

Psychiatry Questionnaire Results

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Results

Psychiatry Questionnaire

A total of 17 questionnaires were issued to Trusts / Organisations for Psychiatry. The response rate was 100%.

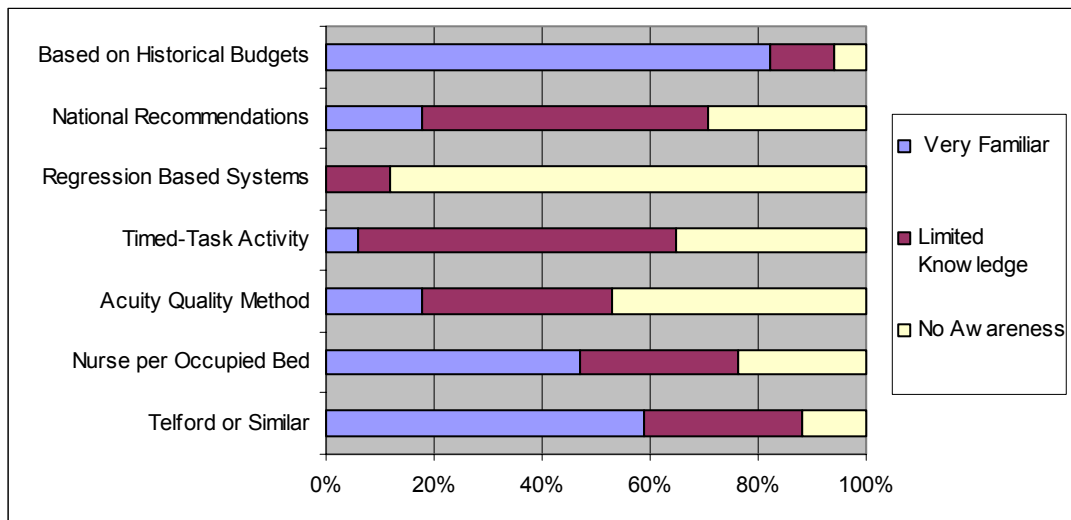
Nursing Workforce Planning Tools (Q1 - Q6.13, Q8 & Q9)

Q1

The tools which respondents were most familiar with were Based on Historical Budgets and Telford or Similar. 15/17 respondents had no awareness of Regression Based Systems.

1. Which of the following Nursing Workforce Planning Systems are you familiar with?

Nursing Workforce Planning System	Very Familiar	Limited Knowledge	No Awareness	Total
Telford or Similar	10	5	2	17
Nurse per Occupied Bed	8	5	4	17
Acuity Quality Method	3	6	8	17
Timed-Task Activity	1	10	6	17
Regression Based Systems	0	2	15	17
National Recommendations	3	9	5	17
Based on Historical Budgets	14	2	1	17

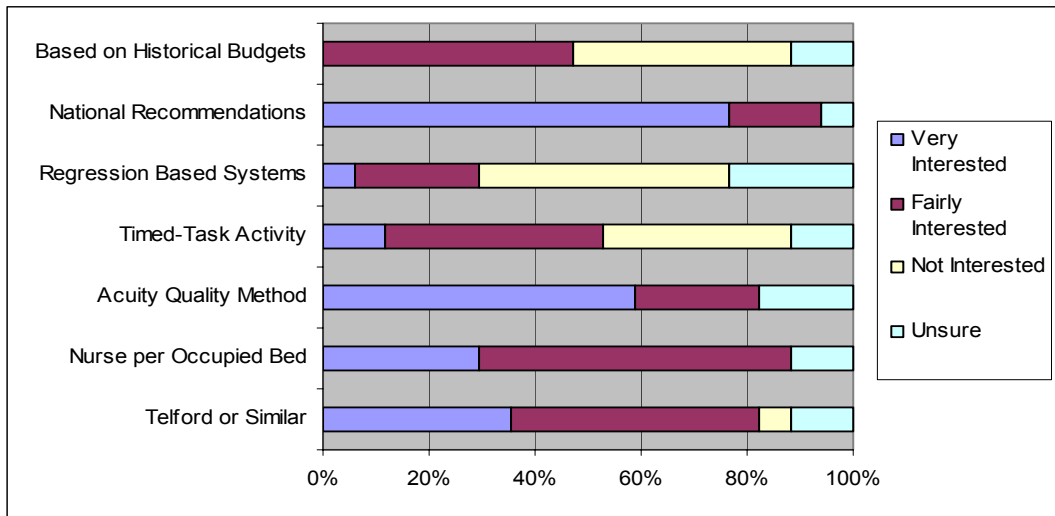


Q2

The tools respondents were most interested in using were National Recommendations and Acuity Quality Method. 8/17 respondents were not interested in using Regression Based Systems and 7/17 were not interested in using Based on Historical Budgets.

2. Which of the following Nursing Workforce Planning Systems would you be interested in using?

Nursing Workforce Planning System	Very Interested	Fairly Interested	Not Interested	Unsure	Total
Telford or Similar	6	8	1	2	17
Nurse per Occupied Bed	5	10	0	2	17
Acuity Quality Method	10	4	0	3	17
Timed-Task Activity	2	7	6	2	17
Regression Based Systems	1	4	8	4	17
National Recommendations	13	3	0	1	17
Based on Historical Budgets	0	8	7	2	17



Q3

The Nursing Workforce Planning Tools which are known to be effective in a particular specialty included:

3. Are you aware of any Nursing Workforce Planning Systems which are known to be effective in a particular specialty?

Nursing Workforce Planning System	Specialty	Number of Responses
Psychiatric Monitor	Mental Health (1) Acute Psychiatry, Continuing Care and Rehabilitation (1)	2
Telford	Acute Psychiatry and Continuing Care	1
SHRUGS	Learning Disability	1
Nurse per Occupied Bed	Older People	1
Acuity Quality	High physical dependency areas	1
Birmingham System	Elderly Care Mental Health	1
National Group (who were unable to arrive at any formula due to differing environment, location etc)	Mental Health	1
Total		8

There was no clearly identifiable Nursing Workforce Planning System which was known to be effective in a particular speciality.

Q4

In terms of the specialty areas present within the organisations, the information returned was as detailed below. Examples of the other specialties listed are: Drug and Alcohol Services, Forensic Psychiatry, Eating Disorders, Assertive Outreach, Cognitive Behaviour Therapy and Brain Injuries.

4. Nursing Workforce Planning Systems Within Your Trust/Organisation
Please identify the Nursing Workforce Planning System used for each speciality within your Trust/Organisation by entering YES or, where appropriate, the name of the tool used.

Specialty	Number of Trusts with Specialty Present	Nursing Workforce Planning System							
		Telford	Nurse per Occupied Bed	Acuity Quality	Timed Task	Regression Based Systems	National Recs	Based on Historical Budgets	Other
Adult Acute Admission	16	6	3	0	0	0	0	11	5
Elderly Acute Admission	15	6	4	0	0	0	1	9	4
Adult Continuing Care	14	5	3	0	0	0	0	9	4
Elderly Continuing Care	14	6	3	1	0	0	1	8	4
Rehabilitation	14	2	2	0	0	0	0	10	5
Intensive Psychiatric Care	12	5	3	0	0	0	0	8	3
Day Hospitals	13	2	0	0	0	0	0	10	4
Learning Disabilities - In patients	12	2	2	0	0	0	0	9	4
Learning Disabilities - Community Based Nurses	11	2	0	0	0	0	0	11	1
Community Psychiatric Nurses	16	2	0	1	0	0	1	13	2
Community Outpatients	6	1	0	1	0	0	0	5	1
Child and Family Mental Health - In patients	5	1	1	0	0	0	0	4	1
Child and Family Mental Health - Out patients	13	2	0	0	0	0	0	11	2
Others	10	3	2	1	0	0	0	9	2

Within all the clinical specialties listed and under the other category, the most commonly used Nursing Workforce Planning System was Based on Historical Budgets with Telford the second ranking system in Adult Acute Admissions, Elderly Acute Admissions, Adult Continuing Care, Elderly Continuing Care and Intensive Psychiatric Care, Learning Disabilities Community Based Nurses and Others.

