Delivering Care Phase 5A (Inpatients) Mental Health

As part of the Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC Health and Social Care

Introduction

Delivering Care aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of staffing models and ranges for the nursing and midwifery workforce within the Delivering Care policy framework.

Phase 5A and 5B of this work focuses on Mental Health Nursing in both inpatient (A) and community settings (B).

This paper is intended to build on the key principles and assumptions that have been agreed in previous phases for Delivering Care. This phase will reflect the methodology agreed with the regional Steering Group and governance arrangements for the overall project, as they relate to **Phase 5A inpatient environments**.

It is recognised that workforce planning processes include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person-centred care. This work has been developed in the context of the principles of Quadruple Aim[1], which combines a focus on population health and wellbeing, safety, quality and experience, cost and value with added experience of care givers.

Context

The subject of nurse staffing continues to be a matter for debate. Ensuring appropriate nurse staffing is in place has been referenced in inquiries and reviews[2], highlighted in research and evidence[2] and is viewed by families and carers as a key element in influencing the quality of care[2]. Phase 5 (Mental Health Nursing, inpatient and community settings) of the Delivering Care framework builds on the methodologies and learning from previous phases.

The Bamford vision for Mental Health in Northern Ireland[3]

At the heart of the Northern Ireland (NI) Mental Health Strategy is the vision to deliver a service which gets the best results at the earliest opportunity.

The Bamford vision for Mental Health strongly supports the following principles:

[1] Bodenheimer, T., (2014) From Triple to Quadruple Aim: Care of the Patient requires care of the Provider, Annals of Family Medicine, University of California

[2] Public Health Agency (2017) Delivering Care: A Literature Review for Workforce Planning for Mental Health Nursing In Northern Ireland, PHA

[3] Bamford Review of Mental Health and Learning Disability https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf

- Good Mental Health should underpin all aspects of health and wellbeing and should be everyone's responsibility.
- People with Mental Health needs should be valued. This includes the right to full citizenship, equality of opportunity and self-determination.
- There is a need for society to address the challenges facing people with Mental Health needs
- There should be a process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with Mental Health problems and to their carers and families.

Within Mental Health services, a person-centred approach is endorsed which is community and family-orientated with a recovery ethos as core to the vision for service development. The Bamford vision also provided a detailed framework for Mental Health promotion, suicide prevention and recovery, with users and carers at the centre. In addition, the strategic policy focus is on the development of leadership, teamwork, workforce and training, acknowledging that reform is dependent upon a sufficient and competent Mental Health workforce.

At all levels of the Bamford Mental Health Strategy there is a requirement for adequate resources, including support for recommended staffing levels to ensure the effectiveness of the Health and Social Care (HSC) workforce. This requirement will be progressed under the key work streams across Mental Health strategies to reform services into the future. Mental Health services incorporate a number of Nurse-led approaches to service delivery.

The key achievements of Bamford

Since the inception of the Bamford vision there have been a number of improvement initiatives, including practice development for staff, introduction of new services and ways of working and improved patient experience. Listed below are some of the key achievements of the Bamford vision:

- The resettlement of the majority of patients out of hospital to the community;
- The establishment of recovery-orientated practice and recovery service development;
- The establishment of a Mental Health "Stepped Care" model for services;
- The development of crisis resolution services and specialist Mental Health services including services for people with a Personality Disorder or an Eating Disorder;

- Improved Mental Health awareness throughout the community and investment in psychological therapies and suicide prevention measures;
- Emphasis on co-production practices and meaningful partnership working with service users with lived experience;
- Recommendations to increase participation of service users in employment programmes and the embedding of Mental Health promotion in schools.
- The development by the Public Health Agency (PHA), Health and Social Care Board (HSCB) and the Department of Health (DoH) of an education and learning framework for Mental Health professionals.

Key Drivers for the Future Mental Health Nursing Service

A range of strategic and operational drivers have been considered within this phase of Delivering Care that will have a significant impact on the future of Mental Health Nursing services. The following policy drivers have been considered:

- **Health and Wellbeing 2026: Delivering Together**[4] **-** This document was produced in response to the report by Professor Bengoa. Delivering Together puts people first and focuses on enabling people to stay well for longer. Where care or support is needed, it will be, wherever possible provided in a community setting.
- HSC (NI) **Workforce Strategy** 2018[5].
- **Quality Care**[6] -The Q2020 Strategy aims to protect and improve the quality of health and social care in Northern Ireland and to be recognised as a leader for excellence. Through its key strategic goal 'strengthening the workforce', the Q2020 strategy is committed to ensuring that we provide the right education, training and support to deliver a high quality service. This is fundamental to the delivery of safe and effective services.
- The **Bamford**[7] vision for Mental Health services, which called for continued emphasis on promotion of positive Mental Health, reform of Mental Health legislation and a continued shift from hospital to community based services with the development of specialist services.

[4] Department of Health (2016) Health and Wellbeing 2026 Delivering Together, DoH 2016
[5] Department of Health, Social Services and Public Safety (2015), Evolving and Transforming to Deliver Excellence in Care. A Workforce plan for Nursing and Midwifery in Northern Ireland (2015-2025) DHSS&PS
[6] Department of Health, Social Services and Public Safety, (2014) Quality 2020: An Attributed Framework for Health and Social Care, DHSS&PS
[7] Bamford Review of Mental Health and Learning Disability https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf

- The DoH Nursing and Midwifery Task Group / Mental Health Nursing Review (2018) aimed at improving the contribution of nursing across the life span.

- **Delivering Excellence, Supporting Recovery**[8] is the Department of Health's Strategy (2011-2016) for Mental Health Nursing.

- **Dementia Strategy**[9] **-** Recommendations aimed at improving the services and support arrangements currently available for people with dementia, their families and their carers, with an emphasis on early diagnosis.

- **Population health**[10] – Increased focus on enabling health promotion, prevention and self-management. The "Making Life Better" NI Public Health framework (DHSSPS 2013) seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of NI where all people are enabled and supported in achieving their full health and wellbeing potential and to reduce inequalities in health.

- **Care enabling technologies**[11] - Building on the "Regional eHealth and Care Strategy" (DHSSPS 2015) it is imperative that there are systems and processes to support timely and consistent sharing of patient information. This should include real time access to all Mental Health and social care information for all relevant care providers to enable them to work effectively and safely with their patients. This will be achieved through the development and implementation of an electronic record in common for all citizens in NI over the next 5 - 10 years.

- A priority for **unscheduled care**[12] in NI is to have effective, integrated arrangements, organised around the needs of individual patients, in place in community settings to provide care for people at home and in their local communities. The intention is to avoid the need for hospital admission for Mental Health services and to support safe and effective discharge planning arrangements when a period of hospital admission is required.

