National Quality Board

Safe, sustainable and productive staffing

An improvement resource for learning disability services

Contents

1. Introduction

This improvement resource is for community and inpatient learning disability services. It is designed to help commissioners and providers of NHS commissioned services to create, review and sustain safe and effective specialist health services within the resources available for people with a learning disability, who have a wide range of needs and varying levels of disability. Our ambition is to make a sustainable difference to the quality and consistency with which safe and therapeutic services for people with learning disabilities are delivered.

The resource draws on evidence from a commissioned rapid review of literature (see Appendix 2) and a professional review of practice. It aims to provide principles and an assurance framework to help standardise approaches to making decisions about staffing in a multidisciplinary learning disability setting, within organisations and across the system supporting the patient experience and outcomes.

NHS Improvement's '*measure and improve*' approach has been a guiding principle in its development. People with learning disabilities, carers and other stakeholders have informed the content.

This work is aligned to Commitment 9 of Leading Change, Adding Value: a framework for nursing, midwifery and care staff (2016).[1] Users of this resource should also refer to the National Quality Board's (NQB) 2016 publication https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf and its three expectations concerning right staff, right skills, and right place and right time. Users should also refer to the other setting-specific guides in this series, in particular those for the adult acute, mental health, community and children's services.

We recommend further research, and will update this resource every two years unless new evidence contradicts its content.

Context

Sustainable safe staffing in learning disability services must take account of the complex nature of the care models and the number and skill mix of professionals and agencies involved in meeting the healthcare needs of people with a learning disability.

We developed this resource in the context of reducing health inequalities and increasing the life expectancy of people with learning disabilities, as well as sustainability and transformation plans in the NHS. The national Transforming Care programme aims to end over-reliance on assessment and treatment units

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[1] https://www.england.nhs.uk/ourwork/leading-change/

and unnecessary hospital admissions for people with learning disabilities and /or autism.

In October 2015 the national plan, *Building the right support*, was published to enable people to live more independent lives in the community, with support, and closer to home. This programme involves new service models to meet local needs. Its success will depend on the workforce being available in sufficient numbers with the right skills, values and behaviours to deliver new models of care across the system.

2. Right staff

There must be sufficient and sustainable staffing capacity and capability in learning disability settings to provide safe and effective care to patients at all times (NQB 2016). These decisions must take account of the financial resources available, so that high-quality care can be provided now and on a sustainable basis. A joint assessment of use of resources will soon be used in CQC ratings, underlining the importance of financial efficiency when setting safe staffing levels and deciding on staffing mix.

Workforce planning

Workforce planning should be an integral part of an organisation's strategy and include the trends for turnover (eg attrition, retirement profile). The staffing required to deliver high-quality learning disability services as effectively as possible within the resources available should be kept under regular review. In particular it should form an integral part of the organisation's operational planning process.

The local team's skill mix, number and form must be based on identified local needs and required functions. At a minimum, across the organisation, there should be enough registered practitioners and assistant practitioners across all professions to deliver high quality care at all times and organisations should not over-rely on agency staff.

Traditionally learning disability teams have comprised nursing, speech and language therapy, psychiatry, psychological therapies, occupational therapy and physiotherapy. Some integrated teams include social workers and other therapist roles, audiology, podiatry and dietetics.

The literature review identifies the need for clarity and clear definition of professional roles within teams as a key theme (see Appendix 2).

Our workforce, like many in other large sectors and industries, is facing numerous challenges and the landscape of transformation, as set out within the Five Year Forward View is being delivered so we have health and care services that can adapt to the future. In this changing landscape we know that we cannot rely on the traditional solutions to some of our major workforce pressures and we need to think differently moving forwards.

We need to build an adaptable contemporary workforce to respond to the changing world as a profession, using our resources wisely, while ensuring that careers remain attractive and accessible to all. Our ability as a profession to adapt and innovate is critical to achieving high-quality care in the right place and at the right time. By modernising, we can shape a workforce that is fit for

purpose for the next decade and beyond and positively demonstrate care, outcomes and experience for those for whom we care.

