

# TRUST BOARD MEETING – PUBLIC

## Meeting details

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<b>Date of Meeting:</b>	25 <sup>th</sup> May 2023
<b>Title of Paper:</b>	Safer Staffing – MHOST annual review
<b>Author:</b>	Portia Aveling, Interim Deputy Director of Nursing
<b>Executive Director:</b>	Andy Cruickshank, Chief Nurse

## Purpose of Paper

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<b>Purpose:</b>	Discussion
<b>Submission to Board:</b>	Regulatory Requirement

## Overview of Paper

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The aim of the paper is to provide a summary of the annual establishment review for all age 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 Board's attention

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The Mental Health Optimal Staffing Tool (MHOST) data collection occurred between 1<sup>st</sup> and 21<sup>st</sup> December 2022. The data collection took place before the wards moved to single sex and the transformation to directorates from care groups. Therefore, the paper will reference care groups rather than directorates and some of the acuity levels context may have been addressed through the gender segregation of wards.

This is the third application of the MHOST to support the annual establishment review in KMPT. The previous data collection periods being March/April 2021 and January/February 2022.

During this time there were 9 COVID record outbreaks impacting staffing and patient numbers due to wards closing to admissions.

### Interpretation of Results:

The headlines are that staffing is safe, with good fill rates for available shifts. The key areas of missing charge cover (number of registrants on duty), additional duties (covering observations and/or unplanned absence) and unfilled roster duties are all showing a steady pattern of improvement through the roster review process. There are certain areas that need to be improved upon for greater consistency and efficiency but do not pose in themselves, any safety concerns. These are:

- 1) Units that stand alone geographically face challenges when the level of acuity/dependency increases. These are mainly our Older Adults Wards and Rehabilitation Units. The move to

Directorates offers some opportunity to use staff within a site or geographical location more effectively.

- 2) Psychiatric Intensive Care (PICU)– the number of individual patients at a high level of acuity is higher than the MHOST benchmarking. The service model needs to be reviewed to establish what can be done to reduce the level of disturbed behaviour and reduce the overall needs for observations to be more in line with other PICUs.
- 3) Delayed transfers of care (DTC) can reduce the level of acuity overall on a ward as people move out of the acute phase of admission and towards recovery. Basing the staffing model on acuity/dependency highlights that these teams can become less efficient in this context. Again, geographical isolation can inhibit the redistribution of staff to other areas with greater need. The move to Directorates offers some opportunity to address aspects of the staffing challenge but the greater work required is on the overall DTC picture within KMPT.
- 4) The model of staffing during periods of high acuity relies heavily on the use of observations. Whilst this is very helpful in the initial phases of admission, it can be an overused approach that can become unnecessarily restrictive and exhaust staffing resource. The QI project into this made some good initial progress but now needs refreshing as the new leadership teams are in place in the directorates.

As previously reported to Board, the new shift pattern commences in June and will be closely monitored for impact on safe staffing.

Please note that all detailed data is available on request.

## Governance

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

## **1. 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”.

This is the Board’s third presentation of the MHOST establishment review with previous data sets being collected in March and April 2021 then January 2022 to February 2022. This MHOST establishment review collected data over a 21-day period from 1<sup>st</sup> December to 21<sup>st</sup> 2022.

The review has fully considered multi professional contributions to inpatient care settings across all care groups.

## **2. 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 wards; 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 of each unit/ward. Wards were provided with the guidance and the data collection tool. The Heads of Nursing and 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 1<sup>st</sup> December to 21<sup>st</sup> December 2022. 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 Equivalent (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 the Finance department and E-Roster for the December 2022 period. Using E-Roster data was different to previous MHOST applications as we looked at the hours confirmed as being worked on the wards through the roster as well as the finance actual worked hours to improve the data accuracy and quality. This data excluded observations for Covid-19 isolations, maternity leave and career breaks as it would skew the

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.