Under the headings listed, the main tools reported were:

Type of Tool	Main Examples Given
Telford or Similar	Telford Birmingham
Acuity Quality	Pilot of Acuity Quality Model Dependency Levels
National Recommendations	Audit Commission Royal College of Psychiatrists Psychiatric Nursing Association
Others	Grampian Model* Clinical Need Assessment Benchmarking with other Trusts In-house activity mapping exercise Regular review by Charge Nurses and Managers Varied via Mental Health reprovisioning Base on service redesign and mapping revised model of care Locally developed approach

* Grampian Model reported by another Trust

The table below shows the spread of tools used per organisation with the exclusion of Based on Historical Budgets. 5 Trusts / Organisations reported using no tools, with the others using a range of 0-3 per specialty.

4. Nursing Workforce Planning Systems Within Your Trust/Organisation
Number of answers regarding tools used per Trust

Org	Adult Acute Admission	Elderly Acute Admission	Adult Continuing Care	Elderly Continuing Care	Rehab.	Intensive Psych. Care	Day Hospitals	Learning Disabilities - In Patients	Learning Disabilities - Community Based Nurses	Community Psychiatric Nurses	Community Out Patients	Child and Family Mental Health - In Patients	Child and Family Mental Health - Out Patients	Others
1	2	2	2	1	1	2	0	0	0	0	0	0	0	0
2	1	2	1	3	0	2	0	0	0	0	0	0	0	1
3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	1	1	1	1	1	0	1	0	0	0	0	0	0	0
5	1	1	1	1	1	1	1	0	0	1	1	0	0	0
6	1	0	1	0	1	1	1	1	0	1	0	0	0	2
7	2	3	2	3	2	2	1	2	1	1	1	2	1	2
8	1	1	1	1	1	1	1	1	1	1	1	0	1	0
9	2	1	2	1	0	2	0	2	0	0	0	1	0	2
10	1	1	0	1	1	0	0	1	0	0	0	0	0	0
11	1	1	1	1	1	1	1	0	0	1	0	0	1	0
12	1	1	0	1	0	0	0	0	1	1	0	0	1	1
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	0	1	0	1	0	0	0	1	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Note: this table does not include Historical Budget.

Q5.1

In question 5 respondents were asked to describe the first most commonly used Nursing Workforce Planning System in their organisation, instruction was given that Based on Historical Budgets should not be included in this response. 12 Organisations described a Nursing Workforce Planning System and 5 gave no response. 7/12 of the respondents to this question reported using Telford or similar system.

Q5.1 Please list the most commonly used Nursing Workforce Planning System in your organisation:

First Most Commonly Used Nursing Workforce Planning System Reported	No of Trusts / Organisations
Telford	7
Grampian Model * – In Patient Units	1
Nurse per Occupied Bed	1
National Guidelines – Royal College of Psychiatrists and Community Psychiatric Association	1
Benchmarking with other Trusts	1
Activity Mapping	1
Total	12

*detailed by another Trust

In question 5.2 respondents were asked to provide details of the frequency of use of the first most commonly used Nursing Workforce Planning System. The majority of responses were in the random or other categories.

5.2 Please describe how frequently this Nursing Workforce Planning System is used:

Frequency of Use	Yes	No	Unsure	Total
Twice-Daily	0	5	0	5
Daily	1	5	0	6
Twice-Weekly	0	5	0	5
Weekly	0	5	0	5
Fortnightly	0	5	0	5
Monthly	2	4	0	6
Random	5	1	0	6
Other	4	0	0	4

Random: at development of services; responding to increased workload; at point of service review or development (2); every 2 years approx

Other: one off exercise; at time of developments; as required to review staffing / service change; annual

Q5.3

Nursing Workforce Planning Systems are used mainly to review nursing establishments in light of changes within the clinical area, to check current nursing establishments and to estimate new nursing requirements.

5.3 Please indicate how this Nursing Workforce Planning System is used?

How is this Nursing Workforce Planning System used?	Yes
To check current nursing establishments	11
To estimate required new nursing establishments	11
To review establishment in light of changes within clinical area	12
Other	3

Other includes: comparative studies; to demonstrate risk; to take account of population shifts and changes in service need

Q5.4

Nursing Workforce Planning Systems are used mainly by Senior Managers, Charge Nurses and Directors of Nursing. They are however used less by Human Resources staff and Workforce Planners.

5.4 Who is involved in using this Nursing Workforce Planning System?

Staff Group	Yes
Clinical Staff	7
Charge Nurse	11
Team Leaders	8
Senior Managers	12
Human Resources Staff	5
Workforce Planner	2
Director of Nursing	9
Other	4

Other includes: Business Manager & Consultant Psychiatrist; Management Accountant; Staff side, Finance Director and staff; Clinical Development Manager

Q5.5

In terms of who was accountable for this Nursing Workforce Planning System, 9 respondents indicated that the Director of Nursing was accountable and 9 also indicated that Senior Managers were accountable.

5.5 Who is accountable for this Nursing Workforce Planning System?

Staff Group	Yes
Clinical Staff	2
Charge Nurse	5
Team Leader	4
Senior Managers	9
Human Resources Staff	2
Workforce Planner	1
Director of Nursing	9
Other	3

Other includes: business manager; clinical development manager; clinical staff are accountable for the data provided but senior nurses and managers accountable for use of data

Q5.6 sought details of the time implications of using the first most commonly used Nursing Workforce Planning System but unfortunately limited data was supplied in response to this question. It was therefore not possible to report any meaningful data for this question.

Q5.7

4/12 of Trusts / Organisations reported having dedicated resources allocated to this Nursing Workforce Planning System. One organisation reported having 4 wte workforce planners; one reported having 0.8 wte Project Facilitator for 1 year; 1 reported part of Senior Nurse Role and 1 indicated Senior Managers but provided no detail on the wte.

5.7 Are there any dedicated resources allocated to the use of this Nursing Workforce Planning System?

Staff Group	Yes	WTE
Clinical staff	0	0
Charge nurse	0	0
Team leader	0	0
Senior managers	1	0
Human Resources staff	0	0
Workforce planner	1	4
Director of Nursing	0	0
Other	2	0.8 WTE for 1 year, part 1 WTE

Other includes: Project Facilitator; Senior Nurse

Q5.8 sought details of the training in hours received to support the use of the Nursing Workforce Planning System but unfortunately limited data was supplied in response to this question. This was often because the details were not known by the respondents or the training that took place “on the job”. It was therefore not possible to report any meaningful data for this question.

Q5.9

The Nursing Workforce Planning Systems were used mainly in the clinical area or off site but within organisation.

5.9 Where is the Nursing Workforce Planning System used?

Location	Yes
In the Clinical area	10
On same site but remote from clinical area	3
Off site - within organisation	7
Off site - outwith organisation	0
Other	2

Other: Directorate Management Team Meetings; Manpower Departments

Q5.10

Planning for a clinical change and professional recommendation from within Trust / Organisation were the 2 main reasons cited for opting to use the first most commonly used Nursing Workforce Planning System.

5.10 Why did you opt to use this Nursing Workforce System?

Reason	Yes to Closest of Reason
Priority area	4
Trust / Organisational policy	2
Professional recommendation from within Trust / Organisation	7
Professional recommendation from out with Trust / Organisation	1
To make cost savings on nursing budget	1
To plan for a clinical change	7
Other	3

Other included: team development, to plan for a hospital closure and newly commissioned service; no off the shelf tool available; historical

Q5.11

The extent to which the Nursing Workforce Planning System is integrated into other service planning initiatives within the Trust / Organisation. 4/13 reported that this was not integrated with other workforce planning and 3/13 reported it is used when planning service change or development.

Response	No of Trusts
Stand alone / not integrated to workforce planning for other staff groups	4
Used when planning service change / development	3
Consultative approach involving clinicians	1
In process of developing workforce planning information across organisation	1
Model applied to mental health in-patient units and community hospitals to date	1
Benchmarking with other Trusts to inform organisational workforce planning	1
Overarching Trust Workforce Planning Committee	1
Specific project to initiate regular workforce planning for nursing in organisation	1
Total	13*

* One organisation gave information which applied to 2 categories

Q 5.12

5.12 Please answer the following questions on this Nursing Workforce Planning system by ticking the most appropriate box for each question.

