Sheffield Health and Social Care NHS Foundation Trust

Board of Directors' Open

Date:	12 February 2020	Item Ref:	5

TITLE OF PAPER	Progress Report on the Business Case for Increasing the complement of Psychological Practitioners and Allied Health Professions across the Inpatient Wards.
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing & Professions
ACTION REQUIRED	For Board's information and discussion.

OUTCOME	Board members are informed of the current position regarding the Business Case to increase numbers of Psychological and Allied Health Professions in the Inpateint Wards.
TIMETABLE FOR DECISION	February 2020 Meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	1. NQB: Safe, sustainable and productive staffing: An improvement resource for mental health (Jan 2018). 2. NQB: Safe, sustainable and productive staffing: An improvement resource for learning disability services (Jan 2018). 3. NHS Improvement: Developing Workforce Safeguards (Oct 2018). 4. Mental Health Optimal Staffing Tool (MHOST) Implementation Guidance for Mental Health Inpatient Wards, the Shelford Group 2019
STRATEGIC AIM STRATEGIC OBJECTIVE **BAF RISK NUMBER & DESCRIPTION**	Strategic Aim: Quality & Safety. Strategic Objectives A1 02: Deliver safe care at all times Strategic Aim: People Strategic Objective A2 03: We will develop an effective culture of leadership & management. Strategic Aim: Future Services Strategic Objective: Deliver new ways of working Strategic Aim: Value for Money Strategic Objective A4 01: We will improve productivity & efficiency of our services, maximizing time spent with service users.

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LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	The NHS Constitution (2015) Principle 3, 'Aspiring to deliver high quality safe effective care, focused on patient experience'. CQC Guidelines (2019) on the, 'Therapeutic Acute Mental Health Ward'. Royal College of Psychiatrists' Centre for Quality Improvement's (CCQI) Guidelines on Standards of Care in Mental Health Inpatient Wards. NICE Quality Standards: Service User Experience in Adult Mental Health (July 2019)
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	The ability of each inpatient ward to work as an effective multiprofessional team delivering high quality compassiontate care and achieve effective outcomes for each service user, is predicated on having the right staff with the right skills providing the right care at the right time and place, our inability to provide an effective staffing skill mix is a risk to patient care/outcomes. Indicative investment for additional staffing is estimated at circa £2M (at the Outline Business Case, OBC, Stage).
CONSIDERATION OF LEGAL ISSUES	Inability to meet regulatory care requirements may affect the Wards and Trust CQC rating and Terms of Authorisation.

Author(s) of Report	Linda Wilkinson and Julie Edwards
Designation	Director of Psychological Services Director of Allied Health Professions
Date of Report	6th February 2020

Sheffield Health and Social Care NHS Foundation Trust

Summary Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
				✓	✓	

2. Summary

At a presentation to SHSC Trust Board in May 2019 on Safer Staffing the Board heard that there are very low numbers of Clinical Psychologists and Psychology Assistants (8) and low numbers of Allied Health Professionals (AHPs) (22) working across the 12 in-patient wards which provide 24/7 care. The Trust Board asked that work be undertaken to address this.

An initial Business Case for increasing the complement of Psychological Practitioners was received at the Business Planning Group (BPG) in September 2019. BPG supported the Clinical Case for change however asked to see more detail / improvements to the economic / financial case.

Further work was ubdertaken and an Outline Business Case (OBC) for Psychological Practitioners and Allied Health Professions (AHPs) was produced and received / presented at BPG in January 2020. It was agreed to progress to Full Business Case (FBC).

The Business Case sets out a clear clinical case for a new model of care and staffing on the inpatient wards to better meet the changing needs of the population of service users we are here to serve.

The ability of each inpatient ward to work as an effective 7 day a week multiprofessional team delivering high quality compassiontate care & achieve effective outcomes for each service user, is predicated on having the right staff, with the right skills, providing the right care, at the right time and place. Care that is more psychologically informed and where assessment, treatment and interventions are wholistic (bio-psycho-social) therapeutic, recovery orientated and evidence based.