New healthcare models, transforming care services and service developments provide an opportunity to review traditional service delivery models utilise emerging roles in the NHS. These include:

- advanced practitioner roles
- apprenticeship opportunities
- nursing associate roles
- consultant allied health professional and consultant nurse roles
- care navigator roles
- non-medical prescribing roles
- experts by experience/peer workers
- physician assistant role
- clinical academic roles
- professional leadership of all professional groups.

Emerging roles should only be used at the appropriate level of assessed skill, competence and attitude. All workforce planning should consider the skills required to achieve holistic, person centred health outcomes and identify the staff best able and most appropriate to deliver them.

Health Education England has recently published 'a set of **five generic role templates'** to support the development of new and different roles in learning disability community services. The templates will help commissioners and providers of health and care services build a flexible workforce capable of delivering the aims of the Building the Right Support agenda'[2] (see footnote for further detail).

Deploying multidisciplinary staff in community settings

When deploying staff in community teams we recommend organisations refer to the five key roles for adult learning disability services from the Learning Disability Professional Senate in 2015 (see Appendix 6 for more details).

- supporting positive access to and responses from mainstream services
- enabling others to provide effective person-centred support to people with learning disabilities
- direct specialist clinical therapeutic support for people with complex need
- responding positively and effectively to crisis

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[2] https://hee.nhs.uk/hee-your-area/east-midlands/news-events/news/new-%E2%80%98generic-role-templates%E2%80%99-support-redesign-learning-disability-workforce

- quality assurance and service development in support of commissioners.

New roles within learning disability teams might also include:

- joint autonomous roles across services enabling good communication and relationship building with and between other providers
- cross-service leadership and collective leadership roles
- a role that focuses on the facilitative values-based elements of delivering services.

Monitoring staffing and staffing reviews

Appendix 3 outlines an approach to staffing reviews and the use of decision making tools specific to learning disability settings that will help organisations to make informed choices for deployment and planning of safe and sustainable staffing.

In its work to develop and implement measures for analysing staff deployment, NHS Improvement has collected data on care hours per patient day (CHPPD) in inpatient settings on a monthly basis. As this source of data develops; specialty specific ranges are emerging that organisations will be able to consider and utilise as a source of benchmark against when planning appropriate levels of staffing.

Unplanned care/intensive support

In some circumstances, it is necessary to provide extra, more intensive support to people using learning disability services. Service development should include contingency planning. This will usually involve a flexible, moveable, multiskilled and adaptable workforce from across the organisation, that can be mobilised quickly in order to respond to people's often rapidly changing needs.

Commissioners should consider the benefits of increased and more flexible local funding to prevent expensive, inappropriate inpatient or out-of-area residential social care. We recommend arranging immediate access to funds that can support increased and flexible skilled staffing when it is needed.

We recommend providers collect data on flexible staffing use and cross-reference to workforce planning, staff training and staff rotas to explore predictability and patterns of extra staffing need. This will provide trend data to make staffing decisions on how to respond to unplanned care needs.

We recommend providers ensure a skilled temporary workforce is available through a 'staffing bank' or other flexible working arrangements, that can respond 24 hours a day, seven days a week and adapt to specialing needs and unplanned variation in acuity and dependency levels (which are likely to vary through the day, eg off-site activity), thereby minimising use of agency staff.

Over-relying on high agency staff is unlikely to represent an effective or sustainable solution to ensuring the right skills mix and workforce. By reducing the amount of external agency staff they use, organisations can not only save money but also vastly improve the quality of service they offer to patients by ensuring that they have skilled staff who are familiar with how the organisation works. People with learning disabilities tell us they feel safer with staff who they know and the evidence indicates that effective teamworking improves outcomes.[3]

Individuals making unplanned staffing decisions based on professional judgement should be backed up and guided by senior staff in the management team. In many cases it is helpful to have predetermined arrangements to support rapid decision in order to lessen the likelihood of poor decisions being made.