### **3. Results**

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

#### **4. Community Recovery Care Group (CRCG)**

##### **Community Rehabilitation Units**

All 6 rehabilitation units have reported low acuity compared to the MHOST benchmark wards for the third consecutive application of the tool. This is despite a slight increase of acuity for 111 Tonbridge Rd, 11 Ethelbert Rd, New Haven Lodge and Rivendell with more level 4 and 5 patients being recorded. Whilst Rosebud centre and The Grove acuity reduced slightly. During this data collection period there were Delayed transfers of care (DTCOC's) which is part of the reasoning for lower acuity.

Although Acuity remains low, the units continued to utilise more staffing resources with each unit being at least double the recommended care hours per patient day (CHPPD) with 11 Ethelbert Road being just under double and 111 Tonbridge Rd being over triple.

It was identified in the previous two MHOST reports that a contributing factor along with the DTCOC's was that the units were running under their bed occupancy. This was also noted during this data collection period with a DTCOC percentage of 9.9% in December 2022. Staffing levels are not varied to reflect the reduction of occupancy and part of this is due to the need to have safe staffing numbers in standalone units.

#### **5 Forensics and Specialist Care Group:**

##### **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.

Acuity remains slightly lower than most wards, although this year staffing is closer to benchmarking for the other inpatient units with MBU recording level 5 patients for the first time. Most patients sit in level 1, although it is important to consider that although the mother may be level 1 the babies usually require more intensive support.

## **Medium Secure Unit (MSU)**

The acuity in the MSU has seen an increase for Walmer and Penshurst in comparison to the last MHOST for the level 4 and 5 patients. In comparison Groombridge and Emmetts acuity has reduced slightly and remains below the benchmarking wards with no level 4 or 5 acuity patients and higher numbers of level 1 and 2 acuity patients.

The MSU wards are still awaiting to be refurbished and professional judgement around staff staffing is required to mitigate against the challenges presented by the environments. The recommended and actual CHPPD hours are more closely matched and are consistent with MHOST benchmark wards with the example of Walmer recommended CHPPD at 11 and the actual CHPPD at 11.4. Groombridge has the largest difference with the recommended CHPPD at 4.6 and actual CHPPD at 9.8 which is 2.1 more when compared to the MHOST wards. Previous years figures have been more than double and, in some cases, triple so this is an improved picture overall.

Previous MHOST reports identified the FTE for MSU had been significantly high outlier. However, this MHOST found the recommended and actual FTE are much more in line with each other. Penshurst has previously recorded 70.9 and 70.5 FTE on the last two MHOST reports and is now recording 44.1 FTE. Walmer previously recorded 56.4 in 2021 and 56 in 2022 and is now recording 37.3. Both are significant adjustments and sit closer to the recommended MHOST benchmark figures. Groombridge and Emmetts FTE have also reduced significantly but due to the low acuity remain higher than the recommended FTE and do not fully align with the MHOST benchmarking ward. This could create an opportunity to consider staffing for the site rather than wards to support the acuity demand with a focus on how other disciplines work into the wards.

## **Forensic Rehabilitation: Low Secure Units**

All the care group wards participated in the application of the 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.

Brookfield has for the second MHOST collection recorded a lower acuity with all patients listed at level 1. Allington recorded no level 4 or 2 patients which is similar to 2021 data collection but less evenly spread as per previous MHOST collection. Tarentfort recorded acuity at all levels unlike the last MHOST when there were no level 1 or 5 patients recorded. Tarentfort's acuity is slightly above the MHOST benchmark wards for levels 3, 4 and 5. This is likely to be contributed to by a number of admissions for patients on 4:1, 3:1 and 2:1 nursing care. These patients are identified as being admitted outside the recommended service criteria due to a lack of availability of specialist placements nationally. This was also identified in the previous MHOST as a concern and the challenges this presents when delivering safe quality care for all patients.

There has been a reduction in the staff used across the wards with a lower FTE compared to the last MHOST and for Allington this is a further reduction from 2021. However, the wards are still above the recommended MHOST benchmarking. Allington staffing has consistently reduced from 72.5 to 64.5 and is now 52.4 - however this is still nearly twice the recommended FTE. Tarentfort's staffing has been 75.2 for the last two MHOST reports and now sits at 72.3 which is 2.5 times more than the recommended FTE.