The fundamental aims of having an improved skill mix / clinical establishment and a greater ratio of registered health care professionals to clinical support staff are to:

- Improve assessment, treatment and outcomes for Service Users
- Improve Service User Experience
- Improve staff health & well being
- Reduce the use of restrictive interventions and observations.
- Reduce length of stay
- Reduce sickness absence
- Reduce workforce turnover
- Improve retention

- Better meet the core needs of staff at work for: Autonomy and Control, Belonging and Competence.
- Create a culture where clinical supervision and reflective practice are routine.
- Improve on the fundamentals of care: physical health assessment and monitoring, application of codes of practice, medicines management and for education, training and development.

At OBC stage the staffing model seeks to:

- Extend AHPs to 7 days a week for 52 weeks
- Extend Clinical Psychology to 5 days a week for 52 weeks
- Introduce a new role of Clinical Associate Psychologist (CAP)
- Use CAPs & Psychology Assistants 7 days a week for 52 weeks

The indicative / estimated cost at OBC stage is circa £2m.

Further work is underway on the FBC, including working with Sheffield University Department of Clinical Psychology and a Health Economist to undertake:

i. a cost benefit analysis: of the anticipated impact of the investment on service user outcomes; staff health and well-being; and quality of care /clinical effectiveness and
ii. an economic evaluation of the potential return on investment from a reduction in: sickness absence; use of out of area placements; high use of support staff for observations; and claims / litigation costs.

3 Next Steps

Progress to Full Business Case, to be presented to Trust Board in May 2020

4 Required Actions

i. Trust Board to receive the Progress Report on the Business Case for Increasing the complement of Psychological Practitioners and Allied Health Professions across the Inpatient Wards.
ii. Discuss and raise any queries / concerns.

5 Monitoring Arrangements

Monthly Progress Reports to:
Clinical Services Performance & Governance Meeting
EDG via 1:1 up-dates with Executive Director of Nursing & Professions.

6 Contact Details

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Sheffield Health and Social Care NHS Foundation Trust

Progress Report on the Business Case for Increasing the complement of Psychological Practitioners and Allied Health Professions across the Inpatient Wards

Executive Summary

At a Safer staffing presentation to SHSC Trust Board in May 2019 the Board recognised that the Psychology staff are thinly spread across 12 Wards (there are currently the equivalent of 5 wte qualified Clinical psychologists and 3 wte assistant psychologists across the 12 wards). Whilst the board recognised Allied Health Profession (AHPs) staff provision was present in most areas, the provision was limited to 5 days a week with no headroom (there are currently the equivalent of 12.6 wte qualified AHPs and 15.7 wte assistants across the 12 wards). Trust Board recommended that work be undertaken to address the shortfall in staffing. What follows is a summary of the work to date and the next steps required.

Review of Therapeutic requirements across the inpatient wards

A task and finish group was established within the Acute and Crisis care network to examine the CQC guidelines for the "therapeutic ward". This has provided a platform for the review of the broad guidelines communicated by the CQC Deputy Chief Inspector in March 2019 alongside the work that the Trust is undertaking related to the national accreditation scheme led by the Royal College of Psychiatrists' Centre for Quality Improvement's standards (CCQI).

The issues/areas for improvement included:

- Physical environment
- Access to full range of therapeutic interventions
- Use of restrictive interventions
- Staffing levels
- Safety and Security
- Quality of leadership

These areas focus on the importance of the development of a ward culture that 'promotes therapeutic benefit and minimise institutionalisation'. There is an emphasis on access to Occupational Therapy, support for therapeutic and physical activity and ensuring service users have access to meaningful activities, which promote recovery 7 days a week. The CQC and CCQI place an emphasis on the access to a choice of psychological treatments as first line interventions based on our increasing understanding of the impacts of adverse childhood experiences (ACE's) and the importance of delivering trauma informed care in psychologically informed environments.

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We have undertaken a benchmarking exercise to map each of the inpatient wards to the 48 CCQI standards related to therapeutic care. Initial results indicate a variable picture of achieving all of the standards across the wards, e.g. Forest Close meet all of the required standards and have achieved full peer accreditation.