Learning disability teams

Community learning disability teams

Community learning disability teams (CLDTs) are acquiring an increasingly complex caseload as people move back into local areas from out-of-area long-term placements. Skill and knowledge of this complexity is essential to effectively provide the support and guidance needed by people with learning disabilities, their families and health and social care colleagues.

It is important that these changes are acknowledged in workforce development, review of skill mix, staff training plans and commissioners' expectations. The increase and changes in intensity of need for some people, can affect the team's public health role and its capacity to prevent ill health, improve health outcomes and support people with less demanding or urgent needs in maintaining good health.

Organisations should ensure their staff have the appropriate competencies and skills to meet peoples' increasingly complex physical health needs.

Intensive support services and community forensic services

Intensive support services are interdisciplinary community-based teams that work with people requiring a level and intensity of intervention much greater than can reasonably be expected of the CLDT and may require support outside of normal working hours.'

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3 Hughes AM, Gregory ME, Joseph DL et al (2016) Saving lives: a meta-analysis of team training in healthcare. *Journal of Applied Psychology.*

Intensive support services need appropriately skilled practitioners to enable adequate[4] and flexible staffing to support people at times of crisis and when there is a very high risk of either home or placement breakdown, which can be influenced by a range of factors. NHS England predicts from its current risk registers that there are around 26,000 adults with learning disability in the high risk category and who are most likely to need inpatient care unless appropriate community services are available. To prevent or minimise this, high intensity community-based staff will be needed to meet people's mental health, behavioural and forensic needs.

In some areas CLDTs include intensive support functions. In these circumstances, it is important that this does not compromise the CLDT's fundamental public health and preventive role. Skill mix and numbers need to be considered with both functions in mind.

NHS England has published guidance for commissioners: *Supporting commissioners to develop service specifications for enhanced/intensive support*. This includes recommendations about the nature of appropriate workforce skill mix for enhanced services. For more details, see Appendix 8.

Mental health learning disabilities community model

Some areas of the country have a mental health and learning disability model (MHLD) that complements community learning disability teams and community mental health teams[5]

In addition, many areas have developed joint protocols between mental health and learning disability services to support people's access to the right assessment and treatment. In such examples, professional staff from both mental health services and learning disability services actively work together to share skills, solve problems and enhance the persons experience of care.

Liaison roles

Our focus group of people with learning disabilities highlighted the need for liaison roles in acute settings. They said:

- "When I spent time in hospital recently I felt alone."
- "I want to have my anxieties understood. I do not feel safe if people don't understand me."
- "Not knowing the hospital routine made me feel unsafe."

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4 'Adequate' is defined as the number of staff required to deliver the requirements of the service as identified through staffing reviews.
5 Chaplin E, Paschos D, O'Hara J (2010) The specialist mental health model and other services in a changing environment.

Evidence shows that where there are learning disability specialist liaison practitioners, people with learning disabilities are at less risk of significant morbidity and premature death and their health outcomes improve. Commissioners and workforce planners should consider the importance of providing these posts in a range of services including primary healthcare, acute physical healthcare, mental healthcare and forensic/prison healthcare.

In *2012 Improving Health and Lives* (IHAL), the Royal College of Psychiatry and the Royal College of General Practitioners published their evidence-based commissioning guide to improving the health and wellbeing of people with learning disabilities. The report and the associated business case recommended one full-time hospital liaison nurse per 350,000 population as the basis for developing a more comprehensive service. The Five Year Forward View mental health also sets out the importance of liaison roles.[6]

Learning disability specialist inpatient services (including forensic, assessment and treatment, mental health)

When community care is not possible or appropriate, short-term inpatient specialist care or forensic care may be needed. Services should be staffed to meet the expected needs of people requiring inpatient assessment, treatment and interventions. High levels of observation and intensive support are often necessary, plus extra support to communicate effectively and to reduce anxiety and confusion. At times challenging behaviours may require enhanced staffing to ensure safe care.