The care group have been impacted by admitting patients that are not appropriate for the service and require increased staffing support as well as a high dependency unit on Allington with enhanced staffing levels. This level of care delivery may not be fully represented in the MHOST benchmarking wards and therefore may account for the difference between the actual and recommended FTE.

## **6 Older Adults Care Group (OACG)**

The Older adult acuity is varied across the wards as they provide a mixed model of organic and non-organic care along with an ECT inpatient provision. All wards continue to sit above the MHOST benchmarking with more level 4 and 5 patients recorded. Ruby ward has a reduced bed provision due to its current dormitory style design and whilst a new purpose-built ward is being constructed. Due to the current environment and standalone status Ruby has restricted admissions criteria which is reflected in its lower acuity and no level 5 patients. In contrast, despite Jasmine's environment, standalone status and restricted admission criteria the ward continues to have above the benchmarking acuity levels with no level 1 or 2 patients.

The care group continues to be affected by DTOC's as previously identified in the last two MHOST reports. The DTOC position in December 2022 was 27.5%. The DTOC patient's acuity varies due to the complexity of physical and mental health in older age yet these patients are ready for discharge awaiting appropriate placement or care packages. There is on-going work to address the DTOC picture but it is recognised that there are major systemic issues that can only be resolved with partners in Kent and Medway.

The recommended FTE for the wards except for Ruby matches the benchmarking wards or are above appropriately reflecting the higher acuity. Similarly, to the MHOST benchmarking pattern, the actual FTE for all wards is higher than recommended number. Jasmine difference is marginal in comparison at 6.4 when the benchmarking is 8.4. However, there are some outliers such as Ruby ward that has partially maintained its workforce with the temporary bed reduction and admission criteria in preparation for the new 16 bedded unit being built. Orchards requires additional staff to support the ECT patients particularly the day before and on the day of treatment. Other wards staffing levels are distorted by the high levels of DTOC patients. The Older adult wards are also required to apply professional judgement around staffing levels due to the estate issues relating to dormitory bed areas, access to fresh air and ligature risks whilst refurbishments and the new build are pending. It is also worth noting that Heather, Ruby, Woodchurch experienced COVID outbreaks during the MHOST collection which impacted staffing, patients and admissions.

## **7. Acute Care Group**

### **Psychiatric Intensive Care Unit (PICU): Willow Suite**

Willow Suite is a 12 bed male ward however for the last two MHOST collections although the ward collected the data there were admissions that distorted this due to high nursing ratios and a temporary bed reduction. Willow suite data was not included in the last MHOST report due to this.

It is worth considering that for this MHOST period Willow suite experienced a COVID outbreak impacting patients and was closed to admissions for part of the data collection. However, the ward was not fully

occupied during the entire MHOST period and this will impact the overall acuity and staffing data sets. Despite this the Willow suites acuity appears slightly higher than the benchmarking with more level 3 and 4 patients.

Willow suite's CHPPD and recommended FTE all run above the MHOST benchmarking. However, their actual FTE and gap between the recommended is less. The recommended FTE sits at 40.9 (MHOST 46.6) with the recommended at 31.6 (MHOST 28.9). The ward doesn't flex its staff to its acuity as MHOST recommends and this may be a consideration for the Directorate when looking at how the multi-disciplinary team operate and the way staffing on the site can be utilised.

### **Acute wards**

Similar to Older adults the acuity is varied across the wards although acuity has dropped since the last MHOST with 3 wards Cherrywood, Bluebell and Foxglove not recording any level 5 patients. It was identified in the previous MHOST that the impact of closed PICU beds to support alternative admissions had increased the acute ward's acuity at the time.

In contrast 5 wards Pinewood, Cherrywood, Amberwood, Bluebell and Fern reported level 1 patients above the MHOST benchmark wards. This is reflective of the DTOC position which was recorded at 15.3% during the data collection period. In addition to this Amberwood had a COVID outbreak which impacted staff, patient and admissions at the time. It was also noted that some wards were operating under capacity during this period which could reflect the festive season with the third week of data collection being the same week as Christmas.