However the acute wards require further work, mainly around standards that measure access to evidence based psychological interventions: therapy staff attending and contributing to MDT meetings: 7 day therapeutic provision of therapeutic activities: family and carer interventions and staff wellbeing interventions including reflective practice/staff support/debrief following incidents and supervision. Work is continuing to develop clear actions plans and with clear guidelines on next steps.

Data and Systems Review

There is a review taking place to better understand the work pressures with in the system in terms of patient flow: bed pressures and bed occupancy and the reported increased levels of acuity resulting in challenges (challenges being defined as incidents/ harm to staff and other services: self harm and restrictive practice/seclusion) within the ward environments. A clinical psychologist is employed to undertake research to identify the factors which may present to potentially predict that outcome to intervene using different approaches. These factors fall in to a number of categories: including background patient factors (presence of abuse, homelessness ACEs etc.), current factors such as drug use. It also includes system factors e.g. Access to services, GP's etc. And ward factors- such as length of stay etc., rate of bed occupancy, ward stability. Initial findings support the development of the clinical and staffing model proposed below. A full report is expected in March 2020 and this will be summarised as part of a full business case.

Outline Business Case

An Outline Business (OBC) case was developed and the authors have proposed an increase in the number of Psychological and Allied Health professions staff on each ward with the aim of implementing NICE Quality Standards, and standards for providing a therapeutic environment for acute inpatients. Alongside this support for the multidisciplinary team to deliver on the therapeutic ward described by the CQC 2019 and the (CCQI) for acute inpatient mental health wards.

The current drivers for the change in the model of care includes:

a. The CQC Therapeutic Ward requirements: Give a greater presence of staff to provide equity of access to psychological and AHP's interventions for all service users. The increased capacity to provide 1:1 and group based/family interventions and to enable attendance at MDT and governance meetings.

b. Reducing Restrictive Practice and deliver NICE guidelines*:* Working more proactively / upstream to reduce the likelihood of use of restricted intervention/ restraint through greater presence of psychological formulation and therapeutic activities on each ward.

c. AIMS accreditation standards*:* greater presence at ward safety huddles and increased capacity to provide complex case formulation, reflective practice, supervision, joint care plans and risk assessments and therapeutic activities.

d. Service user feedback: requesting access to activities and talking treatments.

e. Thematic feedback from LiA and review of increase use of out of city placements: requests from staff for an increased capacity to support staff wellbeing support following incidents for staff and service users

f. Quality Improvement**:** Microsystems focus in several ward areas on activities and therapeutic work

g. Improving the physical health -of people with severe mental illness

h. Response to a short qualitative survey – staff want to see an increase in the provision of psychological services and activities to support the further development of the therapeutic ward.

I. Trauma Informed care- fundamental shift in providing care and moves from thinking 'What is wrong with you?' to considering 'What happened to you?'

Staffing Model

Mental Health Optimal Staffing Tool

The Mental Health Optimal Staffing Tool (MHOST) uses quality metrics alongside acuity and dependency. It has been designed to ensure that NHS organisations have the right staff, with the right skills in the right place at the right time. It is an evidence based tool to better understand patient profiles/need and the clinical establishment required to meet patient need. It emphasises the need for developing evidence-based, patient need-driven staffing levels in all mental health care settings.

As part of the OBC to increase psychology and AHP resources consideration has been given to these quality metrics as part of effectively meeting the service users' needs. (Attached in appendix 1 are some case examples of the clinical impacts of Psychological and AHP interventions).

MHOST Quality Metrics	**Current Position**	**Anticipated Impact of investment**
Staff Related Indicators		
Monitor Sickness absence – monthly HR data Staff engagement staff survey/job satisfaction- through survey and staff interviews	Staff sickness currently reported average 8% (between 6-10%) Staff reporting poor morale/ low job satisfaction and poor engagement – in staff survey and LiA reports	Sickness absence reduces to 6% Staff reporting increases in job satisfaction/ improved morale and well being – good engagement- captured in staff survey