We recommend that providers ensure enhanced support and observation processes include the right checks and balances so the approach used is appropriate with minimum restriction.

In *Building the right support* (2015), NHS England predicts the need for a reduction in learning disability bed numbers to about 40 per million population (15 assessment and treatment and 25 secure beds). Staffing numbers with appropriate skills for such services will be needed.

NHS England is in the process of publishing guidance for commissioners: *Supporting commissioners to develop community forensic service specifications* and *Supporting commissioners to develop service specifications for acute learning disability inpatient services*. These include recommendations on workforce skill mix for community forensic support and acute inpatient services.

NHS England has developed guidance for commissioners in response to the agenda for transforming healthcare: *Supporting commissioners to develop service specifications to support implementation of the national service model*

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[6] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition This includes areas for commissioners to be mindful of when commissioning and measuring the outcomes of service provision and is currently in the process for publication. For details, see Appendix 7.

Recruitment and retention

Good recruitment strategies are essential to recruiting the right staff with the right skills. Values based recruitment plays a major part in ensuring the quality of a service as well as safeguarding people from abuse and exploitation. (This was a key theme from the people with learning disability focus group when we asked questions about safety.)

Organisations should have retention strategies (with supporting processes), and consider flexible working and different methods of deployment for staff, especially those who wish to work beyond retirement age.

It is predicted that there will not be enough learning disability nurses and other professionals with experience of learning disability in the future. NHS organisations must promote this career choice and closely monitor those entering graduate placements as well as considering alternative routes to qualification. Clear career pathways for professional roles provide a pipeline of succession for key posts in the structure.

As new generations enter the healthcare workforce, different expectations of autonomy, flexibility and loyalty arise. Employers need to consider these issues alongside retirement profile, population and education when planning a capable, sustainable workforce.

3. Right skills

Appropriate consideration should be given by decision-makers to the staff and skill mix required to deliver high-quality learning disability services as effectively as possible within the resources available. Clinical leaders and managers should be appropriately developed and supported to deliver high quality, efficient services that are resilient and sustainable. Staffing should reflect a multi-professional, holistic team approach. Clinical leaders should use the workforce's competencies to the full, developing and introducing new roles where they identify a need or skills gap (NQB 2016).

Context

New models of transformed and integrated care will rely on healthcare professionals providing expert care to more people at home 'living in the community' alongside families, personal assistants and social care providers. Learning disability services need to respond to the increasing complexity of need. Clinical intervention should always be based on ensuring safety, minimising risks, reducing health inequalities and improving health outcomes within the resources available.

The significant number of highly skilled health professionals approaching retirement age is already affecting retention. The reduction in workforce commissions for education and training and in the number of professional courses available, is already affecting recruitment and retention. The number of psychiatrists, nurses and allied healthcare professionals in training today is expected to fall short of future demand for their services. If this isn't addressed there will be a serious deficit of skills in the workplace. Organisations need to take an active role in ensuring clear data on demand and skills required is provided to workforce planners and those providing education and training.

To be sure of the right skills, an organisation must have a system for evaluating and reporting on:

- an individual's performance, linked to their continuing development
- sufficiency of the levels of supervision and reflective practice are in place
- a team's capacity and capability to meet the needs of those it serves by using its resources as appropriately, flexibly and efficiently as possible
- the accuracy of demand and capacity planning as services are changed/commissioned'?

Additionally the new professional regulatory revalidation requirements are aiming to help to encourage a culture of sharing, reflection and improvement

while promoting good practice across the professions, as well as strengthening public confidence in both the nursing and midwifery professions.[7]

Competency frameworks and learning needs analysis tools that can help with this and with ongoing staff development and organisational capability, as described below.

Professional skills

Developing and maintaining the clinical skills of staff in accordance with professional, local and national guidance is essential in ensuring safe services.

Within multidisciplinary teams there will be some activities provided across professional groups, eg basic assessment. There will also be explicit activities undertaken by individuals with advanced skills and qualifications. Levels of required clinical expertise will be determined through local skills analysis and caseload need.

