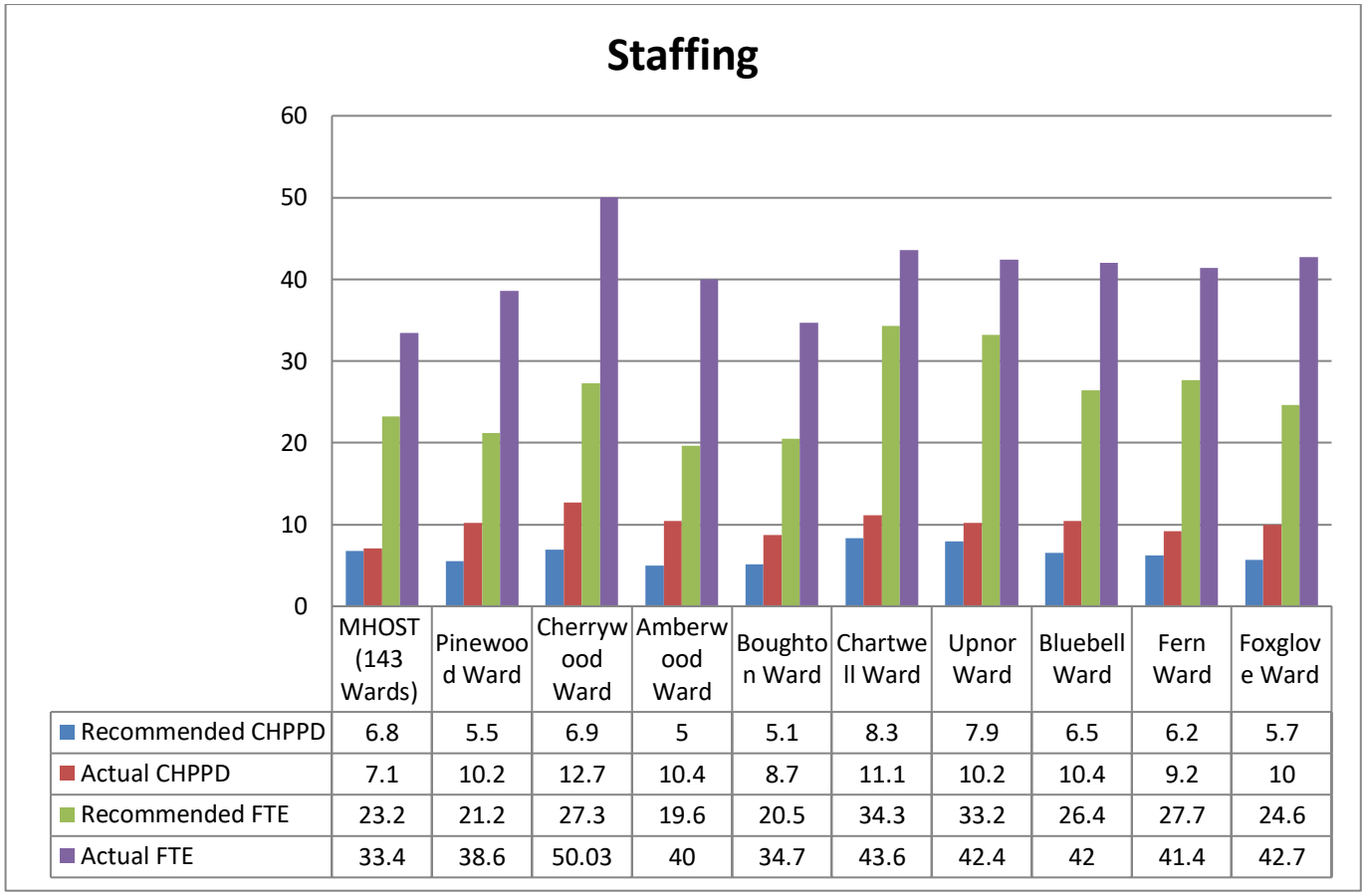
During the MHOST collection period Chartwell was changed from having female to male patients, the impact of this resulted in the ward operating at below bed occupancy for 10 days. There were no reported COVID or infection outbreaks and two InPhase reports were recorded for Insufficient numbers of healthcare professionals on Boughton Ward. Several data accuracy queries were identified around cutting and pasting with errors duplicated, no movement in patient's acuity, and incorrect acuity recording for leave patients or patients requiring 2 to 1 care or rapid tranquilization. This would suggest potential bias for under and over scoring on patient acuity was identified and this has been corrected with learning around quality checking identified for future MHOST data collections.



