In Patient Services Quality Assurance Visit

Bradford District Care NHS Foundation Trust

Quality Assurance Visit In Patient Services Report

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This report describes our judgement of the quality of care provided by our inpatient wards. We based it on a combination of what we observed during the unannounced face to face visits and other information available to us from quality and performance dashboards, care plan audit and patient feedback. We have not scored our visits as we do for other Quality Assurance Framework assessments, as the specific focus for this process was to gain assurance around Closed Cultures.

Overall summary

How we carried out the assessment

Following World Mental Health Day, the BBC broadcast a Dispatches documentary, 'Hospital Undercover Are They Safe?' and a subsequent Panorama documentary, 'Undercover Hospitals: Patients at Risk.' The focus of both documentaries was to highlight gaps in patient safety on the wards and a systemic failure to protect some of the most vulnerable people whilst in Mental Health Inpatient Wards.

The Nursing and Quality Directorate responded to the documentaries with a series of unannounced visits to provide assurance of the quality and experience of inpatient care at BDCFT and to ascertain whether Closed Cultures exist within our services. The visits took place on 21st October and 4th November 2022.
A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones.

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CQC state that closed cultures are more likely to develop in services where:

- people are removed from their communities
- people stay for months or years at a time
- there is weak leadership
- staff lack the right skills, training, or experience to support people
- there is a lack of positive and open engagement between staff and with people using services and their families

In these services, people are often not able to speak up for themselves - this could be through lack of communication skills, lack of support to speak up or abuse of their rights to speak up.

The focus of the visits was to use the lines of inquiry defined by a closed culture to:

- seek assurance of patient safety,
- hear about the patient and staff experience, and
- seek assurance that staff are well led, trained and safe and thus providing a caring, therapeutic environment.

The visits took a compassionate approach and we asked for staff to be honest about their experiences. The Assurance Team explained on all visits that leaders had a shared responsibility to support the clinical teams to address anything that may need a resolution. The Assurance Team agreed to feed back the findings and take any actions away that may need the support of the organisation.

We carried out 12 unannounced visits to the inpatient wards over two nights. Three wards were not assessed as part of this process. The Assessment and Treatment Unit was visited on 4th November however, the staffing for the shift was completely utilised in clinical activity and there was no one available to meet with the team. Bracken Ward and Ilkley ward were not visited due to the number of leaders available to complete the visits within the short time frame. The outstanding wards will be visited in the coming weeks.

For the purpose of this report, the visiting teams are referred to as the Assurance Team. The Assurance Team took a decision to visit during the night shifts, acknowledging that the majority of senior leadership visibility is available during daytime hours and a considerable number of staff prefer to work night shifts via bank and agencies so have limited engagement with senior leaders.

The visits took place after midnight, after medication rounds, when the team felt there would be time and space to listen and learn.

The Assurance Team included senior leaders from the Nursing and Quality directorate and Clinical senior colleagues.

On 21st October, 5 teams of two met and then presented at Lynfield Mount reception and Airedale Centre for Mental Health, they then went to their allocated wards. This minimised disruption on the wards. There was one clinician with the knowledge of the wards as part of each team to assess assurance staff and patient safety. The wards visited were Fern and Heather at ACMH, Clover, Ashbrook, Maplebeck, Baildon and Thornton at Lynfield Mount. The Assurance Team were each given equipment to access the wards. There was no communication with the wards until the team actually arrived at the ward.

On 4th November 2 teams of two met and visited two wards each: ATU, Oakburn, Step Forward and the Dementia Assessment Unit. Due to clinical activity at the time of the visit we were unable to complete a visit on the ATU.

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Involvement Partners:

In addition to the night visits, Involvement Partners attended the community meetings on all wards to seek patient views of their care during the same two-week period.

Patient Records:

A random sample of 5 clinical records on each ward was audited to elicit the following intelligence:
- Quality of care planning in respect of Mental Health Act standards,
- Quality of Life documented in care plans, and
- Person Centred approaches and autonomy in care planning, safety, and risk management.

What we found

Overall Service

1. **Staffing:**

Across every ward on both visits, we consistently observed high numbers of staff available. Every ward was working with significantly higher numbers than their allocated base line rotas; this reflected the acuity on the wards. Staffing was in line with safer staffing levels, which is mapped against acuity. All wards had at least one qualified nurse with most areas meeting the full rota request of two registered nurses allocated per shift. We consistently observed skill mixes with a significant proportion of roles being undertaken by qualified agency and bank workers and minimal substantive staff. An example on one ward was:

9 staff on shift during the visit. The skill mix of the team was:

- 2 qualified agency
- 1 substantive Heath Care Support Worker (HCSW)
- 6 HCSW's mix of agency / bank and "regular bank / agency"

This skill mix was typical across all wards on all visits.

There were an increased number of observations being undertaken on every ward except for Step Forward centre. Staff were able to explain the rationale for increased observations and their role in the care plans of individual patients.

There were male and female staff on every ward, and a mixture of bank, agency, and substantive staff.

We consistently heard that despite the high number of agency and bank staff, most were regular staff to the ward, some having worked on the wards for over twelve months and some as long as two years. We also met staff who had worked for the organisation and left but had continued to work on agency or bank, stating they needed more flexibility than the Trust could offer. The proportion of bank and agency staff was significantly high compared to substantive staff. The staff we met reported they had their regular night workers, and this helped them to feel safe.