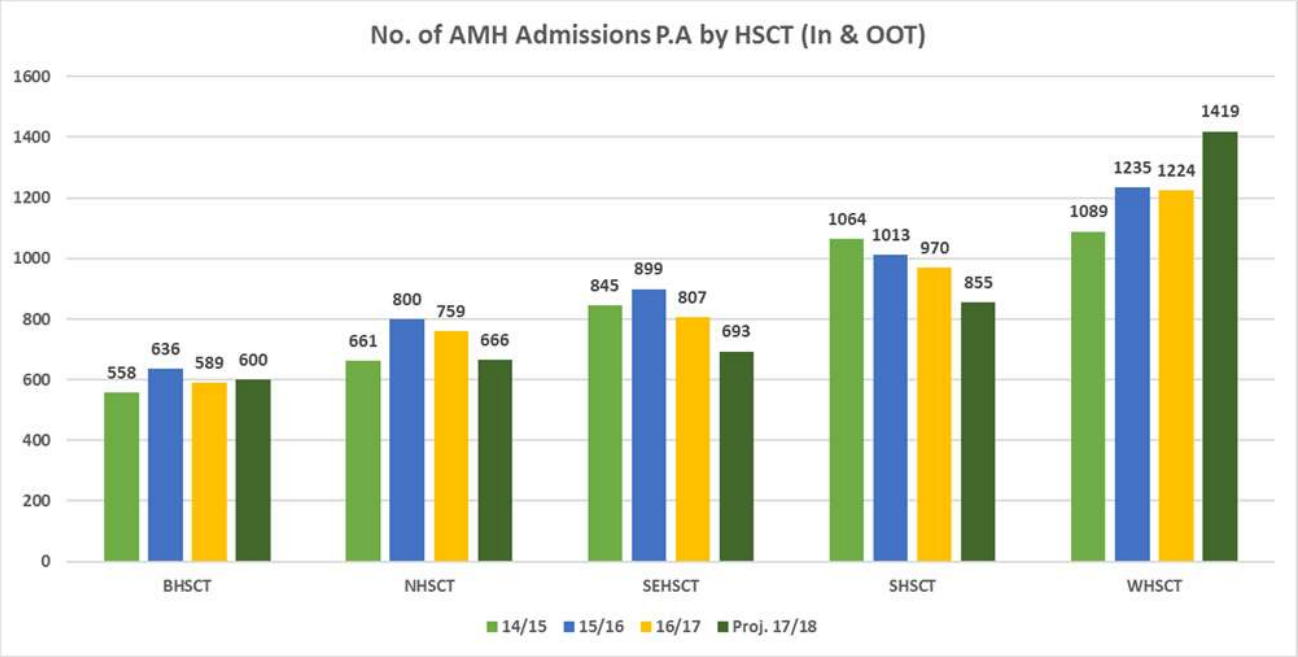
- **Demography** - The population of NI is increasing, and within this overall increase the size of the older population is increasing more quickly.

[8] Department of Health, Social Services and Public Safety (2011-2017) Delivering Excellence, Supporting Recovery, DHSS&PS
[9] Department of Health, Social Services and Public Safety (2011) Improving Dementia Services in Northern Ireland- A Regional Strategy, DHSS&PS
[10] Department of Health, Social Services and Public Safety (2014), Making Life Better 2012-2023, A Whole System Strategic Framework for Public Health, DHSS&PS (2002) Investing for health Strategy 2002-2012, DHSS&PS
[11] Department of Health, Social Services and Public Safety (2015) Regional eHealth and Care Strategy, DHSS&PS
[12] Department of Health (2016) Health and Wellbeing 2026 Delivering Together, DoH 2016

- **Increasing Profile of Demand** - Due to the rapidly changing health and social care landscape increasing numbers of people with Mental Health issues are being cared for at home, which includes people living in deprivation, increased referrals for young people and those living to a very old age. See **Figure 1** (NI Referral Rates).

Figure 1 Number of Acute Mental Health Admissions per annum demonstrates a snapshot of the changing profile of demand for Mental Health services in NI. This Table illustrates the increasing referral rates for inpatient admissions to Mental Health services from 2014/15 through to 2017/18 across all 5 Health and Social Care Trusts (HSC Trusts).

Figure 1: Number of Acute Mental Health Admissions per annum In & Out of Trust



Source : HSCB 14.03.2018

Current Services

Stepped Care model in Mental Health services

In October 2014 the HSCB and the PHA launched a Regional Mental Health Care Pathway for people who require Mental Health care and support. The purpose of the Care Pathway was to provide guidance on the steps of care to be delivered, enhance quality of service experience and promote consistency of service delivery across NI. It describes a Stepped Care approach consisting of 5 distinct steps. When service users are welcomed into the service, the Stepped Care approach means that care provision for any individual can be stepped up or down according to a person's needs.

A step up in care usually means that more intensive specialist support is required. Equally a step down in care means that a person needs less intensive input. This model impacts on the requirements of the nursing workforce. The five steps are illustrated in **Figure 2**, in relation to the types of support and clinical/care environments.