Most wards sat around the recommended MHOST benchmarked CHPPD of 6.8 with Cherrywood and Bluebell at 5.3 and Pinewood at 8. It is also important to note that most wards actual and recommended CHPPD were minimally different for Chartwell (7.4,7.3), Upnor (7.9,7.8). There were a couple of outliers as Cherrywood, Amberwood and Fern but these also had higher level 1 patients and lower level 5 patients reducing their overall acuity.

The MHOST benchmarking actual FTE is 33.4 and all the acute wards recorded an actual FTE between 30.4 to 39.6. However, similar to the MHOST recommended FTE of 23.2, the wards recorded a range of 20.7 to 29.9 with Upnor recording 32.2. The gap between the actual and recommended varied from 0.7 for Upnor to 15.1 for Cherrywood ward. This is likely to reflect the high level 1 patients and no level 5 patients recorded on that ward.

The varied acuity and staffing levels creates an opportunity for the new Acute directorate to look at a more site base working to equally distribute the staffing resource and acuity to deliver care working more closely with other disciplines.

### **8. Roster Review (previously known as Roster Check and Challenge)**

Monthly roster reviews were introduced in 2022 by the care groups and was fully embedded by September 2022 with the roster moving from a 12 week to a 6 week lead time. The reviews were initially led by the HON's of each care group with the support of HR business partners, finance business partners, matrons and ward 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 the percentage of unfilled roster.

- Additional duties were recorded in September 2022 as 1766 with a current low point of 145 for June 2023. This figure may increase slightly as the June roster moves to being live.
- Missing charge cover started at 1004 in August 2022 and has recorded a low point of 326 for the June 2023 roster. Again, this may increase slightly as the June roster goes live but continues to show a downward trend.
- Unfilled roster started at 19% in August 2022 and has recorded a low point 13% in April 2023.

These three areas alone are demonstrating a sustained improvement towards safe and effective rosters. The roster reviews will be taken over by the matrons now as the Trust has moved to the new Directorates. An evaluation of the roster review process, benefits and learning will be completed at the end of August 2023. This will also support initial feedback on the shift pattern project as the shift changes will be implemented from the May 2023 roster period.

## **9. Therapeutic Observations QI**

The therapeutic observations QI started in 2022, however it struggled to move quickly as it was identified that there wasn't a consistent approach to recording therapeutic observations and for most services this was a manual process – and as leadership changed this now work now needs reinvestment. Despite this the Community inpatient rehabilitation services introduced the concept of therapeutic observations and this has enhanced patient and staff experiences of observations. Through this process a partial digital solution to record observations was developed. A smaller QI group has been put together to initially develop consistent recording of observations building on the rehabilitation services work and benchmark the usage across the Trust. The project group is meeting monthly and linking in with the National Therapeutic Observation Project to enhance the patient experience, support more flexible application of observation and reduce the number and length of enhanced observations.

## **10. Recommendations and Next steps**

- 1) Units that stand alone geographically face challenges when the level of acuity/dependency increases. These are mainly our Older Adults Wards and Rehabilitation Units. The move to Directorates offers some opportunity to use staff within a site or geographical location more effectively. This will be explored with the Directorates.
- 2) Psychiatric Intensive Care (PICU)– the number of individual patients at a high level of acuity is higher than the MHOST benchmarking. The service model (in terms of responsiveness and early intervention) needs to be reviewed to establish what can be done to reduce the level of disturbed behaviour and reduce the overall needs for observations to be more in line with other PICUs.
- 3) Delayed transfers of care (DTC) can reduce the level of acuity overall on a ward as people move out of the acute phase of admission and towards recovery. Basing the staffing model on acuity/dependency highlights that these teams can become less efficient in this context. Again, geographical isolation can inhibit the redistribution of staff to other areas with greater need. The move to Directorates offers some opportunity to address aspects of the staffing challenge but the greater work required is on the overall DTC picture within KMPT.

- 4) The model of staffing during periods of high acuity relies heavily on the use of observations. Whilst this is very helpful in the initial phases of admission, it can be an overused approach that can become unnecessarily restrictive and exhaust staffing resource. The QI project into this made some good initial progress but now needs refreshing as the new leadership teams are in place in the directorates.