	MHOST wards (143 wards)	Pinewood Ward	Cherrywood Ward	Amberwood Ward	Boughton Ward	Chartwell Ward	Upnor Ward	Bluebell Ward	Fern Ward	Foxglove Ward
Acuity 1	4.1	10.5	9.4	13.4	15.2	2.88	0.2	1.8	10.9	9.1
Acuity 2	7.7	3.7	2.2	2.8	1.2	4.81	5.8	5.1	6	5.9
Acuity 3	5.5	0	3	0	0.4	5.95	6.1	9.1	1	1.6
Acuity 4	1.1	1	1.1	0	0.1	3	5	0.8	0.1	1.4
Acuity 5	1	0	1	0	0	1.52	0.4	0.2	1	0

Overall the acuity of the Acute wards is lower than expected with no acuity 4 or 5 patients in some areas and higher than expected acuity 1 patients. This was the case for Pinewood, Cherrywood, Amberwood, and Fern for the second consecutive MHOST. This is reflective of the clinically fit for discharge patients with 50 to 55 recorded across the Trust during this period. It was also noted that some wards were operating under capacity during this period with four wards operating below capacity for 2 consecutive days or more. This is not a major concern as wards should be aiming for circa 85% occupancy – but when combined with lower acuity, this indicates that there are patients on the wards who may not require ongoing hospital care.

Most wards CHPPD aligned closely to the MHOST benchmarked CHPPD of 6.8. Similarly, the expected gap between recommended and actual was even for all wards but was larger than anticipated. Again, this reflects low acuity and operating below bed capacity during the data collection period.



	MHOST (143 Wards)	Pinewood Ward	Cherrywood Ward	Amberwood Ward	Boughton Ward	Chartwell Ward	Upnor Ward	Bluebell Ward	Fern Ward	Foxglove Ward
Recommended CHPPD	6.8	5.5	6.9	5	5.1	8.3	7.9	6.5	6.2	5.7
Actual CHPPD	7.1	10.2	12.7	10.4	8.7	11.1	10.2	10.4	9.2	10
Recommended FTE	23.2	21.2	27.3	19.6	20.5	34.3	33.2	26.4	27.7	24.6
Actual FTE	33.4	38.6	50.03	40	34.7	43.6	42.4	42	41.4	42.7

All the wards actual FTE is higher than the MHOST benchmarking actual FTE of 33.4 with the wards recording between 34.7 to 50.03. However, compared to the MHOST recommended FTE of 23.2 the wards recorded a lower range of 20.5 to 34.3. The gap between the actual and recommended varied significantly. This is likely to reflect the higher number of acuity 1 and lower numbers acuity 4 and 5 along with vacant beds during this period.

The FTE incorporated roles that might not be based on the ward like AHP, Psychology and Medics. The variation of acuity, bed occupancy and staffing levels creates an opportunity for the directorate to look at more site base MDT working that is able to respond to the patient population demands across the wards.

6. Safer Staffing:

The National quality board, NHS England, CQC and NHS Chief nurse (in 2014 revised in 2016 and 2018) required all hospitals to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safer staffing guidelines. This was part of the response to the Francis report and the figures are published on our external facing website for public viewing. When considering the safer staffing data against the MHOST findings we can need to take in to account a number of factors. Ward managers, AHP's, psychology, social workers and medics are not included in the RN and HCA fill rate for safer staffing so although there are areas below 80% there could be a ward manager, matron and AHP staff supporting the ward and patient care at the time. This is supported by the low number of InPhase reports submitted for Insufficient numbers of healthcare professionals across the directorates during the MHOST period and 76 reported in the 12 months. However, from the data available there appears to an under

reporting of Inphase and this is why we are developing the 'Red Flag' system on eroster for 'less than 2 RNs on shift' with an identifier if the RN on duty is a preceptorship nurse.

It is anticipated a number of wards being outliers on the safer staffing report, such as Tarenfort with a 254.4% fill rate for HCA's at night due to extra care packages but other areas fill rates are unprecedented when the acuity and bed occupancy levels are considered. There are some other anomalies such as Chartwell, as they would require additional staff to support the ward gender swap, or for other reasons such as additional staff used for ECT inpatients, and increased observations. Often wards use known HCA staff as emergency cover if a second RN cannot be secured.