Question	Yes	No	Not Known	Total
Does this nursing workforce planning system detail requirements for:				
(i) Total Nursing numbers	12	0	0	12
(ii) Qualified Nursing staff only	2	8	0	10
(iii) Qualified and unqualified Nursing staff	10	2	0	12
(iv) Numbers of staff by relevant clinical grade	6	5	0	11
Does this nursing workforce planning system take account of learner nurses?	5	7	0	12
Is this nursing workforce planning system formally recognised by your organisation?	8	3	1	12
Is this nursing workforce planning system effectively supported by available information technology?	3	9	0	12
Have the recommended staffing levels from this nursing workforce planning system been fully implemented?	5	6	1	12

All 12 of the Nursing Workforce Planning Systems detailed under the first most commonly used system were able to provide details of total nursing numbers. 10 also reported that the system could detail numbers of qualified and unqualified staff whilst 6 reported that this could provide details of staff by clinical grade. 8 of the Nursing Workforce Planning Systems were formally recognised by the relevant organisation and 5 respondents reported that the recommendations had been fully implemented. The reasons reported by 6 respondents for non implementation of the recommendations from the Nursing Workforce Planning System are summarised in the table below.

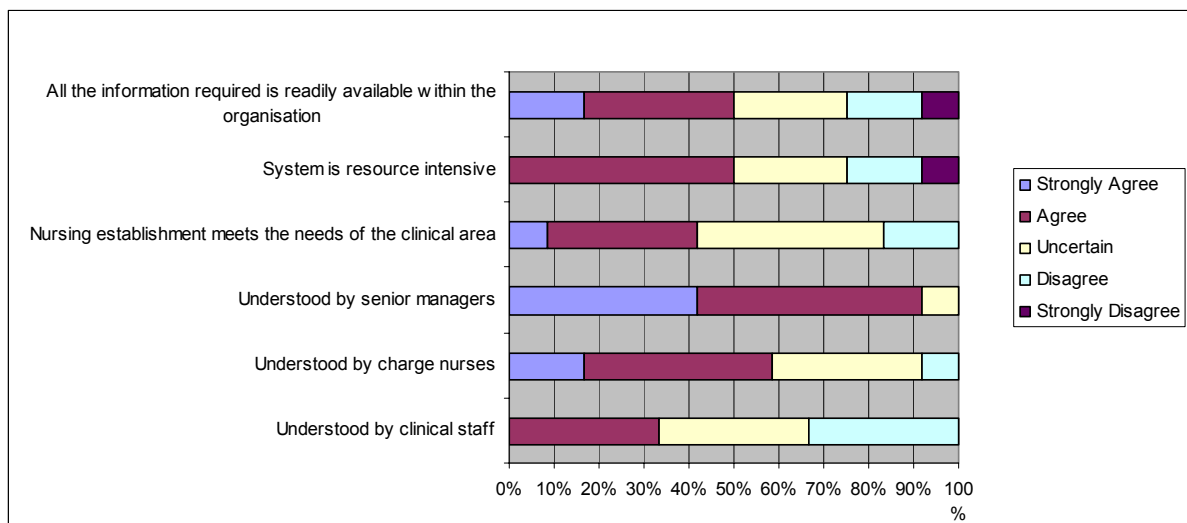
Reason for Non Implementation	Number of Trusts
Exercise was snapshot and does not reflect peaks and troughs in service	1
Implemented as opportunities arise e.g. vacancies and retrials	1
Fully implemented in some areas only – dependent on availability of resources.	1
Project is prioritising clinical areas to match current agreed staffing levels and will be used in discussions with Board regarding future funding allocations	1
Unable to implement proposed changes to post files due to “ <i>amalgamation difficulties between the 2 Trust finance departments</i> ” and need to achieve 1.5% efficiency target annually from nursing budget	1
Not fully implemented as many in-patient areas downsizing as part of modernisation process	1
Total	6

Q5.13

11/12 respondents agreed that the Nursing Workforce Planning System was understood by Senior Managers and 7/12 reported that it was understood by Charge Nurses. There was less clarity on whether the Nursing Workforce Planning System detailed an establishment which meets the needs of the clinical area, with 7/12 either reporting uncertainty or disagreement with this statement. 6 respondents agreed that the information required for the Nursing Workforce Planning System was readily available within the organisation.

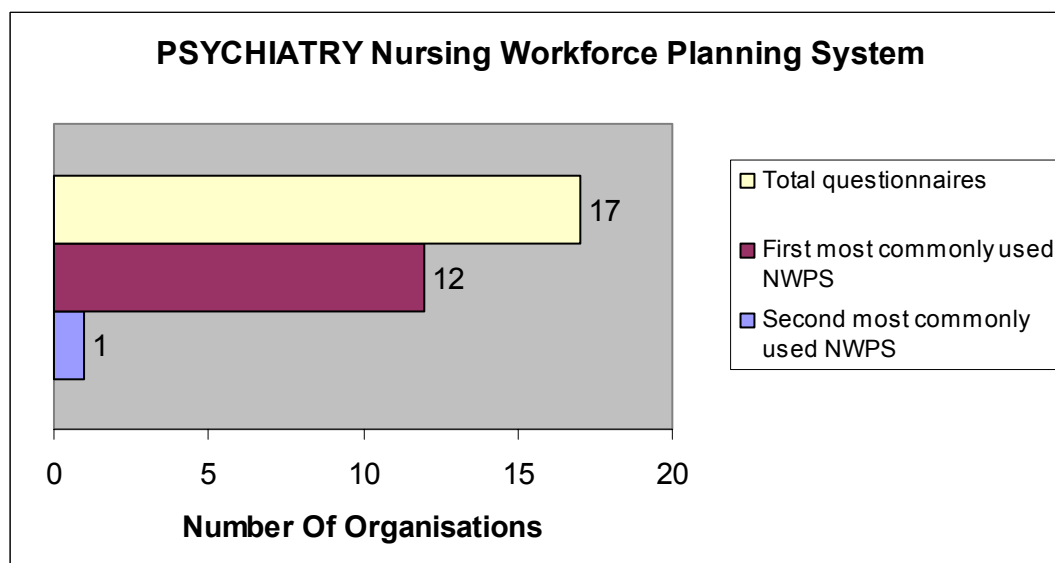
5.13 Please review each of the following statements in relation to this nursing workforce planning system.

Statement	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Total
This nursing workforce planning system is understood by clinical staff	0	4	4	4	0	12
This nursing workforce planning system is understood by charge nurses	2	5	4	1	0	12
This nursing workforce planning system is understood by senior managers	5	6	1	0	0	12
This nursing workforce planning system details a nursing establishment which meets the needs of the clinical area	1	4	5	2	0	12
This nursing workforce planning system is resource intensive	0	6	3	2	1	12
All the information required for this nursing workforce planning system is readily available within the organisation	2	4	3	2	1	12



Q6.1

In question 6 respondents were asked to describe the second most commonly used Nursing Workforce Planning System in their organisation, instruction was given that Based on Historical Budgets should not be included in this response. Only 1 Trust / Organisation reported using a second most commonly used Nursing Workforce Planning System and this was Nurse per Occupied Bed.



Q6.2

In relation to the frequency of use of the Nursing Workforce Planning System the respondent reported "other" and provided details of this as being at point of service review / development.

Q6.3

The Nursing Workforce Planning System is used to check current nursing establishments, to estimate required new nursing establishments and to review establishments in light of changes within clinical area.

6.3 Please indicate how this Nursing Workforce Planning System is used:

How is this Nursing Workforce Planning system used ?	Yes
To check current nursing establishments	1
To estimate required new nursing establishments	1
To review establishment in light of changes within clinical area	1
Other	0

Q6.4

Senior Managers, Human Resources Staff, Workforce Planners and Director of Nursing were all reported to be involved in using the second most commonly used Nursing Workforce Planning System.

6.4 Who is involved in using this Nursing Workforce Planning System?

Staff Group	Yes
Clinical Staff	0
Charge Nurse	0
Team Leader	0
Senior Managers	1
Human Resources Staff	1
Workforce Planners	1
Director Nursing	1
Other	0

Q6.5

Senior Managers, Human Resources Staff, Workforce Planners and Director of Nursing were all reported to be accountable for the second most commonly used Nursing Workforce Planning System.