Figure 2: Regional Mental Health Care Pathway October 2014 HSCB/PHA

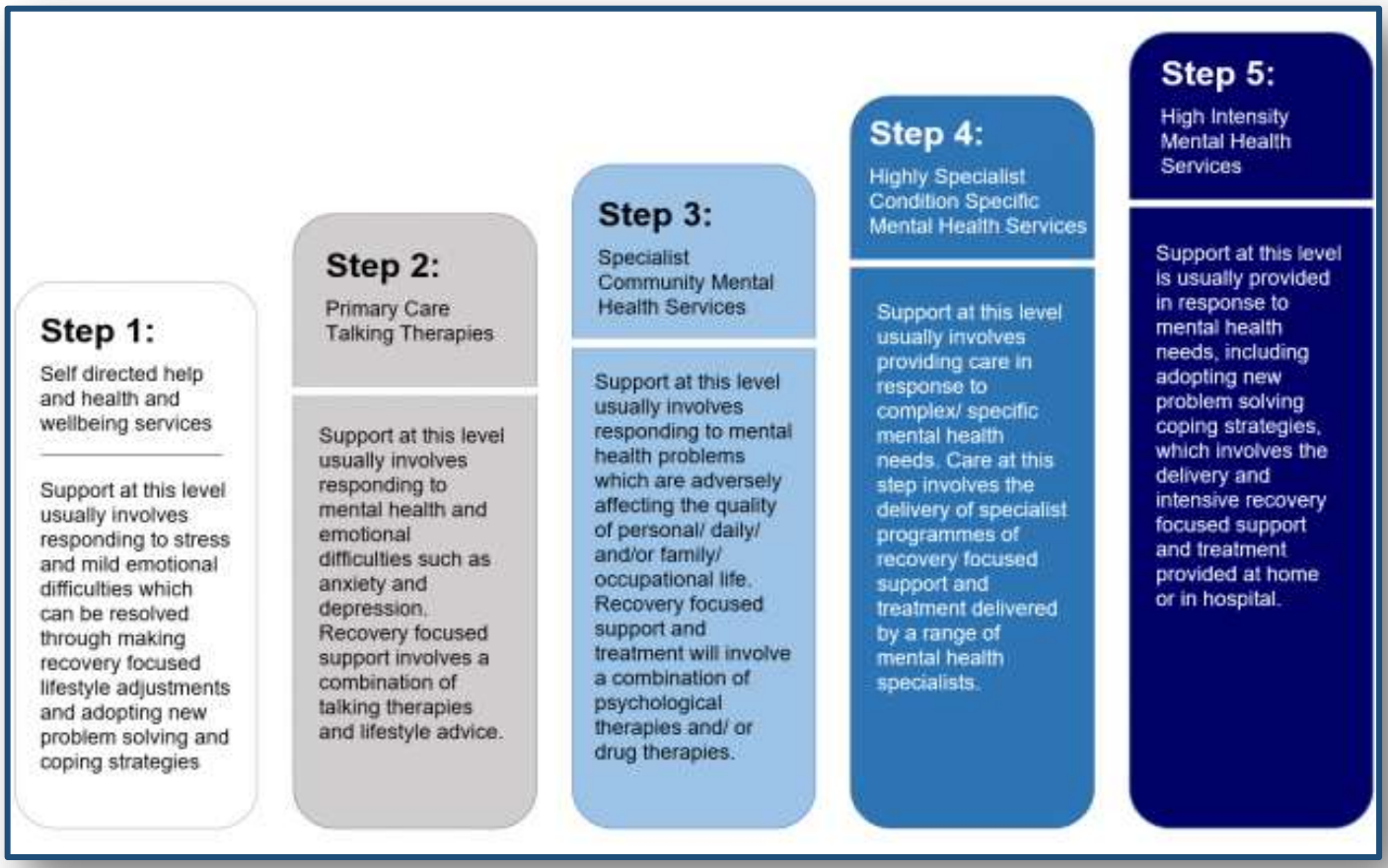


Image adapted from HSC's Regional Mental Health Care Pathway, 2014

Descriptors and category of care environments

Northern Ireland's Mental Health service is made up of hospital inpatient units and community Mental Health services. The inpatient services include acute admission units, dementia assessment, specific admission units for those who are over 65 years of age, addictions units, inpatients and psychiatric intensive care units. There are also low secure rehabilitation units. A regional medium secure unit and the Child and Adolescent Mental Health Service (CAMHS) unit are located in the Belfast HSC Trust. These services will be provided across Steps 4 to 5 in the Stepped Care model.

Within the community there are community Mental Health teams, which include specialist teams such as Addictions Teams, Personality Disorder teams, Eating Disorder teams and Community Forensic teams. Crisis Resolution/Home Treatment teams are based in the community and provide a gatekeeping role to inpatient beds. Day Hospital provision exists in some areas. These facilities are staffed by existing staff based in hospital or community teams. Mental Health services span across acute and primary care teams and across the age spectrum to include Mental Health teams for older people. These services will be provided across Steps 3 to 5 in the Stepped Care model.

There are also services which are situated within the community and other agencies which respond to stress and mild emotional difficulties offering self-directed help, encouraging adoption of new problem-solving techniques and coping strategies. These provide an opportunity for people to be helped within their own community. Finally, there are services which offer help for moderate Mental Health conditions, such as "talking therapies". These services are offered within Primary Care at Steps 1 and 2 of the Stepped Care model. The diagram, **Figure 3** on page 8 gives a description of the Categories of Care in the Stepped Care Model.

Inpatient units

Phase 5A will incorporate inpatient units across the 5 HSC Trusts. Patients admitted to these facilities require acute Mental Health care and support and will be cared for within a whole system approach which includes a Stepped Care pathway. For the purposes of this phase of Delivering Care, each inpatient unit will be described within the following categories of care environments.

Figure 3 Categories of Care Environments

Category 1. **Acute admission, assessment and treatment** wards are clinical environments where patients are admitted in the acute phase of an illness, or require an immediate Mental Health assessment and/or treatment. These wards are where patients can be treated in the least restrictive environment. Their condition is treated and stabilised with a view to discharge back to the community in as short a time as possible. These wards are used for admissions when it is no longer possible to maintain or treat the patient safely in the community or their place of residence. This may also include those patients who are over 65 and who have a functional illness and those who may need admission to an inpatient addiction service. The length of stay can range from 2-6 weeks. This category of care environment is **Step 4** within the Stepped Care model.

Category 2. **Psychiatry of old age/dementia assessment** wards a**re clinical environments where patients are admitted in the acute phase of their illness, or require further assessment**. They may or may not have already been given a diagnosis of dementia and may have further complex health issues and/or co-morbidities requiring a higher intensity of nursing care. This category of care environment is **Step 4** within the Stepped Care model.

Category 3. **Psychiatric intensive care units/beds** are clinical environments where patients are admitted due to increased acuity/need/risk with significant challenging behaviour which could not be managed in an admission or assessment unit. These units have a higher degree of security, safety/safeguarding to ensure patient safety and risk is managed effectively. Patients may be subject to assessment under the Mental Health (NI) Order 1986 before admission. The length of stay should be short within a 6 week timeframe with patients being discharged and/or transferred to a Mental Health care environment/service that meets their needs. This category of care environment is **Step 5** in the Stepped Care model. This Category may include inpatient Child and Adolescent Mental Health Services (CAMHS). These units deliver tertiary level care and treatment to young people with a range of mental disorders and complex needs (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder, severe psychosomatic disorders) associated with significant impairment and/or risk to themselves or others such that their needs cannot be met safely by Tier 3 community CAMHS . This includes young people with mild learning disability and Autistic Spectrum disorders who do not require Tier 4 CAMHS Learning Disability Services.

Category 4. **Low secure** units in Northern Ireland are clinical environments which provide a service for patients with a severe and enduring mental illness and who require high intensity rehabilitation. Due to the level of acuity and risk, these patients have not been able to be rehabilitated quickly to the community and normally remain detained under the Mental Health (NI) Order 1986 prolonging the length of stay. This category of care environment is **Step 5** of the Stepped Care model.

Category 5. **Medium secure** services provide therapeutic psychiatric services for individuals with a mental illness, who present a serious risk of harm to themselves and others, due to their condition. Patients being admitted must be detained under Mental Health (NI) Order 1986. The decision to admit to a secure unit will be based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed whilst in hospital. Many but not all of those admitted to secure services will have been in contact with the criminal justice system. This category of care environment is **Step 5** in the Stepped Care system.

Case studies for each category of care environment

In order to give some understanding of the types of patients and conditions admitted to the various inpatient Mental Health settings, a number of anonymised case studies can be found at ***Appendix 1.***

The Mental Health nursing workforce in Northern Ireland

Mental Health Nurses are the largest professional group within Mental Health and social care services in Northern Ireland (NI). They account for 70% of the total statutory workforce in Mental Health services and also have a significant presence in the independent, community and voluntary sectors.

Mental Health Nurses provide the majority of direct patient care in many settings. Currently, there are a reported total number of 1640 live registrants in Mental Health Nursing in Northern Ireland (*Source DoH March 2017).* It is noted that not all of those registrants may be practising in Mental Health care environments in NI. Commissioning of pre-registration Mental Health places by the Department is aligned with the Nursing and Midwifery Workforce Plan and reviewed annually.

A Mental Health Nurse is a Registered Nurse (RN) who is regulated by the Nursing and Midwifery Council (NMC), under Part (1) of the NMC Register. For the purposes of this paper, Phase 5 will include nurses who work in H&SC Trusts in hospitals (including acute admission wards, secure units, psychiatric intensive care units, psychiatry of old age, continuing care recovery and rehabilitation) and community services.

The Mental Health Nurse is uniquely placed to provide an integrated experience of care with and across a range of inpatient setting. Crucially this involves providing person and family centred care. Mental health Nurses remain the corner stone in the formulation of need, in managing risk and in delivering 24 hour therapeutic care including the delivery of a wide range of talking therapies and recovery based interventions. The Chief Nursing Officer for Northern Ireland has commissioned a review of Mental Health nursing with a view to enhancing and maximising the role Mental Health Nurse can play in delivering better outcomes. The output of this review will shape the future curriculum, the practice model and support the development of a career framework for Mental Health nursing across a range of settings.

The specific requirements of a workforce framework should consider the unique role and function of the Mental Health Nurse, where care of a psychological nature is as important as physical care. There is also a requirement to have an appropriate professional blend of senior nursing staff (Band 6/7) within Mental Health teams, to provide safe and effective skill mix and leadership and provide evidence based therapeutic interventions and care at all times.