Some of the safe staffing data indicates low staff numbers in line with the reduced bed occupancy such as the MBU with 39% RN day fill rate, but the fill rate is set on the establishment need for a fully occupied ward and doesn't reflect flexing of staff.

Safe Staffing Comparison January 2024

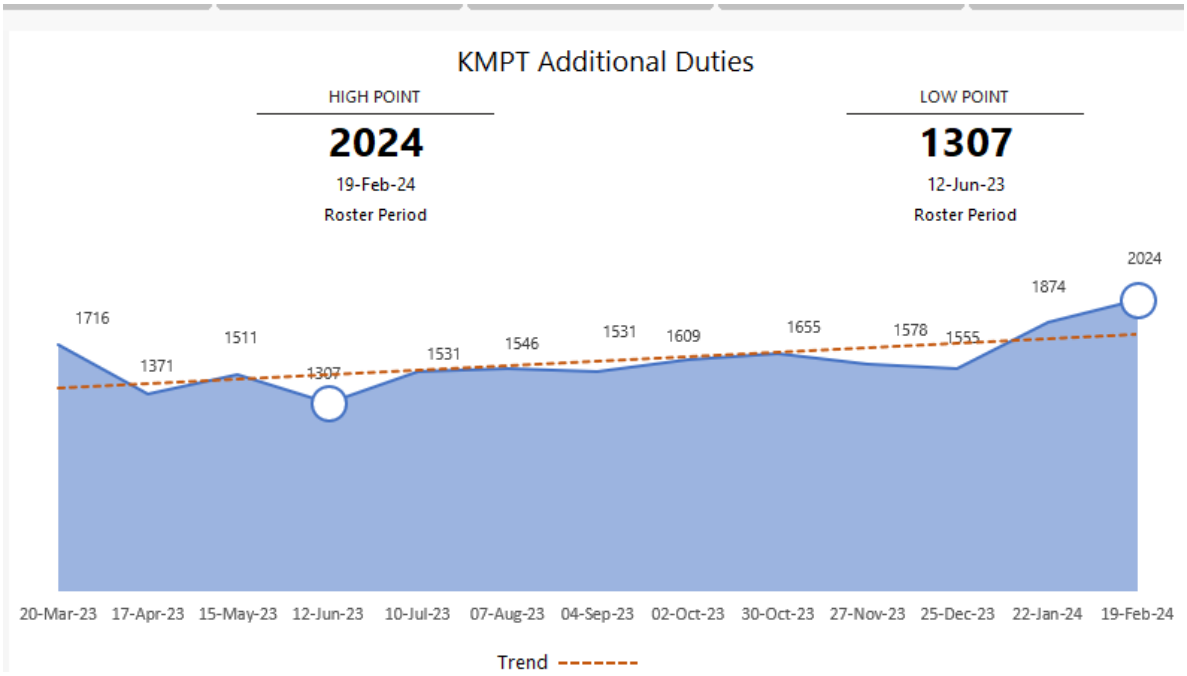
		Day		Night	
Care Group	Ward	RN	HCA	RN	HCA
Acute	Amberwood	75.3%	98.5%	98.7%	95.8%
Acute	Bluebell	74.7%	95.4%	98.3%	111.4%
Acute	Boughton Ward	116.8%	93.8%	100.8%	110.7%
Acute	Chartwell Ward	93.9%	102.3%	102.0%	129.6%
Acute	Cherrywood Ward	66.7%	188.5%	99.2%	257.2%
Acute	Fern	84.3%	110.3%	98.5%	153.6%
Acute	Foxglove	83.3%	110.7%	84.9%	203.8%
Acute	Heather	90.6%	110.5%	100.4%	140.3%
Acute	Jasmine	73.0%	114.6%	98.6%	116.3%
Acute	Pinewood Ward	100.9%	134.8%	97.1%	142.2%
Acute	Ruby Ward	88.9%	85.5%	98.2%	104.6%
Acute	Sevenscore	123.3%	98.1%	87.4%	117.4%
Acute	The Orchards	92.3%	83.4%	100.6%	103.8%
Acute	Upnor Ward	83.2%	121.2%	99.5%	159.5%
Acute	Willow Suite	94.9%	217.0%	152.3%	235.4%
Acute	Woodchurch	66.3%	101.6%	101.8%	117.6%
East Kent	Ethelbert Road	105.2%	74.9%	102.5%	100.0%
East Kent	Rivendell	83.0%	111.5%	100.2%	106.5%
East Kent	The Grove	64.9%	87.4%	107.5%	113.7%
Forensic & Specialist	Allington Centre	97.6%	155.4%	100.7%	148.5%
Forensic & Specialist	Bridge House	97.6%	104.6%	100.8%	100.7%
Forensic & Specialist	Brookfield Centre	101.6%	98.0%	100.6%	100.4%
Forensic & Specialist	Emmetts	76.2%	104.6%	100.3%	99.8%
Forensic & Specialist	Groombridge	117.2%	102.5%	100.8%	100.2%
Forensic & Specialist	Penshurst	119.4%	139.9%	94.7%	176.9%