6.5 Who is accountable for this Nursing Workforce Planning System?

Staff Group	Yes
Clinical Staff	0
Charge Nurse	0
Team Leader	0
Senior Managers	1
Human Resources Staff	1
Workforce Planner	1
Director of Nursing	1
Other	0

Q6.6 sought details of the time implications of using the second most commonly used Nursing Workforce Planning System but the respondent ticked not known and therefore it was not possible to report any meaningful data for this question.

Q6.7 sought details on the dedicated resources allocated to the use of the Nursing Workforce Planning System. 4 wte Workforce Planners were reported and these were also identified in Q5.7.

Q6.8 sought details of the training in hours received to support the use of the Nursing Workforce Planning System but no data was supplied in response to this question.

Q6.9

The organisation reported that their second most commonly used Nursing Workforce Planning System is used in the Manpower Department.

Q6.10

Priority area, Trust / Organisational policy, Professional Recommendation from within organisation and planning for a clinical change were the reasons cited for opting to use the second most commonly used Nursing Workforce Planning System.

6.10 Why did you opt to use this Nursing Workforce Planning System?

Reason	Yes Closest to reason
Priority area	1
Trust / Organisational policy	1
Professional Recommendation from within Trust / Organisation	1
Professional Recommendation from out with Trust / Organisation	0
To make cost savings on nursing budget	0
To plan for a clinical change	1
Other	0

Q6.11

The extent to which the Nursing Workforce Planning System is integrated into other service planning initiatives was described as being *“used in tandem with benchmarking with other Trusts for all in-patient areas.”*

Q6.12

The second mostly commonly used nursing workforce planning system was reported to provide details of total nursing numbers. In addition to this it provided requirements for qualified and unqualified nursing staff as well as numbers of staff by relevant clinical grade. The Nursing Workforce Planning System was formally recognised by the organisation and effectively supported by IT. The recommended staffing levels had not been fully implemented but no details were supplied on the reason for this.

6.12 Please answer the following questions on this Nursing Workforce Planning system by ticking the most appropriate box for each question.

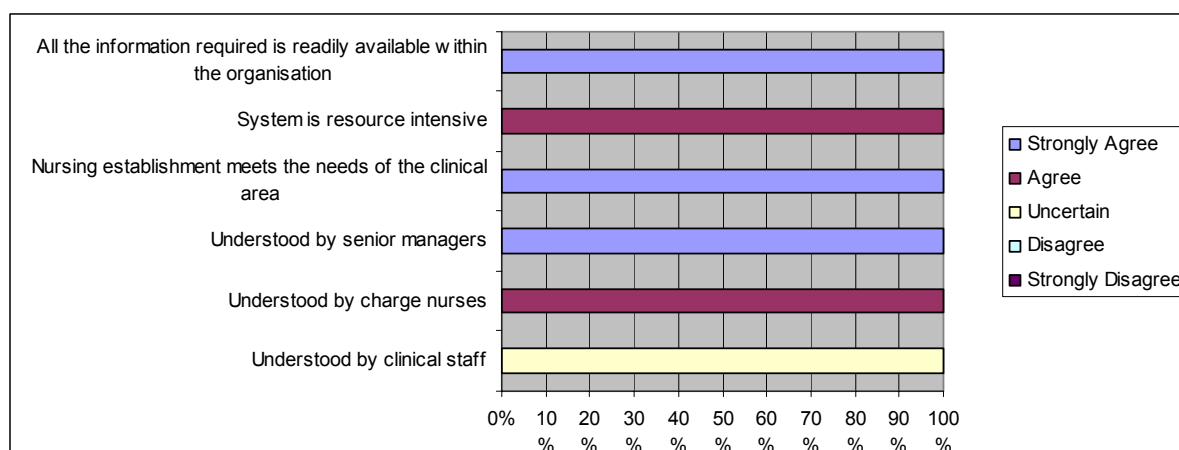
Question	Yes	No	Not Known	Total
Does this nursing workforce planning system detail requirements for:				
(i) Total nursing numbers	1	0	0	1
(ii) Qualified nursing staff only	0	1	0	1
(iii) Qualified and unqualified nursing staff	1	0	0	1
(iv) Numbers of staff by relevant clinical grade	1	0	0	1
Does this nursing workforce planning system take account of learner nurses?	0	1	0	1
Is this nursing workforce planning system formally recognised by your organisation?	1	0	0	1
Is this nursing workforce planning system effectively supported by available information technology?	1	0	0	1
Have the recommended staffing levels from this nursing workforce planning system been fully implemented?	0	1	0	1

Q6.13

The tool detailed under the second most commonly used Nursing Workforce Planning System was reported to be understood by Senior Managers and Charge Nurses. It provides details of a nursing establishment which meets the needs of the clinical area and all the information required is readily available within the organisation.

6.13 Please review each of the following statements in relation to this nursing workforce planning system.

Statement	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
This nursing workforce planning system is understood by clinical staff	0	0	1	0	0
This nursing workforce planning system is understood by charge nurses	0	1	0	0	0
This nursing workforce planning system is understood by senior managers	1	0	0	0	0
This nursing workforce planning system details a nursing establishment which meets the needs of the clinical area	1	0	0	0	0
This nursing workforce planning system is resource intensive	0	1	0	0	0
All the information required for this nursing workforce planning system is readily available within the organisation	1	0	0	0	0



Q8

8/17 of the Trusts / Organisations last used a Nursing Workforce Planning System within the past year, however 4 Trusts / Organisations last used a Nursing Workforce Planning System more than 2 years ago and a further 4 did not know when a Nursing Workforce Planning System was last used.

8. Within your Trust/Organisation, when was a nursing workforce planning system last used?

Length of Time	Yes
Within past month	3
Within past 6 months	2
Within past 6-12 months	3
Within past 12-18 months	0
Within past 18-24 months	1
>24 months	4
Not Known	4
Total	17

Q9

10 Trusts / Organisations indicated that they were considering introducing a new Nursing Workforce Planning System in the near future. 11 Trusts / Organisations provided comments on these proposals as summarised on the table below.

9. Are you considering introducing a new nursing workforce planning system in the near future?

Remarks	Numbers
Considering	10
Not considering	3
Unsure	4
Total	17

Reason for Considering New System	No of Trusts
Workforce Planning System / Strategy	5
Awaiting Outcome of this Review	2
Activity Mapping exercise used at present	1
Workforce Planning exercise undertaken during redesign of Mental Health Services (2 years ago)	1
Triangulation approach currently underway using historical budgets, acuity model and professional judgement	1
Currently re-designing inpatient services and reconfiguration of wards will require analysis of workforce planning	1
Total	11

Resources / Budgets / Establishments (Q7, Q10 - Q12)

Q7

The process for setting the nursing budget for 2003/04 was described by all 17 of the Trusts / Organisations. The reasons given are summarised in the table below:

Response re Budget Setting	No of Trusts
Based on Historical Budgets or Establishments plus other factors / uplifts	9
Rollover budget from Previous Year plus uplifts	6
Based on Historical Budget only	1
Negotiation between Trust and Board taking account of a number of factors	1
Total	17

Q10, Q11 & Q12

The amalgamated data for questions 10, 11 and 12 can be viewed in Appendix 1 of this report. The data from the Nursing and Midwifery Workload and Workforce Planning Project (at June 2003) is presented alongside data from ISD (at March 2003). Please refer to Appendix 6 of the main report for technical summary on this data.

Patient Care Characteristics

Quality Rating Scales - Q14

Q14.1

14 Trusts / Organisations reported using quality of care measures. A range of measures were reported as detailed in the listing below:

- Patient satisfaction audits
- Complaints
- Referrer satisfaction
- Clinical Governance Standards
- Audit including audit of national standards, guidelines and good practice statements
- Local and national guidelines
- Local nursing audit tool
- Monitoring of national standards compliance
- QIS standards
- SHAS quality standards for Learning Disability
- SHRUGS – annually
- CRAG guidelines
- Care standards
- Incident Reporting
- Risk assessment tools e.g. Waterlow, Beck Depression Inventory and choking assessment
- Maxwells Multidimensional Learning tool
- HoNOS

- Factual Evaluation of Care Evaluation (FACE)
- Avon Mental Health Measures
- Chartermark award
- ISO 9002
- Quality visits
- Clinical effectiveness / Nursing guidelines

Q14.2

Only 6 Trusts / Organisations reported using IT to determine quality of care measures. There was minimal information returned in relation to the IT systems used.