Education and training framework

The learning disabilities core skills education and training framework supports the implementation of the transforming care plan, and contains a learning needs analysis tool.[8] This is a useful guide for organisations to consider skills requirements from a basic awareness level to specialist roles. Various e-learning packages are available to access from this tool.

Non-clinical skills

Learning disability services should also consider the non-clinical skills and roles needed to enable providers to collaborate effectively with others in the wider system, for example:

- leadership
- facilitation between people accessing services, their families, carers and other providers
- negotiation
- communication
- strategic thinking
- collaboration
- economic evaluation
- operational workforce planning
- quality monitoring

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[7] http://revalidation.nmc.org.uk/
[8] http://www.skillsforhealth.org.uk/services/item/449-learning-disabilities

- data collection, analysis and management
- resource management and allocation
- information technology
- training and enhancing skills of others.

Quality assurance

Quality assurance mechanisms such as quality checking schemes run by people with learning disabilities are another way employers can actively seek to determine where and how to improve the quality of their service and those working for them.

Staff working in learning disability settings should support skills transfer to carers. They deliver training to other community providers and have a vital role in prevention and safeguarding. Our focus group of people with learning disabilities endorsed the importance of this:

- "Health plans are good but they are used by staff who do not value the individual."
- "Staff need better training."
- "Safeguarding and knowing information about me is in a safe place.

Quality monitoring should include evaluation of the knowledge, skills and attitudes of staff, to make sure they have a person centred approach to their role and identify when their knowledge or skills are deficient. The organisation and individual staff share responsibility for maintaining and developing skills and upholding values.

4. Right place, right time

Staff should be deployed in ways that ensure people receive the right care, first time, in the right setting making the best possible use of local resources. This will include effective management and rostering, with clear escalation policies if concerns arise (NQB 2016) as well as effective system-level planning.

The literature review suggests that where there is inter-professional and inter-agency working such as joint community teams, collaboration and integration mechanisms need to be clear. Achieving safe and sustainable staffing in learning disability services requires a great deal of co-ordination over a long period. A care co-ordinator must also be a service navigator for the person, aware of potential pitfalls and service gaps as well as individual vulnerability during transition. Much of the clinical work with people with learning disabilities is delivered where they spend most of their time. This will vary.

Services should be centred on the person. Under the transforming care agenda, most service provision will be where the people live in the community. However, some specialist inpatient services will continue to be needed.

Many variations of service models, team structures and provider organisations are involved in delivering community-based learning disability services. Community learning disability provision is multi-agency and inter-professional across adult and children's services, and delivers a wide variety of services through integrated teams managed by local authorities, the NHS, third sector and private sector organisations, and family and carers.

Prevention role

Staff in NHS-commissioned learning disability services will be role modeling and teaching how to deliver person-centred healthcare and interventions. They will have a role in ensuring the wider workforce is skilled to take this approach. They will also provide some scrutiny of whether people's needs are being met. They must understand and invoke adult safeguarding processes where necessary to ensure safe and adequate support.

Capacity should be adequate for this preventive role to minimise avoidable cost of people re-presenting to higher dependency, into more restrictive services.

Capacity should also be sufficient to allow time to meet the accessible information standard (Section 250 of the Health and Social Care Act 2012). Staff interventions take longer than in other specialist areas due to this requirement. Our learning disability focus group highlighted this as important:

- "Doctors and professionals need to give extra time."
- "Talking and explaining things clearly, including changes for me."

Managing productivity in this context

Given the variation in place and provider of learning disability services, providers need to operate at a systems level to create a seamless and person-centred 'flow' across teams. It is essential that planning around each part of the pathway be carried out in relation to the whole system. People may enter the system at various points and require support across the whole system during their lifetime.

Agreed shared templates between organisations in the pathway will support transitions across boundaries.