The significance of the profile of the Mental Health Nurse

Nurses are a unique group of professionals within health care, not least because they constitute the largest group of staff in the HSC system. They are central to the provision of quality care and are highly valued by the public in NI, a view expressed in the *Patient and Client Council Report (2010).*[13]

Mental Health Nurses gain an in-depth knowledge of the clinical perspective of disease. This knowledge is gained through a 3-year graduate programme leading to NMC registration as a Registered Nurse Part 1 (Mental Health). The course equips the graduate nurse with the knowledge, skills and attitude to deliver high quality, complex Mental Health nursing. The modules cover the theory and evidence for person-centred nursing, providing a holistic assessment of health needs, including therapeutic relationships, bio-psycho-social assessment and risk assessment.

There are also modules in leadership and management, professional values and practice learning opportunities, in a range of Mental Health settings, with 50% practice learning and 50% theory. The NMC has recently published new education and proficiency standards[14] for undergraduate and registered nurses respectively. The NMC as the professional regulator exists to protect the public. The education framework contains the standards and requirements that together signify what effective professional education and training looks like. Similarly, the standards of proficiency reflect the anticipated future needs of the public for expert nursing care and provides guidance on what the newly registered nurse should know and be able to do at the point of registration in order to practise safely and effectively.

This range of learning experience gives Mental Health Nurses an all-round suite of skills in assisting patients in the Recovery process. They are adept at building psycho-social support systems*. (Foundation of Nursing Studies, Playing our Part, 2017)*[15]

Within a multi-disciplinary team, nurses are the professional group which spend the most time with patients. They form a therapeutic relationship with patients which creates a dynamic which cannot be under-estimated. Psycho-social and interpersonal skills used by Mental Health nurses are critical and central to delivery of care. Mental Health Nurses are able to provide high quality behavioural or psycho-dynamic interventions *(Devane, 1998)*[16] through the use of the therapeutic relationship. They also have a critical role in medicines management, administration and patient education and self-management.

[13] Patient and Client Council (2010) The People's Priorities, A View from Patients, Service Users, Carers and Communities on Future Priorities for Health and Social Care in Northern Ireland

[14] Nursing & Midwifery Council (2017) Education Framework: Standards for Education and Training, NMC

[14] Nursing & Midwifery Council (2017) Standards of Proficiency for Registered Nurses, NMC

[15] Foundation of Nursing Studies (2017) Playing Our Part, The Work of Graduate and Registered Nurses, London

[16] Devane et al (2014) The Clinical Skills of Community Psychiatric Nurses Working with Patients Who Have Severe and Enduring Mental Health Problems: An Empirical Study. Journal of Advanced Nursing, Vol 27, No 2, pp 253-262

This therapeutic relationship also extends to include assessment, advice and support to family, carers and nominated friends in the care of the individual. These elements need to be recognised and valued as an integral part of the patient's recovery.

Evidence

Determining the appropriate skill mix and caseload size for all Mental Health nurses is a complicated process due to a range of variables that impact on health and social care needs. These include:

- Workforce;
- Environment;
- Activity (Clinical);
- Professional Regulatory Activity

These are further described as influencing factors in ***Appendix 2.***

Within Mental Health inpatient settings in NI, the current method that is used to calculate staff is the Telford method. This approach is underpinned by the clinical judgement and experience of registrants and is often used with other methods of workforce calculation in order to provide a degree of triangulation.

Within Community Mental Health Teams the capacity method that is used is a "workforce utilisation tool," the "Choice and Partnership Approach" (CAPA)[17]. This model combines collaborative and participatory practice with service users bringing together active involvement of patients, supporting the recovery ethos of care, essentially managing demand and capacity within the existing workforce. Further review of caseloads based on populations for NI will be explored in Phase 5B.

A literature review was carried out as part of the Phase 5 framework in 2017 to ascertain the evidence base for Mental Health workforce planning. The key findings are highlighted in ***Appendix 3[18].***

Methodology

The methodology for this phase of Delivering Care follows on from the previous phases. This approach is based on a range of workforce intelligence information, best available evidence, literature reviews, benchmarking, application of the core assumptions of the framework and scoping exercises with Trusts. Engagement with key stakeholders on the proposed staffing recommendations for the current workforce requirements has been done in collaboration with the expert reference group, working group and steering

[17] York, A., & Kingsbury, S., (2013) The Choice and Partnership Approach: A Service Transformation Model, Short Run Press, Exeter

[18] Public Health Agency (2017) Delivering Care: A Literature Review for Workforce Planning for Mental Health Nursing in Northern Ireland, PHA

group. The methodology is aligned to the agreed governance arrangements for the project.

Approach

The approach is based on best evidence and promotes a quadruple aim methodology (see **Figure 4)**, and includes reference to recognised workforce planning tools.
The 'Triple Aim' was developed in 2008 to guide the redesign of healthcare systems with an emphasis on population health, patient experience of care and reducing costs. In recognising that the backbone of any effective healthcare system is an engaged and productive workforce, a 4th aim was added - *Improving the experience of providing care*.

This 4th aim holds particular importance within the delivering care process. Nurses are often central to the teams of health and social care professionals charged with delivering health and service improvements. Effective workforce planning is vital, not only in ensuring the availability of sufficient numbers of skilled staff but also in providing structures and support so that each member of the nursing workforce can realise the sense of accomplishment and success that results from meaningful work.

Figure 4 The Quadruple Aim Method

The outputs of the approach for Phase 5A have been produced in consultation with a wide range of key stakeholders including planners, service providers, professional managers, senior nurses and expert reference group. Following a review of baseline data, modelling the data during the development of Phase 5A, it has been proposed that the core elements will be the development of a guide for a nursing staff to bed (range)

for staff based across the categories of care environments, in inpatient settings in Mental Health services.

The financial analysis and data collection templates, for the recommended model follow the same methods as for previous phases. Each phase has a review date to ensure the framework is refreshed regularly.

Assumptions

The following assumptions of the framework are built into the principles of the recommended staffing range for Mental Health Nurses in inpatient settings. Outcome indicators for monitoring the Mental Health Nursing workforce have also been built on the assumptions of the framework.

a) Assurance of safety, quality and experience through the following key performance indicators (to be agreed regionally)

- Organisational; absence rates, vacancy rates, staff in post, skill mix via Delivering Care monitoring returns.
- Safe and effective care, e.g. incidence of SAIs which will be agreed regionally.
- Patient experience, e.g. involvement in person-centred decision making re: care needs and decisions in relation to treatments and direct patient contact.

b) Planned and unplanned absence allowance

Planned and unplanned absence allowance (PUAA) refers to periods of absence from work which can be described as anticipated and therefore must be factored into the workforce planning process. This includes annual leave, sickness and mandatory study leave. The allowance agreed for NI is set out in **Table 1**. It should be noted that the agreement throughout the phases of the policy for Delivering Care does not include a specific mandatory allowance for maternity leave.

Table 1: Percentage uplift for planned and unplanned absence

Annual leave	Sick leave	Study leave Mandatory	Total allowance NI
15%	5%	4%	24%

c) Skill mix

The skill mix refers to the ratio of registered to non-registered nursing staff working within Mental Health teams across inpatient and community settings. The level of skill mix may vary across both these settings. A level of skill mix has been recommended for the funded establishment of each category of care environment, based on best evidence and the use of recognised workforce planning tools. In addition, the skill mix should take into consideration the allocation of the 100% ward sister/charge nurse/nurse team leader role across all Mental Health settings. There is also a requirement to ensure that senior nursing posts make up part of the registered nurse skill mix requirement, in mental health care environments. These posts will ensure the delivery of nurse led, psychological therapeutic interventions and drive forward evidence based practices.