Q14.3

This question sought information on the extent of use of Quality Rating Scales. 1 Trust / Organisation reported using Psychiatric Monitor and 3 reported using other. The others included: local quality indicators; local standards, SHRUGS, Maxwells Multidimensional Learning Tool, Quality Visits; Quality Network and SHAS Quality Standards for Learning Disabilities.

Q14.4 & Q14.5

3 Trusts / Organisations reported using the quality data to inform Nursing Workforce Planning and 1 respondent reported that this had influenced skill mix. The way this has affected skill mix has been through reprovisioning of Psychiatric services and in regular reviews carried out by Charge Nurses and Managers.

6 Organisations provided comments on how the data is used in relation to Nursing Workforce Planning as detailed below:

Response	No of Trusts
Used in providing full picture when reviewing staffing levels	1
Not used in any formal sense but used in exercises to review staffing levels as part of risk assessment process	1
Quality data not formally linked to workforce planning but informs debate about staffing at local and Trust level	1
Used on day to day basis for needs assessment	1
Psychiatric monitor previously used and considered unreliable	1*
Quality outcomes examined and discussed with relevant stakeholders. Many outcomes have addressed realignment of existing workforce resources.	1
Total	6

* this was different organisation to the one which reported using Psychiatric Monitor in Q14.3

Patient Dependency - Q15

Q15.1 & Q15.2

10 Trusts / Organisations reported using Patient Dependency Scoring Systems. 3 of these organisations used Information Technology to determine patient dependency information. Responses included excel system, part of Psychiatric Information System and revised elderly person's disability score generated by computer.

15.1 Within your Trust/Organisation, do you record patient dependency information?

Yes	10
No	7
Not Known	0

A wide range of Patient Dependency Measures were used as detailed below:

Patient Dependency Measure	No of Trusts
SHRUGS	6
Risk Assessment Tools / Rating Scales for example <ul style="list-style-type: none"> • Hamilton • Becks • Shelton • Waterlow • Revised Elderly Person's Disability Score • Choking Assessment 	4
Integral to care planning based on risk assessment	2
Information that can be applied to resource use is measured	1
Acuity Quality Method Dependency Assessment	1
Blackpool Dependency System	1
Carenap D	1
HoNOS	1
Camberwell Needs Assessment	1
REPDS	1
CAPE Assessments	1

Q15.3

The table below details how frequently patient dependency information is recorded. Some Trusts / Organisations reported using more than one patient dependency scoring system or using systems differently in different clinical specialties. This accounted for the higher number of responses in Q15.3 than in Q15.1.

15.3 How frequently is the patient dependency information recorded?

Frequency Of Use	Yes
Twice - daily	2
Daily	5
Twice - weekly	2
Weekly	2
Fortnightly	2
Monthly	3
Random	1
Other	7

Random: As necessary determined by nurse in charge

Other: 6 monthly; after each visit; integral to care plans and updated as required; annual – SHRUGS; 6 monthly or annually; as required; on-going assessment

Q15.4

Only 1 Trust / Organisation reported using patient dependency information to inform Nursing Workforce Planning with a further 5 reporting that it was used sometimes.

15.4 Is the data generated from the patient dependency scoring system used to inform nursing workforce planning in your Trust/Organisation?

Yes	1
No	2
Sometimes	5
Not Known	2

Q15.5 asked if patient dependency information was not linked to nursing workforce planning how is it used? 7 Trusts / Organisations provided a response and these included:

Develop appropriate care plans(3); as part of national data collection; community care planning; NHS bed planning/retraction; used by charge nurses, managers and other stakeholders in planning and review meetings to link available resources to changes in workload at macro and micro level; used by clinical team to assess appropriate treatment and placement.

Patients Requiring Constant / Special Care - Q13

Q13.1

15 Trusts / Organisations reported having patients who required constant care.

13.1 Do you routinely have patients requiring constant care within your Trust/Organisation?

Remarks	Numbers
Yes	15
No	2
Not Known	0

Q13.2

Patients requiring constant care were in a number of specialty areas including: Acute Admissions, Psychiatric ICU, Elderly Care, Dementia Assessment and Continuing Care, Learning Disabilities, Forensic Unit and Elderly Challenging Behaviour Ward.

Q13.3

Staffing requirements for constant care patients were calculated by a number of means as detailed below. 6 reported using a Professional Judgement approach to providing staff for constant care patients. Some clinical areas appear to have capacity within nursing establishments to care for 1-2 constant care patients without requiring additional resource.

Method Reported	No of Trusts
Telford / Professional Judgement	6
As per Organisational Policy	2
Determined by multidisciplinary team	1
Staffing levels on wards can cope with 1 constant care patient but each patient requiring constant or special care thereafter requires additional resource usually through overtime	1
If numbers of patients in ward requiring constant observation goes beyond two then extra hours or bank staff might be needed (adult mental health) Extra hours, bank, overtime may be needed if demand exceeds staffing complement (old age psychiatry)	1
Increase in staffing level at appropriate grade to meet demands	1
Based on existing staffing with uplift from bank as required	1
Additional 1 nurse to each constant care patient	1
A number of factors considered including: needs of patients, number on constant care, overall number of patients on ward, risk, patient mix, staff competence and compliance with observational policy	1
Total	15

Q13.4

6 respondents reported being satisfied or very satisfied with the system used to determine staffing requirements for patients requiring constant care and 6 others reported being dissatisfied with the system used.

13.4 Please indicate how satisfied you are with this system.

Very satisfied	1
Satisfied	5
Uncertain	3
Dissatisfied	6
Very dissatisfied	0

Q13.5

14 Trusts / Organisations reported having patients who required special care.

13.5 Do you routinely have patients requiring special care within your Trust/Organisation?

Yes	14
No	3
Not Known	0

Q13.6

Patients requiring special care were in a number of specialty areas including:

Acute admissions, Psychiatric ICU, Continuing Care, Forensic Unit, Learning Disability in-patients, Forensic Unit and Elderly Acute Admissions.

Q13.7

Staffing requirements for special care patients were calculated by a number of means as detailed below. 5 reported using a professional judgement approach to providing staff for patients requiring special care.

Method Reported	No of Trusts
Telford / Professional Judgement	5
As per Organisational Policy	1
Determined by multidisciplinary team	1
National recommended staffing levels for PICU patients and for forensic patients are used	1
As per clinical need. Managed within establishment with additional bank nursing support	1
Increase in staffing level at appropriate grade to meet demands	1
Based on existing staffing with uplift from bank as required	1
Additional 1 nurse to each patient on special observation. This may be increased if patient is leaving building / hospital site	1
Minimum of 1 nurse at all times to carry out special nursing care. Staff not funded through present budget setting methods and overtime working is normally necessary	1
A number of factors considered including: needs of patients, number on constant care, overall number of patients on ward, risk, patient mix, staff competence and compliance with observational policy	1
Total	14

Q13.8

6 respondents reported being satisfied or very satisfied with the system used to determine staffing requirements for patients requiring special care but 5 reported being dissatisfied with the system used.

13.8 Please indicate how satisfied you are with this system.

Very satisfied	1
Satisfied	5
Uncertain	3
Dissatisfied	5
Very dissatisfied	0

Q13.9

3 Trusts / Organisations reported that an outreach team from the Intensive Psychiatric Care Unit and 2 reported that this provided support for special and constant care patients. The other outreach team prevented admissions to hospital rather than provide support to in-patients.

The 2 outreach teams who did provide support to patients requiring constant and special care reported that this was in the form of nursing support. One out reach team provides support Monday – Sunday (24 hours) and the other only when pressures in PICU allowed. One team was reported to cover up to 24% of patients requiring constant and special care but no details of percentages of patients covered were provided for the other team. A comment was however detailed in response to this question as follows: “*Challenging behaviour team provide support to patients with learning disabilities living in community accommodation.*”

In terms of effectiveness, one Trust / Organisation reported uncertainty with regard to the support given and the other reported that the outreach team was effective for both patients requiring constant care and for those requiring special care.