Forensic & Specialist	South Central EDMBU	39.0%	72.7%	50.4%	88.0%
Forensic & Specialist	Tarentfort Centre	98.7%	175.6%	100.8%	254.4%
Forensic & Specialist	Walmer	83.8%	103.3%	76.0%	122.1%
North Kent	Newhaven Lodge	94.3%	129.9%	100.1%	128.6%
West Kent	111 Tonbridge Road	126.6%	159.1%	99.3%	102.8%
West Kent	Rosewood Lodge	102.7%	181.2%	100.5%	130.9%
Grand Total	**Grand Total**	**86.23%**	**118.37%**	**95.76%**	**139.15%**

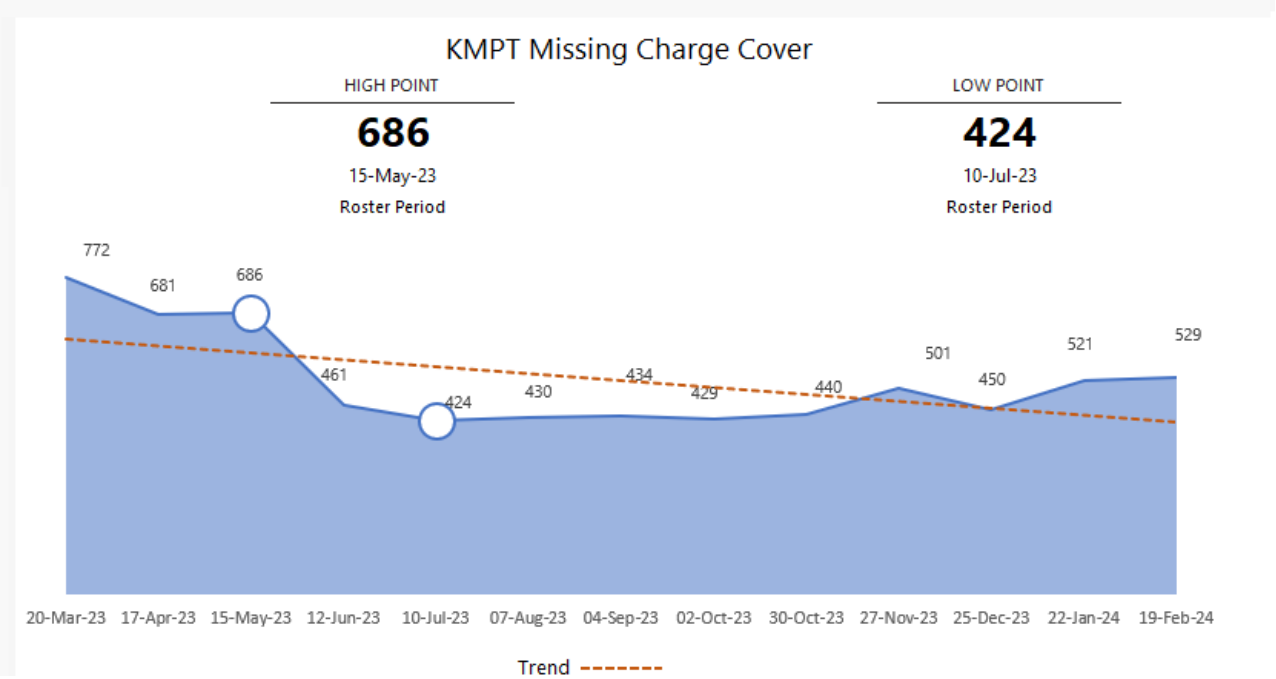
7. Roster Reviews:

All directorates are required to review safe care and safer staffing through their patient safety governance structures as well as completing monthly roster reviews led by the Head of Nursing and Quality or matrons. The reviews were initiated across the Trust in September 2022 and supported by HR business partners, finance business partners, and ward or unit manager. Together they considered a number of key performance indicators around efficiency, skill mix and resource distribution. This has seen a number of improvements across the Trust with the biggest impacts on additional duties, shifts missing charge cover and unfilled roster %.