Following a review of evidence and current baselines and benchmarks, the proposed skill mix for inpatient units will range from 70:30 - 80:20.

d) Management of recruitment

Whilst there are recognised challenges around nurse recruitment in NI it will be essential that all Nursing vacancies across Mental Health services are filled within a prompt timescale by registered and unregistered nursing staff respectfully to ensure that Nurse staffing levels support safe and effective person-centred care as set out in the framework recommendations.

Employers must ensure that a risk-based approach is adopted to managing recruitment, taking into consideration the maintenance of safe nurse staffing levels against the recommended range within the framework. Every effort should be made to avoid the overuse of temporary, bank and agency staff. This is a regional priority across Northern Ireland.

Matching skill mix to band mix to patient acuity and dependency within recognised professional standards and guidelines will be a fundamental requirement to ensure that professional judgement is incorporated to reviewing required staffing levels.

The availability of senior nursing posts across inpatient units as part of the workforce requirements should support the proposed staffing model.

Benchmarking of Inpatient Nurse to Bed Ratios across the UK

In NHS England, the preferred model for inpatient workforce tools is based on the time spent on activity matched with the acuity of patients and recommends a set of best practice workforce guidelines for Mental Health nurses regarding staffing. It should be noted that the Grade Mix in England incorporates Band 2 and 4 and there is a slightly higher percentage of Band 6 posts that may, in some cases, sit outside some of the current establishments of inpatient units, which may cover Nurse Therapist posts and

other services i.e. Day Hospitals within some units. The skill mix varies across the inpatient environments reviewed from 58/42 to 70/30, in other countries in the UK. Band 7 posts exist as "supervisory" in some areas but not all. The model in England includes 22.5% uplift for planned and unplanned absences (PUAA). It should be noted that daily measurement of acuity of inpatients determines the recommended staff ratios across many Inpatient units in the UK. A review of Inpatient staffing levels was also sourced from NHS Scotland. **Table 2** below provides an example of the nurse to bed ratios (NTBR) reviewed as part of the benchmarking exercise across Mental Health inpatient environments in the UK.

***Table 2: Benchmarking examples of staffing based on nurse to bed ratios from inpatient units reviewed in NHS* Scotland and NHS England**[19][20]

Ward Description	NTBR
Category 1 Acute Admission*	**1.5 - 1.92**
Category 2 Psychiatry of Old Age	**0.83 - 1.85**
Category 3 PICU*including CAMH's	**1.79 – 3.69**
Category 4 Low Secure* *(as with Cat 1)*	**1.80 - 1.92**
Category 5 Medium Secure	**3.26 - 4.26**

**In mainland UK, PICU and some inpatient admission and assessment units will have access to other services which provide a higher level of security, such as Low Secure and Medium Secure units, and in some cases flexible high dependency beds. In Northern Ireland, there are no low secure units as defined in England and one regional Medium Secure unit based within the Belfast Trust.*

In psychiatry of old age units there is a high incidence of enhanced care in place (Special Observations) and high bank expenditure, over and above the average nurse to bed ranges funded in these environments which is reflective of the NTBR in Category 2.

[19] NHS Mental Health Staffing Framework, UK Case Studies, 2014/15 https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/.../mh-staffing-v4.pdf

[20] Ayrshire Central Hospital, Irvine, Scotland NHS 2018 (aacpt)

Staffing Model – Phase 5A Inpatient Units

In order to provide good governance, a professional lead for Mental Health is recommended and should be identified in each HSC Trust within the organisational structures, within a collective leadership framework. The professional lead in each HSC Trust should provide leadership to all nursing staff in Mental Health, ensuring they are facilitated to deliver a service of high quality and safe, person-centred care in accordance with the NMC Code. In addition, it is recommended that the availability of senior nursing staff (Band 6) is prioritised as part of the blend of registered nursing staff to ensure the delivery of evidence based care and nurse led therapeutic interventions within inpatient environments on a 24 hour basis.

Based on the application of the assumptions/influencing factors, the Benchmarking information and a peer review of staffing levels, which included Telfords in each Trust for inpatient Mental Health Services, the recommended nurse to bed staffing ranges are outlined in **Tables 3a and 3b.**

Table 3a: Phase 5A Proposed Nurse to Bed Ratio / Range for Inpatient Units

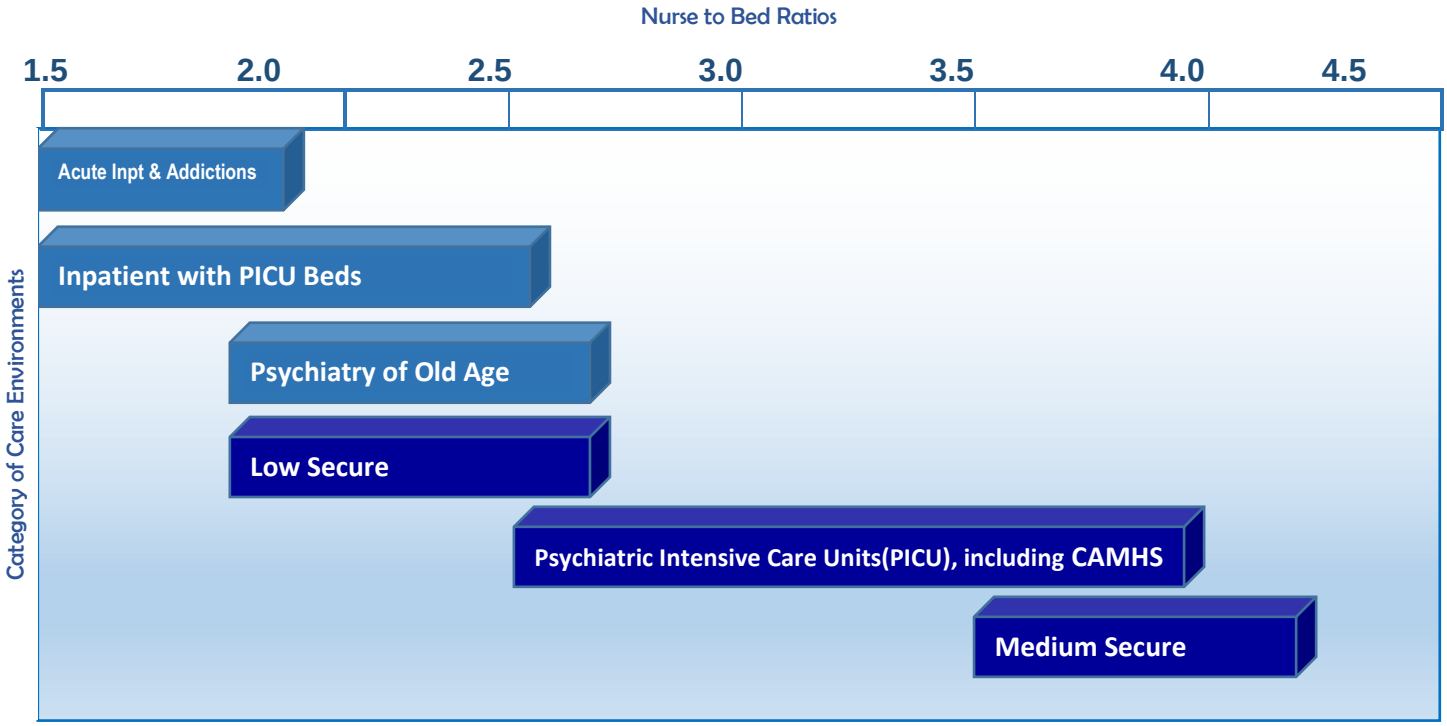


Table 3b: Category of Care Environments Phase 5A

Category of Care Environment	Inpatient facility	Proposed Nurse to Bed Ratio Range	Proposed Skill Mix
1	**Acute Assessment & Treatment Units including Addictions**	1.5 – 1.8	70/30
	For units with PICU beds and higher acuity patients	1.5 – 2.6*	Minimum 70/30
2	**Psychiatry of Old Age Dementia Assessment Units**	1.8 – 2.5**	70/30
3	**Low Secure Units**	1.8 – 2.5	80/20
4	**Psychiatric Intensive Care Units and CAMHS**	2.5 – 4.0	80/20
5	**Medium Secure Units**	3.5 – 4.2	80/20

* For inpatient assessment units who have PICU beds or on occasions have to deal with patients of higher acuity

** For units that have patients who require enhanced care and have higher acuity e.g. Dementia, functional illness/healthcare needs

Monitoring

Compliance in delivering on agreed key performance indicators requires a sufficient Nursing workforce to deliver safe and effective care. On occasions when Nurse staffing may be outside the policy range, the Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks.