Nursing and Midwifery Workforce Characteristics

Protected Time - Q16, Q17

Q16

This was referred to as “time out” in the questionnaire but was amended to “protected time” following a decision of the Nursing Workload and Workforce Planning Steering Group.

Respondents were asked if there was any allowance for Charge Nurses to be released from clinical numbers. 6 Trusts / Organisations confirmed that there was an allowance for this and a further 6 answered sometimes.

16. Within your Trust/Organisation, is there any allowance included to enable Charge Nurses to be released from the clinical numbers?

Yes	6
No	5
Sometimes	6
Not Known	0

The responses from 12 Trusts / Organisations who provided details of time out for Charge Nurses are summarised below:

Description	No. of Trusts
Monies from leadership development programme (1 day per fortnight for 6 months to 1 year)	1
Only if can be released. Within Learning Disability service, charge nurse not ward based	1
Funding from Health Board for development of clinical leadership (available for past 2 years). Allows each Ward Manager to be released 1 day per week for approximately 20 weeks	1
Charge Nurses in hospital setting integral to clinical numbers but freed from therapeutic input to oversee standards / develop practice / ensure appropriate skill mix In community time out influenced by demands of clinical caseload and more ad hoc	1
Where Telford used staffing numbers calculated to allow Charge Nurses to be additional to numbers required per shift. In practice time out and workload pressures negate this	1
G grade entirely supernumerary in one area. Variable in other areas. Charge nurses have specialty / hospital wide responsibilities as co-ordinating Charge Nurse	1
Dependent on clinical activity	1
Clinical manager authorises time out but no official allowance in budget	1
Aiming for situation which would see charge nurses released from clinical numbers. Some success achieved to date but this has proved difficult to maintain due to levels of sickness and recruitment difficulties	1
Skill mix of Community Mental Health Team revised to enable team leader to take on responsibility for social care day centre and staff	1
On one site Ward Managers have 60/40 management: clinical practice split Ward managers in Old Age Psychiatry work on flexible basis and Community Psychiatric Nurses may work from home	1
Career development opportunities, personal development and training, specific secondment opportunities, specific project work	1
Total	12

Q17

In response to the question relating to the minimum time out which was felt to be required for Charge Nurses. There was strong support (11/17 respondents) for an allowance of one day per week. Additionally the 4 respondents who ticked other all recommended a time out allowance greater than 1 day per week and this ranged from minimum of 2 days per week to 5 days per week.

17. Please indicate what you feel should be the minimum amount of time out (from direct clinical work) for Charge Nurses.

Time Out From Direct Clinical Work	Yes
Nil	0
1/2 day per week	1
1 day per week	11
1 day per fortnight	1
1 day per month	0
6 days per year	0
Other	4

Others: 50% of time; 5 days per week; minimum of 2 days per week; 3 days per week

Predictable Absence Allowance Q18 & Q19

Q18

The current predictable absence allowance ranged from 0-23% (only 1 reported '0%'¹), with 1 able to provide data for learning disability service only ('20-23% funded') and 1 Trust / Organisation unable to quantify. It should be noted, however, that the organisation which was unable to quantify this allowance did not use agency staff, had staff available to cover absence and funding for this was within budget. Of the remaining 14 Trusts / Organisations who provided details of an allowance, 10 reported this was fully funded, 1 reported this was funded in all areas except for day hospital, Community Psychiatric Nurses (CPNs) and Learning Disability community based staff (for whom there was no allowance), and 3 reported partial funding ('17 of 20% allowance but with major review currently underway'; 'funded in some areas but not in others and currently being investigated'; 'variable 16-20 of 20% funded').

Q19

In relation to the optimal percentage for predictable allowance, there was strong support (13/17 respondents) for a predictable absence allowance of greater than 21%.

19. Please indicate what you feel would be the optimal percentage allowance for predictable absence.

Time Out	Yes
Nil	0
Up to 10%	0
11-15%	2
16-20%	2
21-25%	12
Other	1
Total	17

Other: minimum of 25% required

¹ Initial indications from this organisation that predictable absence allowance was reported as '0%' raised concerns. Following discussion with the relevant Director of Nursing, it was established that the predictable absence allowance was in fact 18%, which was funded.

Flexible Working & Bank and Agency Use (Q20 - Q26)

The next section of the questionnaire addressed the flexible working practices in operation within each organisation.

Q20

There were 2 flexible working practices which all 17 Trusts / Organisations reported to be using and these were part-time working and time off in lieu. This was followed closely by shift swapping (16), bank (14) and flexible shift patterns (14). Annualised hours, however, was not used in any of the organisations and term time working was used in only 1 organisation.

20. Which of the following flexible working practices are in operation within your organisation?

Flexible Working Practice	Yes	No	Not Known	Total
Self Rostering	6	11	0	17
Flexi-time	9	8	0	17
Shift Swapping	16	1	0	17
Flexible Shift Patterns	14	3	0	17
Part-time Working	17	0	0	17
Compressed Working Hours	6	10	1	17
Time Off In Lieu	17	0	0	17
Job Sharing	13	3	1	17
Rotational Posts	12	4	1	17
Annualised Hours	0	17	0	17
Term Time Working	1	16	0	17
Zero Hours Contracts	4	14	0	18
On Call	11	6	0	17
Staff Pool	6	11	0	17
Bank	14	3	0	17
Rescheduling of Workload	11	5	1	17
Others	0	1	n/a	1

One organisation responded yes and no to 'zero hours contracts'

Q21

5 Trusts / Organisations reported using computer packages to support flexible working practices and 3 of these reported use of budgetscan, 1 used a nurse bank system and 1 used an excel spreadsheet developed to manage rotas.

Q22

The frequency of use of flexible working practices in each organisation is summarised in the table below. The practices most commonly used "routinely" (every week) were bank, change duty roster and extra basic hours. The practice most commonly used "frequently" (most weeks in at least some areas) was overtime. The practice most commonly used "occasionally" (every few months) was cancel work (if possible). Staff pool and agency were the practices which scored highest under the "never used" category.

22. Please indicate which of the following measures are used within your Trust/Organisation and how often?

Measures to address staffing shortages	Routinely (every week)	Frequently (most weeks/in at least some areas)	Occasionally (every few months)	Never	Not Known	Total
Internal transfer of staff from other area of organisation	5	4	6	2	0	17
Change duty roster	10	6	1	0	0	17
Time off in lieu	7	6	4	0	0	17
Extra basic hours	9	5	3	0	0	17
Extra hours at enhanced rates	7	5	2	3	0	17
Overtime	5	8	2	2	0	17
Staff pool	3	1	1	10	2	17
Bank	11	3	0	2	1	17
Agency	3	3	2	9	0	17
On call	7	1	3	5	1	17
Rescheduling of workload	7	4	3	3	0	17
Cancel work (if possible)	2	1	8	6	0	17
Other	0	0	1	0	0	1

Other: advertised secondments

Q23

7 respondents reported having access to a Trust / Board Area General Bank and 10 respondents reported having access to a Trust / Board Area Specialist Bank. 3 organisations reported having access to both a Trust General and Trust Specialist Bank. The specialty banks provided Mental Health and Learning Disabilities Nurses.