Figure 2: Example of how people flow and transfers between teams

The diagram below represents the flow of service users through a complex system with multiple providers. Managing this flow effectively and productively will have a significant impact on the person's experience, clinical outcomes and costs. Poor management of the flow will create inefficiencies, poor experience and less effective clinical outcomes.
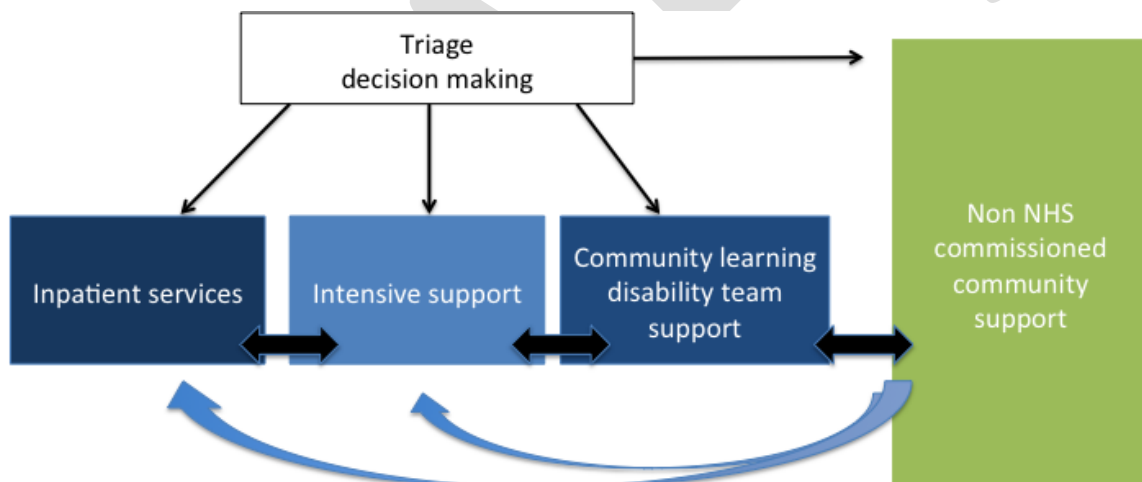
Cost and inefficiency increase when:

- triage is ineffective and people are referred to specialist services inappropriately
- people present back into NHS-provided services
- preventive work is lacking (reducing the capacity of carers and third sector providers)
- risk assessment is poor or inconsistent throughout the person's journey
- people have to wait for assessment due to lack of specialist staff
- there is ineffective transfer between intensive support teams and CLDT
- eligibility criteria are incorrectly applied or used in a risk-averse way

- relationships between the intensive support teams and CLDTs are poor
- partnerships are poor, communication inadequate and influencing skills limited in the wider health and social care system to respond to people's needs
- discharge rates from inpatient services to non-NHS providers are slow
- staff take an inflexible attitude to change in developing and delivering services
- systems and processes impede creative solutions
- medication reviews are infrequent
- inappropriate diagnosis is linked to inappropriate medication
- environment-specific issues increase specialing requirements (for example, poor building design creating dark or restricted visibility areas, layout of single sex accommodation resulting in shared corridors to access bedrooms and bathrooms)
- When people themselves and their family or carers are not actively engaged in the design and delivery of care.

Organisations should consider factors impacting on efficiency as part of the staffing reviews, ideally in alignment with the organisations operational and strategic planning process.

Costs increase and outcomes are adversely affected when reasonable adjustments are not made within mainstream services. (Appendix 9 outlines a statement for acute and other mainstream health services)

Using technology

Community services are most efficient when teams are agile and have appropriate technology to minimise travel and administration.

Technology can also be used within teams to review staffing levels to re-deploy staff based on changes in dependency and remote assessment monitoring.

Innovative technology such as motion sensors in corridors in inpatient facilities can be used to protect people and alert staff when there is a need (rather than having a member of staff always present).

8. Safe staffing dashboard

Given that NHS trusts provide a range of services and are configured in different ways, we recommend a framework approach to monitoring safe staffing levels rather than a prescriptive or standardised model. This also enables provider organisations to tailor their reporting and assurance process to reflect specialist services.