The testing of new models for Mental Health Nursing service provision and reform into the future should incorporate a triangulation approach allowing for professional judgement.

As with the Delivering Care approach, the final staffing ranges for Mental Health Nursing in Trusts will be agreed with reference to the recommended ranges set out in Phase 5A, following a discussion with the Trust Workforce Lead, the Trust Mental Health Nursing Lead and the Chair of the Working Group/ Steering Group. This may require a phased approach to implementation.

Review

This Phase will be reviewed in 2020/21.

Appendix 1

Case Studies for each Care Environment

Care Environment Category 1 Acute Admission

Harry's story is typical of an admission to an acute admission/assessment ward. Harry is 58 years old and has a diagnosis of Bi-Polar Disorder. His mood can fluctuate very quickly from a hypomanic state to a depressive state and is known as rapid cycling.

On admission Harry is usually elated, presenting as over active and over talkative, removing his clothes inappropriately and singing offensive songs. He would have increased thirst and would drink copious amounts of fluids, increasing his risk of hyponatraemia. At times he would also be doubly incontinent and would be aggressive both physically and verbally.

Nursing interventions would include protecting Harry's dignity and reducing his risk of aggression. This requires him to be nursed on 1:1 observations in a single room to reduce stimulation and ensuring Harry has a male member of staff with him at all times. If Harry is so over active that he could present as a danger to himself or others, detention under the Mental Health Order may be necessary. It is the nurse's responsibility to ensure that the detention process is completed in detail. Nurses will also provide care through monitoring Harry's physical well-being. He may need to have fluid intake monitored due to his excessive drinking and be encouraged to take his medication and have a referral to the dietician.

When Harry is aggressive he may require de-escalation and physical restraint. This will be carried out by nursing staff. This may require up to 6 staff at any one time.

At all times Harry's family will be kept informed of his care.

Care Environment Category 1 Addictions

Stephanie is a typical example of a patient admitted to an addiction unit as part of a treatment plan for detoxification and stabilisation.

Stephanie is a 28 year old with a history of substance misuse. She has been engaging with the community addictions service and has agreed with them that admission is appropriate. This is a planned admission.

Stephanie is inducted into the ward and detoxification is started. This will be undertaken by qualified nursing staff and the patient will remain under observation throughout the process. She will have daily medications administered and will collaborate with nursing staff to develop her nursing care plan, which will be reviewed weekly.

On admission Stephanie has various blood tests completed such as blood borne virus screening and a Hepatitis B vaccination will be administered by a nurse. Stephanie will also be encouraged to attend a group psycho-educational recovery focused programme on a daily basis. All physical health monitoring will be completed by a nurse and Stephanie's family and support network will be engaged in her treatment plan to promote successful after-care post discharge.

Discharge planning will commence on admission and a plan will be developed with the patient and nurse. On discharge Stephanie will be offered a 7-day follow-up appointment with the community team.

Care Environment Category 2 Psychiatry of Old Age (Functional Illness)

William's story is a typical example of an admission to a bed for patients who are over 65 and who have a functional illness. William is 91 and has had a 3-month history of increasingly out-of-character erratic behaviour. This includes disinhibition and inappropriate conversation and overspending. His daughter moved home from abroad in order to support him, but despite this his behaviour continued to deteriorate, requiring admission.

On admission he was agitated shouting loudly, describing panic attacks and behaving erratically. He was given a diagnosis of Bi-Polar Disorder. Nursing care provided was to preserve William's dignity, ensure his safety, ensure adequate food and fluid intake, reduce the frequency of disinhibited behaviour and any aggression, monitor medication and provide a low stimulus environment to help manage his symptoms. The therapeutic alliance with the nursing staff will be paramount in managing this gentleman's behaviour.

Care Environment Category 2 Psychiatry of Old Age Dementia Assessment

Roy's story is typical of an admission to a psychiatry of old age ward. He is 74 years old and has had a diagnosis of Alzheimer's disease since 2013. He was living at home with his wife prior to admission and required assistance with all activities of daily living.

He was admitted as a detained patient, due to a decline in his mental state over the preceding 8 weeks. He presented with increasing levels of agitation, particularly in the evening. There was increasing confusion regarding his surroundings and he had made several attempts to leave home in search of his childhood home. Medication compliance had declined and his sleep pattern had become disturbed. He also made many attempts to leave home to go to work. Roy would become distressed when his wife would not let him leave whereby he would hit out.

On admission following physical examination, blood tests and urine testing there were no abnormalities detected.

Nursing care would be required to stabilise Roy's condition, ensure his safety, review his medication, reduce his level of agitation and regulate his sleep. On occasions following appropriate risk assessment, Roy required enhanced care and one to one nurse supervision for long periods of time.

Care Environment Category 3 PICU

Barry is a typical example of a patient who requires to be admitted to a PICU.

Barry had been an inpatient in an acute admission ward for 6 weeks. His behaviour had been aggressive periodically for three days and he had been restrained on 4 occasions. His medication was reviewed and changed and he had been placed on continuous observation during the period of his disturbed behaviour.

Due to the rapid deterioration in his mood and behaviour, a multi-disciplinary meeting was convened and it was decided that for his own safety and the safety of others he met the threshold for admission to PICU. Nursing staff will co-ordinate this transfer making it as seamless as possible, providing information to the PICU staff about previous incidents and then completing the transfer to the new ward.

Once safely transferred Barry will have a higher ratio of staff to monitor and manage his behaviour with enhanced care and one to one supervision when required. If he requires restraint there are less staff and patients around thus preserving his dignity. There is also the option of seclusion or 'time out' where Barry can be more closely monitored in a room by himself, which provides less stimulus to help him reduce his anxiety and agitation.

PICU staff will meet regularly to discuss Barry's progress, with a view to moving him back to an admission ward within 6-8 weeks.

Care Environment Category 3 CAMHS

Sarah's story is an example of an admission to the regional CAMHS unit. She presented with low mood, self-harm and suicidal thoughts to her GP and has also taken overdoses in the past. Sarah has a belief that she has been told that she is beyond help. It was an overdose of medication that prompted her current admission.

Since admission Sarah has absconded from the ward and has made attempts to cut herself, placed ligatures around her neck, has continuously displayed risk taking behaviours and been physically aggressive to others and property.

She has had a history of low mood since primary school and poor concentration resulting in poor motivation engaging in therapeutic activities. There is a history of abuse of the female children in her family by their biological father. His subsequent conviction has had a profound impact on the family. Father subsequently committed suicide, which has resulted in Sarah experiencing feelings of guilt and responsibility.