23. If you have access to a Bank, please indicate the type of Bank available.

Bank Categories	Yes	No	Not Known	Total
Trust General Bank	6	4	0	10
Trust Specialist Bank	9	2	0	11
Board Area General Bank	1	7	0	8
Board Area Specialist Bank	1	8	0	9
Other	0	3	0	3

Q24

7 Trusts / Organisations reported using a preferred provider for agency staff.

24. If you use Agency staff is this from a preferred provider?

Yes	7
No	1
Not Known	0

Q25 Requests Trusts / Organisations to indicate the top four measures they would prefer to employ in their organisation. The top four weighted choices were as follows:

1. Change duty roster
2. Internal transfer of staff from other area of organisation
3. Extra basic hours
4. Bank

25. From the measures listed below please indicate the top four options/measures you would prefer to employ in your Trust/Organisation (weighted)

Measures to address staffing shortages	1st choice	2nd choice	3rd choice	4th choice	Totals
Internal transfer of staff from other area of organisation	20	12	2	0	34
Change duty roster	32	3	6	0	41
Time off in lieu	0	9	4	5	18
Extra basic hours	4	18	10	1	33
Extra hours at enhanced rates	0	3	2	1	6
Overtime	4	0	0	2	6
Staff pool	4	0	2	1	7
Bank	0	6	8	6	20
Agency	0	0	0	1	1
On call	0	0	0	0	0
Rescheduling of workload	4	0	0	0	4
Cancel work (if possible)	0	0	0	0	0
Other	0	0	0	0	0

Q26

A number of measures were detailed by 13 Trusts / Organisations as methods of reducing bank and agency spend and these include:

- “Spend to save” increased staffing levels above funded establishment
- More flexible working practices (2)
- Pilot of staff pool proved ineffective
- Amalgamation of Trust Banks into Board Area Bank
- Review of Trust Banks undertaken and now considering Board Area Bank
- Giving consideration to annualised hours contracts, part time and overtime before agency
- Review payment for additional hours to avoid having to use agency
- Shorter shifts, shorter working week, flexible rostering to take into account child care etc
- Planning to focus on reducing sickness / absence levels
- Very limited use of agency and only in a couple of areas
- West of Scotland wide working group exploring options to reduce bank / agency use
- In remote and rural areas less opportunities to use the variety of flexible working options which we would like to
- Reviewing existing staffing levels and work practices
- Undertaking a review of skill mix and shift patterns to determine optimum design of workforce
- Major exercise underway to bring establishments in line with requirements. Investing in establishments with adequate allowance for predictable absence will reduce reliance on bank and agency for planned shortages
- Uplift of staffing levels in acute wards
- Redesign of services
- Development of new Community Assessment and Treatment Service
- Cross cover across wards

- Agency staff not used routinely
- There is no bank for Mental Health Nursing
- Continuing recruitment drive to address trained staff vacancies
- Trust committed to reducing agency and used “guaranteed” bank shifts as a means of achieving this.
- Trust has tight control measures which are monitored at Trust level monthly
- Trust participating in Board Area taskforce which will take forward measures to reduce bank and agency usage

Role Expansion / New Roles (Q28)

Q28 sought details of initiatives which have been implemented in response to reduction in Junior Doctors Hours, Pay Modernisation or Changing Workforce Programmes. 8 Trusts / Organisations responded and examples of initiatives prescribed are listed in the box below.

- Nurse Screening Pilot
- Duty Nurse Co-ordinators screening calls for Junior Doctors
- Reviewed on-call and call out process for SHOs
- Use of time in motion process for on call SHOs for audit/change process
- Cognitive Behavioural Therapist (2) has been appointed to undertake work previously done by medical staff
- Trust Steering Group established to consider implementation of new GMS Contract and potential for development of nurse led services.
- Stakeholders event planned for later this year to review workload of Consultants in relation to Consultant vacancies and new contract. It is envisaged this will lead to the development of Nurse Consultant posts
- Revised Junior Doctors On Call Policy
- Increase in phlebotomy hours
- Nurse Prescribing
- Patient Group Directions
- Single Shared Assessments
- Nurse Phlebotomists
- F grade Charge Nurses introduced to Acute Admission Unit (mental health) on night duty (developed from upgrading E grade posts). These post holders act as filter for telephone calls to junior doctors. Also have access to patient information on Epex System.
- Workload of Junior Doctors in community teams is reducing but this is impacting on Community Psychiatric Nurses
- Joint SHO / nursing staff admission assessments
- Pilot site involvement in workforce planning tools

Examples of Good Practice (Q27)

15 Trusts / Organisations provided 20 examples of good practice in relation to Nursing Workload and Workforce Planning

- Psychological Therapies Project
- Centralised Nurse Bank
- Dedicated Nurse Bank
- Spend to Save Initiative
- 1 Year Guarantee and Development – Return to Practice
- Flexible Working Patterns
- Shift System Review
- Home Treatment
- Epex System – allows staff in A&E and GPs to access relevant up to date patient information on patients out of hours
- Review of staffing needs
- Delayed Discharge Project
- Workforce Model
- Old Age Psychiatry Workforce Initiative
- Packages supporting discharge including transitional discharge as part of an international project and development of day care to support the move into the community
- In Acute Psychiatry Ward, a day service has been developed for patients following discharge
- Supported day care for patients with Mental Health Problems
- Re-provisioning of Psychiatric Services
- Acute Adult Mental Health Service Re-design
- Resource Network Development
- On Call Escort Team

Additional Comments (Q30, Q31, Q29 & Q32)

Q30

16 Trusts / Organisations provided details of additional factors which create workload for nurses as summarised below:

Administrative

Increased emphasis on accountability i.e. documentation and recording

Lack of clerical support / admin support (2)

Increased levels of paper work associated with clients, assessments, interagency referrals

Nursing Characteristics

Expanding nurses' role (4)

Competency development new areas

Clinical supervision

Management

Staff absence / increasing levels of sickness

Staff appraisal

Contribution to Working Groups e.g. PIN guidelines / Family Friendly Policies, Working Time Directives and Agenda for Change

Meetings and liaison with voluntary agencies and community teams

Debriefing after incidents

Searching for staff from bank

Time spent responding to fire alarms in other parts of hospital when acting as directorate bleep holder

Nurses having to respond to aggressive situations in other wards or departments can entail significant workload

Patient / Clinical Characteristics

Long distance escort of patients sectioned under the Mental Health Act

Escorts via air ambulance or land ambulances (can mean that 2-3 staff members are away from clinical area for up to 5 hours plus)

Escorting patients within site and off site

Section 18 recalls

Staff member to accompany patients receiving ECT

Changing / emerging client group

Patient dependency / complexity

Support to carers

Increase in admission for self harm/suicidal ideation

Shift in emphasis to community care

Bed management issues in acute psychiatric nursing both within our organisation and occasionally for other NHS Board Areas

Blocked bed pressures increasing time spent locating beds on daily basis

Increased admission rate of patients with co-morbidity diagnosis

In acute mental health no control over number of admissions at any one time and little control over number of patients who require constant care

Historical budgets may not take account of changing morbidity levels due to e.g. service redesign and increased substance misuse

Public Partnership

Patient public involvement

Increased emphasis on user / carer involvement

Remote and Rural Factors

In rural areas lack of service from other agencies such as social care results in additional workload

Distance from an in-patient facility means more individuals may require more support from CMHT members prior to an admission to hospital

Admission and discharge from a hospital 200 miles away also results in more time and effort required to liaise with staff and make satisfactory discharge arrangements for patients

Other Professions

Junior Doctors' Hours (3)

The different working practices of Consultant Psychiatrists and the additional workload this can create for nursing staff – varied clinical practices

Education

Increased mandatory training commitment

Increased personal development / training issues thereby creating gaps in daily workforce

Investment in training and development

Staff Supervision

Supernumerary status of student nurses

Study time and updates associated with nurses taking on new skills as result of reduction in junior doctors' hours

Quality Initiatives

Risk assessment and risk management(2)

Infection Control

CNORIS (2)

Dealing with complaints

CRAG recommendations on the nursing role in relation to patients receiving Electro Convulsive Therapy

Other

Degree of change occurring in organisation

Service retraction / redesign

The number of initiatives staff are expected to work with, that have an impact on daily workload

Centrally driven national initiatives

National Priorities

The way non-recurring funding is allocated to the organisation and the timescale within which targets have to be achieved

Joint futures

Internal geography of wards

Whether clinical areas are fit for purpose or contain clinical risks inherent in the design

New services being cash limited and staffing being compromised to ensure compliance with budget, skill mix often diluted to ensure adequate numbers within budget constraints.

Shortage of staff with requisite skills on the bank

Implementation of new Mental Health Act may have consequential impact on nursing staff

In parts of service nurses generally have very little control over their workload, something which is acknowledged as a major cause of stress

Stand alone units

Q31 asked if the factors identified in question 30 were accounted for in the Nursing Workforce Planning System used. 7 organisations provided a response.