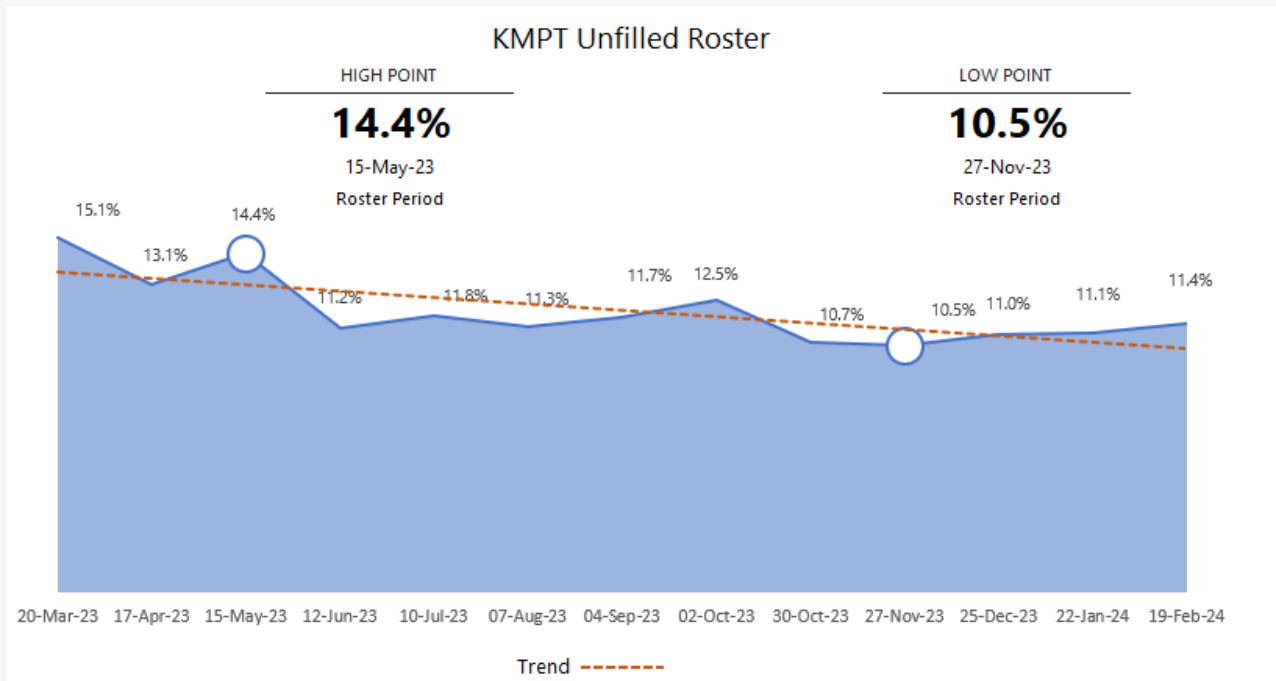
Initially this saw a reduction in additional duties, missing charge cover, unfilled shift cover, roster lead time and temporary staffing lead times demonstrating a sustained improvement towards safe and effective rosters. However, with the changes in shift patterns, directorates and key staffing roles changing we have started to see an impact on the performance trajectories. Additional duties were recorded in January 2024 as 1874 this is an increase from the previous MHOST and there is an upward trend is starting to emerge.



Missing charge cover was recorded as 326 at its lowest in the last MHOST and although this has increased slightly with 521 recorded in January 2024 we are seeing an overall reduction trend in this area.



Unfilled rosters continue to be on a downward trajectory with January 2024 being recorded at 11.1%. However, this is not necessarily represented in the safer staffing figures for January 2024 but demonstrates a balance between specific roles not being included and these roles being used to support patient safety gaps.



Safecare and NHSP compliance has dropped significantly since the last MHOST report with only Jasmine Ward being 100% and Orchards, Sevenscore and Allington compliance at or above90%.