Sarah has feelings of low self- esteem, high levels of anger and has experienced panic attacks. She experiences derealisation and displays a lack of concern regarding the impact of her risk taking behaviour. She also has reported feeling unsupported by her mother and describes having to be very independent. However, her mother is currently struggling to manage the demands of a large family. Sarah's mother also has hearing difficulties, making communication more challenging. It has been reported that her mother and her new partner are abusing substances and gambling causing financial worries.

Sarah's inpatient stay will be aimed at helping her understand her feelings and risk behaviours. It will provide a consistent and supportive environment where she can use therapeutic interventions to help her modify her behaviour and raise self-esteem and build emotional resilience.

Care Environment Category 4 Low Secure

John's story is typical of an admission into a low secure unit. He is 33 years old, detained under the Mental Health order, is deemed capable of managing his own affairs and has a diagnosis of schizophrenia. He has been in the low secure unit for 10 months.

He experiences paranoid thoughts and would resort to violence and aggression in response to his thoughts and what he believes to be true. He has made many attempts to leave the ward.

Historically, his mental state has deteriorated when he has been discharged into the community and he frequently would fail to attend outpatient appointments. At times there has had to be police involvement to manage his aggression in the community and in the past he has assaulted a member of staff in a hostel.

A few months previously, he was referred to the medium secure unit, but he was assessed as not requiring that level of security.

In the past 8 weeks his medication has been reviewed and changed and there have been no further physical assaults on staff, just a few verbal altercations.

Nursing care would be required to manage risk and ensure John's safety and the safety of others, review his medication and to engage him therapeutically in order to reduce his agitation and aggression. There would also be ongoing therapeutic input to hopefully prepare him for a return to the community, engaging with the community Mental Health team.

Care Environment Category 5 Medium Secure

Tim's story is an example of an admission to the regional medium secure unit. Tim is a 50 year old man, who is single and unemployed. He has been known to psychiatric services since 1977, when he was given a diagnosis of adjustment disorder. He was then diagnosed in 1994 with paranoid psychosis. Tim's first admission to hospital was in 2007 after being assessed in police custody following an alleged assault on a member of the public.

Tim has a forensic history of 39 convictions between 1975 and 1990. These were for 3 counts of riotous/disorderly behaviour, 6 counts of deception, 20 convictions for road traffic offences and other offences such as carrying weapons and a breach of the peace. He has served as a remand prisoner for an alleged sexual assault.

Tim is currently under police investigation facing a charge of actual or grievous bodily harm.

Tim's admission will provide him with treatment and care for his condition. He will be assessed and treated appropriately to his mental state. The admission also provides him and the general public with a degree of safety given his forensic history. He will be managed with a view to stabilising his mental state and to assisting him to be rehabilitated back into the community, when appropriate.

APPENDIX 2

INFLUENCING FACTORS FOR PHASE 5 MENTAL HEALTH NURSING

WORKFORCE

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	• Rosters are structured process matching staff skills to workload variations. • Shifts plus sequence of contracted working days per staff member = available numbers of staff to manage workload demand.	• Optimal rostering of staff **=** effective management manpower to deliver on workload demand. • Imbalance in the numbers available to meet demand can increase risk to patient safety. • Appropriate shift pattern key factor in delivering safe effective care and maintaining staff morale.
Planned and Unplanned Absence Allowance (PUAA)	• Periods of absence from work - expected or unexpected - factored into workforce planning. • (A) Sickness both short and long term, (long term = 20 days or over/up to six months). • (B) Study leave (as a minimum for mandatory training). • (C) Non-clinical working, e.g. management time.	• PUAA acknowledges staff have particular requirements and rights that render them unavailable to be rostered. • Allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.
Department Sister's/ Charge Nurse's /team leader time	• Agreed allocation of 100% of ward manager's (WM) time to fulfil their leadership responsibilities. • Supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures. • Be a role model for good professional practice and behaviours; oversee the environment and assume high visibility as nurse leader.	• Absence of an agreed allowance of time for ward managers can result in essential responsibilities being neglected and failure to provide leadership at department level. • Currently WM's co-ordinate a significant staffing complement with associated appraisal, supervision, regulatory, HR responsibilities and budgetary management including salaries and wages and goods and services.

Skill mix	• Percentage ratio of registered to unregistered nursing staff working within an individual care setting. • Blend of multidisciplinary registered staff including Nurse Therapists that support the Mental Health workforce. • Clinical Leadership should be reflected in the skill mix of the nursing workforce	• Inappropriate skill mix can result in a mismatch of duties and responsibilities to roles, including clinical leadership/senior cover. • Can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources. • Appropriate delegation of care to unregistered staff promotes good professional Governance. • Determination of % of nurses required to constitute a Community Mental Health Team.
Management of Recruitment	• HR policies and procedures take weeks to recruit staff. • Notwithstanding this process, it is essential that nursing vacancies are filled promptly (to ensure staffing levels for safe and effective, person-centred care). • Employers must ensure that a risk-assessed approach is adopted to manage recruitment.	• Vacancy rates should continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills. • Recruitment and retention strategies need to be put in place to support and sustain the nursing workforce. • Absence rates should be monitored and managed accordingly at HSC Trust level. • Maintenance of staffing levels (which support delivery of safe and effective person-centred care) should be reported on at HSC Trust level. • Avoidance of overuse of temporary staff, eg bank and agency staff. • Matching of staff skill and experience and band mix to patient acuity and dependency within approved guidelines. • Timely and ongoing review of risk assessments linked to service reconfigurations.

		• Annual review of uptake of MH students. • Lack of forward planning will result in inadequate succession plans for post registration MH nursing.
Management of absenteeism/ sickness	• The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable (5% target).	• Effective approaches to the management of periods of staff absence support the continuity of services, provision of safe and effective person-centred care, patient safety and good staff morale.
Competence skill set to work flexibly	• The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of patient needs.	• The absence of a core set of transferable skills can limit the capacity of Mental Health nursing staff to meet a broad range of patient needs in a given care environment. • To ensure that the essential clinical professional nursing skills are developed within a Mental Health team demands careful identification of learning needs and development opportunities and identified roles for all staff including senior nurses, nurse therapists and unregistered nursing staff.

ACTIVITY

Term Used	What does this mean?	Impact?
Planned ward Attendances	• Persons who attend a clinical setting for a planned visit to seek advice, review or treatment.	• Planned attendances must be captured as a workload indicator at all times. • Incremental growth in these attendances can place increasing demands on nursing teams, without appropriate increases in staffing levels. • Could potentially become an unfunded service development if not appropriately managed.
% Bed occupancy	• A measurement of the percentage of time that beds are occupied measured at midnight. • Day attenders are excluded from this number. • Unplanned review attendances and planned review attendances.	• Capturing bed occupancy at 12 midnight can only result in substantial activity and workload being omitted. • Collection at other times of the day can assist with this measure. • The 24-hour, 7-day service needs to be factored into workforce requirements across Mental Health care environments where appropriate.
Patient Dependency/ Acuity	• An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	• Appropriate workload measurement tools can inform the utilisation of appropriate staffing levels for departments and localities, thus supporting safe and effective direct and indirect care.
Demand, need and throughput	• Length of stay; • Caseload analysis; • Trends in increase in mental illness requiring assessment 24/7. • Referral rates	• Trend in H&SC services towards reducing the time spent in Inpatient units. • Increase in demand on services requires a capacity modelling tool (eg. CAPA). • Increased complex discharge processes, (ongoing treatment and care in community setting). • Increase in the throughput of patients and results in an increase in the workload demands for staff.