“Increase in workload, less on direct patient care, difficulty in meeting requirements in relation to Clinical Supervision, Staff Appraisal, Statutory & Mandatory Training, personal development. No system in place that responds flexibly to the changing care environments.”

“Staffing levels appraised, shift by shift.”

“Version 4 workforce plan was developed prior to the inception of many of the current national directives.”

“The activity mapping process is attempting to take account of the issues which impact on nursing, the project is encouraging flexible working patterns to enable staffing to reflect the activities within the ward area.”

“Not through the funded establishment but it has to be managed through overtime working”

“No-one has clear responsibility for running/managing the Bank.”

“To some extent”

Q29 sought details of anything significant related to Nursing Workforce Planning which respondents felt was missing from the questionnaire. 7 organisations provided a response.

“The lack of validated work that enable service managers to establish staffing levels and skill mix that reflect the specialist nature and needs of patients in services for people with mental health problems, dementia (challenging behaviour), learning disability and addictions.”

“Little reference to workload and nature of interventions required to meet patient needs: no reference to impact of national standards, good practice statements or clinical guidelines: no reference to joint future agenda: no adequate description on the role and functions of mental health nurses.”

“Question 18 asks us to list predictable absence percentages that are in operation for various subsets of absence and certainly question 19 asks us for our views on what we feel the optimal percentage should be. I think it would then have been useful to ask us to split what we would wish to see as the optimal percentage allowance down into its subsets in the same format as question 18. This may give an indication of respondents perceptions of how much each these subsets appeared to be contributing to overall predictable absence”

Discussion at meeting clarified the following information. In psychiatry the impact of other staff should be considered for example social workers, occupational therapists and administrative staff. Mandatory training requirements for example control and restraint training requires 5 days plus an annual refresher day. Additionally there are also ad hoc training requirements. Escort of patients is another area which impacts on nursing workload. The Trust has services on 3 sites and frequently nursing staff have to make their own way back to their base following an ambulance transfer. Learning Disabilities and Old Age Psychiatry are in the process of site retractions therefore as services on site are reduced there is less opportunity for flexibility and sharing of staff. Administrative support on the affected sites has also been reduced and some of this work now falls to nursing staff to deal with.

“Local and regional issues affecting recruitment, in particular the lack of availability of potential staff, the cost of living, transport difficulties to remote hospital sites and proposed service changes causing anxiety among existing staff.”

“There is no reference to the report of the in-patient mental health nursing workforce planning group”

“Acceptance of validity / argument in relation to submission of “business case” for service developments and initiative what part of service development takes priority”

Q32 asked respondents to provide additional comments on relation to Nursing Workforce Planning which respondents felt may have been of assistance to the project. 8 Trusts / Organisations provided a response.

“Little of no awareness of training around workforce planning and resourcing same.”

“Models need to be flexibly interpreted and locally adopted to meeting changing needs of patients and systems. There needs to be a national systematic approach to upskilling the workforce, allowances made when establishments are agreed. Benchmarking should not be relied upon unless you are comparing like for like.”

“Need realistic but dependable mechanisms for measuring patient dependency and required level of engagement: need mechanisms for measuring how much nursing staff time is spent on direct patient care, indirect patient care, record keeping and admin and clerical duties.”

“Because of the lack of an available pool of qualified staff the solutions to manage workloads are limited. The lack of resource within other care providers i.e. social care has an effect on nursing workloads.”

“We look forward to examining the outcomes from the Nursing Workload and Workforce Planning Psychiatry Questionnaire as we feel that budgets need to be reviewed to reflect the increasing workloads due to legislative frameworks, continuing professional development, implementing quality and patient-public expectations.”

“We anticipate that the impact of implementing Agenda for Change will have a significant effect on our workforce planning as our organisation has a high number of nursing staff who would be entitled to increased annual leave due to length of service.”

“The planning and delivery of a Community Mental Health Service in a remote and rural area with no inpatient facility does have an impact on the number of patients which can be actively managed within a caseload in order to provide a quality service to the patients as well as making a manageable job for the post holder.”

“It might be helpful to have annual national comparisons of staffing levels, skill mix and shift patterns for the Mental Health Services in Scotland.”

Appendix 1 Establishment Data

PSYCHIATRY

10. Specialty Information

Please complete the information requested in the table below for each of the psychiatric specialties within your Trust/Organisation.
Please use figures as at 20th June 2003.

Specialty Information - Total														
Specialty	Occupancy Rates (as %)	ISD Occupancy Data	Number of Staffed Beds	Total Funded Nursing Establishment (in wte) Excluding Specialist Nurses	Funded Qualified Nursing Establishment (in wte) Excluding Specialist Nurses	Qualified Nursing Vacancies (in wte) Excluding Specialist Nurses	Vacancy Rates (using workload data)	ISD Qualified Nursing Vacancies (in wte)	Total ISD Vacancy Rates	ISD Qualified Nursing Vacancies less than 3 months (in wte)	ISD Qualified Nursing Vacancies 3 months or more (in wte)	ISD Qualified Nursing Vacancies unknown (in wte)	Total Funded Establishment of Specialist Nurses (in wte)	Specialist Nurse Vacancies (in wte)
Adult Acute Admission	95.46		1574	1685.3	1101.5	76.6	7.0%						12.6	0.0
Elderly Acute Admission	85.26		896	942.3	512.5	18.6	3.6%						4.0	0.0
Adult Continuing Care	85.07		887	862.8	420.9	21.0	5.0%						2.0	0.0
Elderly Continuing Care	88.66		1483	1431.2	615.1	42.7	6.9%						4.0	0.0
Rehabilitation	76.13		405	469.3	291.2	15.5	5.3%						4.0	1.0
Intensive Psychiatric Care	77.54		182	405.4	221.0	20.4	9.2%						2.0	0.0
Day Hospitals	0.00		0	388.4	307.3	15.2	4.9%						0.0	0.0
Learning Disabilities - Inpatients	94.30		581	1382.6	634.5	49.1	7.7%	32.1	4.3%	3.6	21.9	6.6	9.0	0.0
Learning Disabilities - Community Based	0.00		0	232.7	202.5	8.8	4.3%	13.9	5.5%	10.0	2.9	1.0	2.0	0.0
Community Psychiatric Nurses	0.00		0	1441.8	1205.9	25.0	2.1%						58.0	23.0
Community Out Patients	0.00		0	0.0	0.0	0.0							0.0	0.0
Child and Family Mental Health - In Patients	100.00		23	70.7	60.7	13.0	21.4%						1.0	0.0
Child and Family Mental Health - Out Patients	0.00		0	75.9	76.3	3.9	5.1%						19.4	0.0
Other	73.99		951	1575.5	1113.4	52.4	4.7%						40.1	2.4
Other ISD Vacancies								174.9	2.80%	127.3	43.5	4.1		
Total			6982	10963.8	6762.6	362.3	5.4%	220.9	3.00%	140.9	68.3	11.7	158.0	26.4

11. Please provide details of the total funded nursing establishment for Psychiatry (excluding specialist nurses, nurse practitioners and other similar staff involved in clinical care). Please provide data as of 30th June 2003.

	Funded Establishment in Whole Time Equivalent (in wte)	In Post in Whole Time Equivalent (in wte)
First Level Registered Nurses	5655.04	5258.66
Second Level Registered Nurses	365.97	417.5
Total - Registered *	6659.6	6281.96
Grade C	14.62	11
Grade B	562.84	606.63
Grade A	3532.78	3433.24
Total - Other *	4115.34	4057.47

* Not all trusts were able to provide a split between first and second level nurses and between Grades A, B, C and some have provided only a total

12. Please detail the total funded establishment of specialist nurses, nurse practitioners and other similar nursing staff involved in clinical care in Psychiatry. Please provide data as of 30th June 03.

	Funded Establishment of Specialist Nurses in Whole Time Equivalent (in wte)	Specialist Nurses In Post in Whole Time Equivalent (in wte)
Grade I	29	28
Grade H	65.21	65.66
Grade G	115.78	114.78
Grade F	27.08	26.08
Other	2	2
Total	239.07	236.52