MHOST Quality Metrics	Current Position	Anticipated Impact of investment
Clinical Supervision completion rates- monitored for the team on a monthly basis	Low rates of supervision compliance on the acute wards (32-75%)	Higher rates of supervision compliance – attendance at reflective practice – team formulation and 1:1 supervision
Patient related indicators		
Patient experience data and Friends & Family test Provision of therapeutic activities 7 days a week Restraint episodes; clinical incidents resulting in harm	Patient experience feedback inconsistent collection of data across the wards – some feedback lack of meaningful activities on the ward lack of access to psychological interventions Upwards linear trend in assaults towards staff – increase in restrictive practice on some wards	Establish Routine collection of patient experience across the wards – improvements in the provision of meaningful activities on the ward land improved access to psychological interventions – resulting in improvements in the quality of experience for service users. Enhance coping strategies/opportunities to learn new skills Reduction in restraint and incidents on the ward Reduction in harm to staff
Care Process Related Indicators		
Monitor bed occupancy levels Complaints/ Compliments Re admission rates	Occupancy levels consistently 100% on the acute wards Patient reports “want staff to have time to listen” There are currently 12-15 patients with more than 3 admissions in an a 2-year period	Reduce bed occupancy to 90-95% Reduced bed occupancy frees staff to provide good quality care and improved patient experience. Targeted work to support those with more than 2 admissions per year to work to reduce admission and find alternatives to support crisis care management

The OBC recommends that the Trust moves forward with the option to develop an increase in Psychological Professions staff to provide access to a qualified member of staff 5 days a week, 7.5 hours for 52 weeks of the year based on x 2.0 wte per ward. The increase in psychology staff will provide trauma informed care, access to NICE guideline recommended psychological assessment, formulation, treatment and care planning, discharge support, individual, group and family interventions and support the ward staff in developing a sense of psychological safety. Increasing staffing would ensure all service users had access to psychological treatments and staff have access to support, consultation and advice recommended by the CCQI and the CQC.

The increased Allied Health Professionals staff to provide 7 day a week, 7.5 hours a day for 52 weeks of the years the current budget based on current staffing x 1.70. This would ensure every ward and service user had access to a registered OT/AHP 7 days a week to provide therapeutic programmes, leisure and recreational activities. These interventions will enable service users to maintain the functions of their daily lives, address physical health care issues e.g. diet and exercise, develop new ways of coping to support their recovery and facilitate a positive discharge.

The anticipated impact of investment includes the staff, patient and carers related indicators described above, e.g. improved supervision reflective practice/staff support resulting in improved morale/sickness/reduced use of bank and agency consistent staff teams and better-quality care for patients. Reduced incidents access/therapeutic activities/escorted leave/self-harm management/whole team approach/family interventions/ improved self-coping skills for patients – better quality patient care matched NICE guidelines and improved patient experience.

Finance and Funding

Trust Board recommended that work be undertaken to address the shortfall resulting in an OBC that reviews the broader therapeutic requirements across the inpatient wards. Business Planning Group reviewed the case for investment made for the Psychological practitioners in September 2019, but wanted to see an improvement around the economic case for change alongside an integrated business case that outlined the needs for Psychological Practitioners and AHP's. The OBC was presented and approved at BPG on 21st January 2020: to EDG for approval on 6th February 2020 and recommends moving forward as a full business case.

The indicative cost of the propsed staffing model at OBC stage is circa £2m.

Further work is underway in preparation for the FBC to explore the potential options for funding with work planned with Sheffield University Department of Clinical Psychology and a Health Economist to further analyse the anticipated impact of the investment in relation to the clinical quality outcomes an potential economic savings from the new model of care.

Appendix 1

Psychological interventions

Clinical Vignette Acute Wards

L had a history of engagement with a variety of services, which included receiving psychological interventions as an adolescent and prior to admission L was working with a psychotherapist in the private sector. L was admitted via HTT team/Crisis House due to self-harm (cutting/burning and ligation–with a history of numerous suicide attempts meant that the teams felt that risks were escalating and could not be managed in the crisis house and she was admitted to an acute ward. L had a numerous admission to a variety of different hospitals thought-out the country. L's experiences of mental health services were negative. L spoke of feeling traumatised after first admission to an acute hospital in Scotland whilst studying at University.