Specialties/ Case Mix	• Range and variation of patients' health conditions managed in a particular clinical setting/care environment, including the demand for psychological therapies.	• A broader range of specialties and case mix being managed in a care setting presents a greater demand on the Mental Health nursing team in terms of knowledge, skills and complexity.
Number of spaces for diagnosis and treatment	• There are a number of appropriate treatment areas within Inpatient units that can be used for assessment and management of patients' conditions.	• The number of spaces for diagnosis and treatment and design of a care environment can have an impact on the efficiency of the department, e.g. ECT suites and group therapeutic interventions.
Assessment of Risk	• Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care. This includes risk to people in their care, members of staff and other members of the public.	• By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. • Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. • Time is required from the nursing team for this activity to carry out ongoing risk assessments for patients within their care environments.
Incremental Service Improvements/ Development and Reform	• This is activity concerned with testing new ideas and ways of working, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users.	• Incremental service improvements are designed to implement improvements in patient care and/or outcomes. • Can result in improved working conditions for staff. • Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale if not supported with appropriate workforce requirements. • Staff requirements should be factored into elements of reform agendas where appropriate.

ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	• Support provided within a clinical area by Information Technology and other mechanised systems eg ECR. • Sufficient equipment maintained and stored appropriately (which may assist nursing teams in caring for patients).	• Access to available software which links to a range of data systems (can enable efficient transfer of information which assists at many stages of the patient care pathway). • Efficient systems may reduce workload requirement. • Inefficient systems may add to the workload, eg staff spending time sourcing equipment.
Geographical Layout/ Room Structure	• Arrangement and layout of the physical clinical environment, including use of single rooms. • Impact of physical arrangement of clinical setting on workforce planning (may require more staff where there are areas of poor visibility or require staff to work in discrete teams).	• A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements. • Where single rooms restrict visibility and therefore compromise clinical observations, this will have an impact on staffing levels in care environments.
Population profile for MH services	• Demographic profile for the population of NI and the significance of incidence of mental illness. • Includes relationship to deprivation/ incidence of Mental Health risk factors.	• The demographic profile of any geographical area may determine the service profile and priorities for nurse staffing models required to meet the demand on Mental Health services, also population workforce profiles and community and voluntary sector support will need to reflect this.
Number of beds	• Number and type of beds will determine the range or ratio for staff in each care environment across Mental Health inpatient facilities.	• Additional beds to meet demands and acuity of patients may impact on the capacity of staff to provide person-centred care.

Departmental Adjacencies Escorting Patients	• Where there may be a number of patients requiring nurse escort, workforce planning impact needs to be considered re staffing levels to support safe, effective person-centred care.	• Nursing staff may be required to escort or transfer patients to other units thus removing the member of staff from the core team.
Supportive Staff Infrastructure	• The support provided within a care environment by other members of staff, who are not registrants or within the family of nursing, eg 'patient trackers', administration or housekeeping staff.	• There are a range of tasks which can be completed by individuals who are not identified as working specifically within the family of nursing, e.g. administrative staff, housekeeping staff. • The support provided by these staff members has an impact on the Mental Health nursing team to be able to deliver the care required. • Conversely, the absence of such members of staff should be highlighted where there is an indication that this support would be helpful to the nursing team to facilitate effective care delivery. • Additional nurse therapists and nurse specialists facilitate the delivery of patient centred care and can provide enhanced therapeutic interventions in a range of care environments. • These posts are **in addition** to the core requirements for inpatient workforce requirements but have a significant supportive role in Mental Health service provision.

PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	• Activity linked with nursing care delivery but not a direct element of the process of care delivery, e.g. multi-professional case meetings, referrals to other agencies/services, resetting/restocking environments following use.	• Level of this activity and requirements for delivery of such can impact on the workload of nursing teams. • This requires definition as to what elements are present within the nursing workload and how much time is expended on them for their specific role.
Revalidation	• NMC introduced revalidation for Nurses and Midwives in October 2015. All nurses are required to revalidate to maintain their registration. • The allowance in the planned and unplanned allowance incorporates training.	• Nurses will have to be supported to revalidate every three years to demonstrate that they practice in accordance with the NMC code in their nursing role.
Compliance with professional regulatory standards	• Activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a care environment, eg revalidation or learning and assessment and practice/mentorship. This may include ongoing monitoring of these standards.	• High activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards. This is of particular importance with the introduction of revalidation.
Supervision	• Process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service user protection, quality and safety.	• An element of the time required to develop nurses and those within the family of nursing, including the time requirement for supervision processes, is included in the Planned and Unplanned Absence Allowance of 24% as endorsed in the Delivering Care policy framework (2014).

Accountability and governance requirements	• The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services.
	• Governance has been defined as 'systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations (DoH Integrated Governance Handbook 2006). Accountability embodies key attributes:
	  • Recognisably high standards of care;
	  • Transparent responsibility and accountability for those standards;
	  • A constant dynamic of improvement.
		• In order to provide safe, effective, person-centred care, appropriate staffing levels are required to impact positively upon the profession's ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators agreed regionally.
		• This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review, user engagement and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of nursing practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires time for the Mental Health nurse to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care in all settings

APPENDIX 3

Key Themes Highlighted in PHA Literature Review Mental Health Workforce Planning (2017)

- *"Mental Health Services require a higher proportion of interventions"*
- *"Interventions are often reactive and unplanned"*
- *"A higher proportion of service users are ambulatory rather than bed-based"*
- *"Length of stay in hospital tends to be longer for Mental Health patients"*
- *"Higher percentage of service users are detained rather than there by choice"*
- *"Around 50% of service users require a higher degree of security."*

The **key themes** that emerged from the literature review were as follows:

- The increase in incidence of Mental Health problems across Northern Ireland;
- The need for services to react accordingly;
- The significance of the role of the Mental Health nursing workforce and the requirement to meet the demands appropriately;
- The strength of the nursing role within this context, with nurses forming the largest group of staff within the NHS and with respect to the unique role and function of the Mental Health nurse;
- The requirement to shift from a paternalistic approach to a more inclusive approach to health care in order to support people to take control of their own lives (Making Life Better, 2012-2023);
- The challenge of supporting more people in the community;
- Significant challenges for sustaining and managing the numbers of nurses who will leave the service in the next 5 years due to Mental Health Officer status.

In addition, the Royal College of Psychiatrists (RCPsych), in an occasional paper OP 79, [21]created 10 standards for good practice on an acute Mental Health ward (refer to footnote below). Within a hospital ward, a professional blend of nursing staff provides care for a set number of patients. One of the recommendations was that the optimum number of beds would be 18. In 2006 the Royal College of Nursing in its policy document 15/2006 specified that the ratio of registered to non-registered nursing staff should not fall below 65:35 in general wards in mainland UK. It is accepted by the Royal College of Nursing that the ratio in acute Mental Health wards in Northern Ireland should be 70:30.[22]

[21] Royal College of Psychiatrists, OP79 Do The Right Thing: How to Just a Good Ward (June 2011) www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op79.aspx

[22] RCN Policy Unit, Policy Guidance (15/2006) Setting Appropriate Ward Nurse Staffing Levels in NHS Acute Trust. Royal College of Nursing.

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NHS Mental Health Staffing Framework
*https://www.*england.*nhs.uk/6cs/wp-content/uploads/sites/25/.../mh-staffing-v4.pdf*

Department of Health Mental Health Nursing Review (2018), Nursing and Midwifery Task Group.