For the NHSP Interface compliance, most wards are recording 90% or more compliance. There are a number of roster initiatives starting that are linked to Safecare and therefore there the plan is to refresh Safecare for staff with additional training.

SafeCare Compliance

				27 Nov Roster Period				25 Dec Roster Period				22 Jan Roster Period			
Care Group	Short Name	Total	Comparison	27-Nov	4-Dec	11-Dec	18-Dec	25-Dec	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb
Acute	Amberwood	27%		50%	14%	21%	0%	0%	0%	0%	71%	✓	14%	-	-
Acute	Bluebell	20%		36%	21%	36%	36%	0%	0%	0%	29%	21%	21%	-	-
Acute	Boughton Ward	37%		✓	✓	✓	71%	0%	0%	0%	0%	0%	0%	-	-
Acute	Chartwell Ward	11%		7%	0%	43%	7%	0%	14%	43%	0%	0%	0%	-	-
Acute	Cherrywood Ward	69%		57%	79%	57%	57%	71%	64%	71%	79%	64%	93%	-	-
Acute	Fern	88%		✓	✓	✓	79%	43%	57%	✓	✓	✓	✓	-	-
Acute	Foxglove	46%		50%	50%	50%	43%	50%	50%	43%	50%	50%	29%	-	-
Acute	Heather	66%		64%	✓	64%	71%	64%	79%	64%	57%	71%	29%	-	-
Acute	Jasmine	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
Acute	Pinewood Ward	28%		36%	36%	36%	36%	21%	29%	36%	14%	0%	36%	-	-
Acute	Ruby Ward	65%		64%	50%	64%	79%	71%	50%	64%	71%	86%	50%	-	-
Acute	Sevenscore	96%		93%	✓	✓	✓	93%	✓	93%	86%	✓	✓	-	-
Acute	The Orchards	99%		✓	✓	93%	✓	✓	✓	✓	✓	✓	93%	-	-
Acute	Upnor Ward	74%		79%	✓	✓	50%	0%	86%	86%	✓	✓	36%	-	-
Acute	Willow Suite	87%		71%	71%	86%	79%	93%	93%	93%	93%	✓	93%	-	-
Acute	Woodchurch	10%		14%	21%	21%	0%	21%	0%	0%	0%	21%	0%	-	-
Forensic & Specialist	Allington Centre	92%		64%	93%	79%	✓	✓	✓	93%	93%	✓	✓	-	-
Forensic & Specialist	Bridge House	9%		7%	21%	0%	14%	21%	21%	0%	7%	0%	0%	-	-
Forensic & Specialist	Brookfield Centre	72%		64%	57%	86%	71%	57%	86%	64%	86%	✓	50%	-	-
Forensic & Specialist	Emmetts	30%		14%	21%	43%	29%	43%	29%	21%	21%	29%	50%	-	-
Forensic & Specialist	Groombridge	59%		43%	64%	57%	64%	71%	50%	64%	57%	50%	71%	-	-
Forensic & Specialist	Penshurst	8%		21%	14%	7%	0%	0%	0%	7%	0%	21%	7%	-	-
Forensic & Specialist	South Central EDMBU	77%		79%	36%	43%	64%	64%	✓	✓	✓	✓	86%	-	-
Forensic & Specialist	Tarentfort Centre	66%		57%	64%	64%	64%	79%	86%	57%	71%	64%	57%	-	-
Forensic & Specialist	Walmer	51%		64%	36%	50%	57%	50%	71%	57%	36%	57%	36%	-	-
Total Compliant Wards				4	7	5	4	3	5	4	5	10	4	-	-