After 2 days on the ward L made a serious suicide attempt through ligature, which resulted in an admission to (physical intensive care). L made a full recovery and returned to the ward. The nursing team on the ward were becoming increasingly concerned with L's presentation. They found the self-harming behaviour anxiety provoking & challenging and some staff were reporting finding it difficult to wind down and sleep after the shift. A common narrative among the staff included the perception that L was manipulative, as staff would see L laughing and joking with peers and an hour later unable to tolerate her distress. This resulted in a reduced empathy for L and they often got caught in the struggle around control.

Clinical Intervention Plan - *The intervention from the Clinical Psychologist included* ***individual therapeutic work*** *with L to develop a* ***shared psychological formulation*** *and understanding of her history of childhood sexual and emotional abuse and the impact on her current relationships in the here and now, particularly related to emotional sensitivities to fears of abandonment, rejection and the need for L to feel powerful and in control. There was some focus around how this need to be powerful and in control was being played out in her behaviour and relationships with the ward team, which helped L to understand her reactions to others.* ***Work focused on building emotional coping/distress tolerance skills*** *with L, finding ways to identify triggers to emotional distress recognise and label the emotions,* ***build trust with the staff team and acceptance of support from staff to contain distress.*** *The clinical psychologist worked with the* ***staff team in a team formulation and reflective practice*** *session to build understanding with the staff team and worked with the named nurse to develop the care plan which all the team signed up to deliver consistent contained care. L was successfully discharged to the community with no re admissions over the last 18 months*

Case Vignette *- S is 29 years old and was admitted to the acute ward from A&E following assessment by Liaison. This is the third admission in 6 months. S was taken to A&E from the 911 Project where she lives after being found in her room by staff, S had taken a mixed overdose, which she took with the intention to end her life. S reports feeling low in mood with poor sleep and reduced appetite and struggling with feelings of guilt, hopelessness and concentration levels. S does not recognise any protective factors beyond her 3-year-old daughter (currently living with grandmother) who she hasn't been in contact with recently. When S's mood is very low she can hear her grandfather talking to her and has recently begun to hear young voices, which she doesn't recognise. These experiences are unpleasant and tell her to hurt her family or kill her family. S has a history of multiple mixed overdoses and admissions: substance induced psychosis (7 admissions in the last 2 years).*

Clinical Intervention Plan -*The clinical psychologist is asked by the MDT to meet with S. A full assessment, formulation and risk plan are devised with S. During the assessment S disclosed a history of childhood sexual abuse by grandfather and concerns related to her 3-year-old daughter being at risk. Safeguarding alerts are raised and action taken. In the formulation there is acknowledgement that substances were S's way of trying to "block out memories of the abuse". The psychologist works with S to understand and process complex trauma: build coping strategies using DBT skills: develop ways to understand and manage hearing voices and works to support S in engaging with the substance misuse team, recovery college and employment. A longer-term formulation care plan is devised with S for additional support in the community including allocation to the EI team care coordinator. Family intervention with her mother and daughter are started on the ward: a permanent housing/accommodation and benefit advice via the CAB.*

AHP Case Vignette

Over the last 6 months an additional 2 Band 5 Occupational Therapists have been appointed to join the existing AHP staff at Forest Close. This has supported a revised offer of input with a clear pathway and improved therapeutic programme focusing on life skills, health and wellbeing, work and education, leisure and creativity and the introduction of standardised assessments and outcomes with increased capacity for individual interventions and a doubling of activity. They have started to undertake Functional assessments to inform future support/care package in the community and discharge placements and are now completing a standardised discharge summary for each individual at Forest Close.

Case Vignette – Acute wards

Service user A in a particularly distressed state threatened to 'smash some computers' on the ward. We took him into the gym, where he worked out for 30 minutes. He then returned to his room and fell asleep thus saving the ward from having to manage this behaviour, a possible risk of confrontation and restrictive practice and provided him an appropriate way to vent his excess energy. (A technique he could hopefully use in the future)

Service User B was becoming increasingly agitated pacing on the ward, verbally hostile expressing threats to harm staff and other service users. Ward staff informed the senior OT that seclusion was imminent and the staff team started to gather around the service users. The senior OT moved alongside the service user and asked if they wanted to go through to the activity hub and make some breakfast. They went with the OT into the kitchen, he cooked some breakfast, sat and ate and was calm when he returned to the ward area.