The staffing, people and process indicators suggested, are proxy measures to help organisations understand whether their services are safe. Organisations are encouraged to monitor them in combination rather than in isolation. Dashboards or balanced scorecards help do this systematically.

Measures that matter – safe staffing

Trusts can use several indicators as proxies of safe or effective staffing levels. Some are more reliable than others in that they are likely to be directly linked to staffing levels (eg planned leave not going ahead); others are more indirectly associated (eg length of stay, delayed discharge).

It is important to understand the combination effect of proxy indictors. Taken at face value, none of the indictors tells us much about staffing levels and the quality of care. However, they each prompt *'so what?'* questions that trust boards and ward or team managers may need to consider – particularly when consistent upward or downward trends occur across the suite of metrics.

NHS providers of learning disability services should use dashboards or balanced scorecards to ask 'so what' questions and use the answers to review the current context.

Examples of measures that matter

Potential staff-related indicators	Potential people-related indicators	Potential process-related indicators
Sickness; staff turnover; bank and agency/locum use Clinical supervision; essential learning; staff survey scores Inability to engage in wider agency meetings Training uptake Friends and Family Test staff Staff satisfaction survey Care hours per patient day	Restraint, physical/restrictive practice; Untreated conditions Length of stay; readmission rates Delays in transfer; occupancy levels; Planned leave going ahead Physical health presentations Access to therapy Unmet needs Incidents, complaints Levels of observations on wards People safety metrics redirection of referrals internally/teams placement breakdown undiagnosed dysphagia Access to activities Care Programme Approach compliance Experience data (feedback) (FFT) Safeguarding incidents	Complaints; waiting times Reporting of incidents; open learning from incidents; open learning from complaints Repeat and admission to hospital Tightening of eligibility criteria Waiting times Mortality reviews Increase use of 'when required' medication

Designated roles and responsibilities

To ensure board-level staffing reports are consistent with team-level reporting, providers should have a safe staffing framework setting out roles and responsibilities in relation to 'practice area to board-level assurance'. This

should include a locally standardised procedure for raising concerns about staffing; reporting positive or negative exceptions to planned staffing levels; and monitoring actual staffing levels. In particular, the roles and responsibilities of professional leads, team managers, matrons, service managers and directors should be clearly outlined.

Reporting frameworks

NHS providers report and monitor staffing levels in different ways. Regardless of which reporting systems are used, there should be a clear framework for monitoring how staffing resources are deployed at ward or team, and service or locality level. Those in designated roles should have access to a regular dashboard or balanced scorecard, which gives them a view of the services for which they are responsible. We recommend sharing the dashboard with the multidisciplinary team.

We recommend that trusts organise the dashboard or balanced scorecard 'view' at three levels:

1. **team or ward level –** this provides clinical managers with a local view of staffing levels and indicators at single team or ward level
2. **service, locality or network level –** this enables clinical leaders and service managers to monitor and systematically deploy staffing resources across multiple sites using a framework, which shows where demand is greatest, or risk is potentially highest; we advise a multidisciplinary approach, and reviews including people with learning disabilities are becoming more popular
3. **trust-wide level –** this provides boards with a whole-organisation view of staffing levels and indicators.

Assurance tools

Reporting and monitoring alone will not provide assurance that staffing levels are safe and sustainable, so it is good practice to use a range of mechanisms to cross-check data from dashboards or balanced scorecards. Like the staffing indicators, these mechanisms in isolation tell us little about the safety or effectiveness of care but in combination they form part of a systematic assurance framework. Such assurance mechanisms include:

- **walkabouts –** these enable team and ward managers, clinical leaders, service managers and executive directors to cross-check their understanding of the safety of staffing levels in teams or on wards based on dashboard or balanced scorecard views
- **exception reports –** these enable clinical leaders, service managers and executive directors to gain assurance that upward or downward trends on

dashboards or balanced scorecards are not compromising the safety or quality of care at team, ward, service or network level

- **acuity and skill mix reviews –** these enable team or ward managers to continually and systematically review whether peoples' needs are reflected in ward or team-level establishments.