NHSP Interface Compliance

				27 Nov Roster Period				25 Dec Roster Period				22 Jan Roster Period			
Care Group	Short Name	Total	Comparison	27-Nov	4-Dec	11-Dec	18-Dec	25-Dec	1-Jan	8-Jan	15-Jan	22-Jan	29-Jan	5-Feb	12-Feb
Acute	Amberwood	94%		97%	97%	90%	88%	✓	98%	93%	94%	91%	90%	96%	✓
Acute	Bluebell	96%		94%	93%	97%	✓	✓	93%	89%	96%	94%	✓	✓	✓
Acute	Boughton Ward	96%		97%	91%	✓	98%	97%	93%	96%	96%	✓	86%	✓	✓
Acute	Chartwell Ward	91%		79%	87%	94%	✓	90%	88%	91%	79%	93%	97%	✓	98%
Acute	Cherrywood Ward	91%		75%	80%	87%	94%	97%	88%	93%	97%	85%	93%	✓	✓
Acute	Fern	90%		88%	77%	80%	77%	88%	88%	✓	91%	97%	✓	93%	✓
Acute	Foxglove	90%		97%	91%	90%	89%	80%	90%	81%	87%	93%	89%	✓	93%
Acute	Heather	99%		96%	97%	98%	98%	98%	✓	✓	✓	✓	✓	✓	✓
Acute	Jasmine	99.5%		✓	✓	✓	98%	✓	97%	✓	98%	✓	✓	✓	✓
Acute	Pinewood Ward	74%		67%	68%	63%	73%	72%	68%	45%	89%	89%	79%	87%	94%
Acute	Ruby Ward	88%		87%	97%	87%	92%	94%	81%	94%	71%	73%	76%	✓	✓
Acute	Sevenscore	80%		65%	83%	63%	✓	80%	91%	62%	77%	55%	95%	96%	93%
Acute	The Orchards	98%		✓	94%	92%	✓	95%	95%	97%	✓	✓	97%	✓	✓
Acute	Upnor Ward	94%		✓	93%	89%	98%	85%	87%	95%	94%	90%	94%	✓	✓
Acute	Willow Suite	94%		91%	97%	95%	94%	94%	91%	92%	94%	89%	97%	✓	✓
Acute	Woodchurch	90%		94%	89%	91%	95%	85%	81%	79%	92%	93%	87%	✓	95%
Forensic & Specialist	Allington Centre	98%		99%	95%	98%	98%	98%	99%	97%	✓	99%	✓	✓	✓
Forensic & Specialist	Bridge House	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Forensic & Specialist	Brookfield Centre	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Forensic & Specialist	Emmetts	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Forensic & Specialist	Groombridge	99%		✓	✓	96%	✓	✓	90%	✓	✓	✓	✓	✓	✓
Forensic & Specialist	Penshurst	98%		✓	✓	99%	94%	98%	96%	98%	98%	93%	99%	✓	98%
Forensic & Specialist	South Central EDMBU	80%		87%	82%	88%	93%	84%	91%	81%	71%	89%	97%	✓	0%
Forensic & Specialist	Tarentfort Centre	99.6%		✓	✓	✓	✓	✓	✓	98%	98%	✓	✓	99%	✓
Forensic & Specialist	Walmer	98%		✓	98%	93%	✓	✓	97%	✓	98%	98%	98%	✓	✓
Total Compliant Wards				10	7	6	10	9	5	8	7	9	10	20	18

Further work is needed to ensure roster reviews triangulate data between safe care, safer staffing, eroster and the planned use of MHOST moving forward. KMPT have been working on a digital solution to support this and collection of MHOST data in an accessible, regular way. We, have purchased a module through Allocate to digitally collect the data required for MHOST. However, this requires Allocate and KMPT to reconfigure and load our Safecare system before it can be used. The erostering team are supporting this work as well as the relaunch and training. It is important to understand the digital solution will only be accurate and beneficial if wards are Safe care compliant.

Red flags will be introduced and used to further support this work and understand when there are ‘less than 2 RNs on shift’ with an identifier for if the RN on duty is a preceptorship nurse. Again, this will support the triangulation required to have robust establishment reviews and reduce the data inaccuracy found.

09. Recommendations and Next steps

- Each directorate to consider the MHOST findings
- Directorates to review site delivery of safe staffing and movement of staff to support varying demands and acuity
- A review of outlier wards resources and function in comparison to MHOST recommendations
- Clinically fit for discharge and admission criteria to be reviewed as part of the bed occupancy work in the Trust.
- Inpatient rehabilitation model to be reviewed
- Roster reviews to triangulate safer staffing, safe care and MHOST data (when available).
- Implementation of Red flags and the MHOST Safecare module with training for staff
- Safer staffing and MHOST training to be developed for key senior nursing staff responsible for establishment reviews. Safer staffing module are already available on iLearn
- Planning for regular establishment reviews once the MHOST module is functioning
- Closer monitoring of roster data and compliance in particular safe care and MHOST by Heads of Nursing and Quality, Matrons and Governance Leads
- Review of headroom and RFA data sets used for MHOST