- **person and family/carer feedback** – the engagement and inclusion of the person themselves and their family or carer can be of real value in understanding how the service feels for those accessing it and gaining ideas about potential improvements.

Shift questions

Information on effective delivery of services can be reviewed at a local level by asking staff questions at the end of their working day or shift. This is a technique used by Care Point – Care Capacity Demand Management (New Zealand). Examples include:

- I was able to complete all care and to a satisfactory standing without undue delay: Y/N.
- If no, was the deficit:
  - inconvenient to people
  - distressing to people
  - putting people at risk
  - resulting in harm to people.
- The degree to which I felt satisfied with what I achieved today was:
  - very dissatisfied, dissatisfied, satisfied, very satisfied.
- The amount of effort I had to put in to get the work done was:
  - easily manageable, about right, too high, exhausting.
- I was able to take all my breaks full length and on time.
- I came to work early to get my work done.
- I stayed after the end of my shift to get work done.
- One or more people suffered a harm incident today.
- One or more of my people had an unexpected clinical deterioration on this shift.

Collecting this data regularly allows providers to keep track of trends.

9. Conclusions and recommendations

This document is informed by a rapid review of literature, professional review and stakeholder engagement.

1. **We recommend that a set of 'always events' (minimum standards) be developed as guidance for inpatient and community learning disability services during 2017.**
2. Reasonable adjustments, mental capacity assessment and consent to treatment are important elements in safe and effective care for people with learning disabilities. We therefore recommend that healthcare providers collaborate with commissioners and acute hospitals to implement hospital communication passport and learning disability liaison nursing to ensure that appropriate reasonable adjustments are made.
3. While we are aware of the limited evidence available to support the effectiveness of work loading tools, we recommend that healthcare organisations supplement professional judgement with the use of evidence-based processes for managing staff deployment (Mafuba et al 2016)
4. Organisations should consider the contextual factors that affect the delivery of safe and sustainable services
5. Organisations should ensure that those involved in making staffing decisions have the necessary competencies and that such decisions are objectively reviewed.
6. Service users should be involved in the competency and values-based recruitment and development of staff.
7. Where there are inter-professional and inter-agency working arrangements such as joint community teams, providers should work together to provide seamless transfers with clear processes outlined and roles understood.
8. There should be liaison nurses as well as other professionals available to support people transferring to acute services, mental health inpatient admissions and close liaison with community teams.
9. Providers should monitor data on staffing unplanned care and develop a flexible, moveable, multi-skilled adaptable workforce from across the organisation to respond seven days a week to increased staffing requirements based on fluctuating need. Commissioners should consider the benefits of increased and flexible local funding to prevent expensive inappropriate out-of-area residential social care.
10. Providers should measure and improve areas of inefficiencies associated the poor flow of people through their services as part of their staffing reviews and ideally as an integral part of the operational planning process.
11. Providers should identify 'measures that matter' in making decisions

about safe and sustainable staffing and ensure there is a framework of multidisciplinary staffing reviews (eg floor/team-to-board reporting).

Areas for further research

There is a pressing need for robust evidence on sustainable safe staffing in learning disability services.

1. Research needs to focus on the context of care, relationships between sustainability, safety, effectiveness, efficiency and staffing levels, the models of service provision, and hospital communication passports.
2. The reliability and validity of current workload/multiplier tools for use in staff deployment decisions should be reviewed.

Appendices (supporting material)
(available from https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-learning-disability-services)

1. Summary of documents relevant to safe and sustainable staffing in learning disability services

2. Literature review

3. Strategic staffing reviews

4. Decision-making tools in learning disability services

5. Context of care tool

6.: Learning Disability Professional Senate professional roles outlines

7. Speech and language therapy roles

8. NHS England guidance for commissioners

9. Generic statement for other workstreams and mainstream services

10. Working group members (Including declarations of interest)

11. Stakeholders consulted