Staff said:

The majority of staff we spoke with were able to articulate the rationale for patient observations, requirements to remain on observations and documentation requirements when completed. They were able to explain what clinical information they needed to share when handing over every two hours to the next person.

Regular bank staff were seen as equitable to substantive employees. Some bank and agency staff reported they have the same level of responsibility, however, the support and training they have access to potentially differs from substantive staff. Other bank and agency staff said they had the same training and reported that BDCFT do not allow staff on to the wards without all of the mandatory training having been completed. There was a consensus that bank and agency staff do not get the same opportunities as substantive employees. Staff reported the high proportion of bank and agency was not an issue if staff are 'regular'. They described that is the most important thing as 'regular' bank and agency staff are familiar with the ward and can still do 'tasks' and 'allocation.'

Some staff reported that access to IT can be problematic, and there is inconsistency in skills of some regular bank and agency staff, reporting that some know how to document on the patient record, but some do not. All staff are trained on the use of SystmOne, this comment implied confidence to use the system of specific workers and not a training issue for the team members

Staff told us that the role of the Duty Senior Nurse can be a daunting for less experienced nurses, despite their grade, and some staff reported they had no support as they transitioned into the role and were being expected to fulfil the role without induction or supervision. They also reported they had escalated this concern, and it was managed with kindness and support by their manager.

We heard across all wards that staff like to know where they are working. They understood the reasons for moving people to manage wards safely, but said it destabilised them. Some said agency workers have left shifts when they are told they have to move, and so those who cannot say no get moved instead, this is usually the substantive staff team. This puts additional pressure on individuals. This was heard on every ward.

The Assurance Team Observed:

We consistently observed that the wards were still active at 1am, patients were up but engaged in calming interactions such as low lighting and had people sitting with them. All staff were friendly and welcoming, they appeared relaxed and caring when discussing their work on the ward. Staff were genuinely open and happy to see senior leaders, requesting that this becomes a regular opportunity. The teams felt cohesive, they were not flustered by an unexpected visit and all the wards felt calm and inviting.

We heard that the duty senior nurse (DSN) role can often be compromised. On both nights we visited, there were registered nurse roles that had been cancelled. This meant the DSN then had to be included in the numbers on the ward, which limited the role when offering support to teams. The teams reported that this happens most nights.

One of the duty nurse for the evening was a band 5 nurse. They reported that lately they had frequently been put on the rota as duty nurse. They explained that if agency nurses have to carry out the duty nurse role, they are paid at band 6 but substantive staff are just paid at their regular banding. Staff told us that although the DSN should be a band 6, due to staffing issues it can regularly be filled by a band 5 practitioner as there are gaps at band 6. The nurse we spoke to said they enjoyed being a band 5 nurse and didn't want a band 6 role.

Staff said they could see the pressure cascading down as everyone at all levels picks up roles above their banding. The staff articulated that there is a risk we will lose substantive nursing staff to agencies if there are greater incentives for them to work in this way. All agency nurses we spoke to said they chose to work for agencies for the flexibility it gives them, and nurses reflected on this being a direction they are seeing a lot of nurses going.

In terms of challenges, the registered nurses described the difficulties if there is only 1 nurse on the ward overnight. Examples provided included the signing for controlled drugs requires 2 nurses. They also told us that the emotional support is impactful. All nurses stated when there are 2 nurses working, they are able to respond promptly and feel more relaxed. Many people spoke positively about the on-call doctor and how responsive they are.

2. **Safety, feel of the ward:**

Staff were asked if they felt safe on the ward and what it was like to work there.

Staff said:

All staff said they felt safe and equipped to do their job. They reported feeling safer when the shift is made up of regular staff and they acknowledged this must feel better for patients too. One team reported there are times when the ward has been short of staff which can cause it to feel unsafe. They told us this gets reported and staff are moved around to keep it safe. Staff consistently told us that when there is a mix of staff who are not regular, it feels more challenging as there is a lack of understanding of colleagues' capabilities and how they work.

Most staff stated the reason they returned to work each shift was because of the "team." The staff consistently told us that everyone works well together and gets involved on all wards. One staff member said BDCFT had felt disorganised in the past and they did not want to work here compared to another Trust they had experience of. However, having returned back to BDCFT [mainly for the locality] they let it had improved and is more organised now.

Staff on bank and agency resoundingly explained they preferred this contract due to flexibility, they were able to do permanent nights and achieve a work life balance with education and family. They all said this flexibility was not available for substantive staff. They reported that feeling valued and receiving acknowledgement for doing a good job is really important to them. Some reflected this does happen, others felt it didn't happen as much as it should. Most said they didn't see their leaders to get any feedback. This implies an inconsistent acknowledgement from leaders to bank and agency workers.

The Assurance Team Observed:

The impact on staff demonstrated that closed cultures work needs to extend beyond nursing staff and staff on shift. Understanding of each other's roles and responsibilities across disciplines is important and an awareness of how behaviours impact others needs to be a priority. The conversations demonstrated a mixture of responses, and whilst there were lots of positive comments, it seemed apparent that how staff feel in terms of being valued and safe is not consistent.

3. **Patient Experience:**

Staff were asked about the opportunities for patients, and a series of questions around autonomy, care planning, activities and engagement on the wards.

Staff Said:

Staff on all wards stated that debriefs are offered to patients and staff following incidents on the ward. They described how in terms of staff debrief they are often supported by ward psychology and can access further follow up sessions where needed. They also described how this can be inconsistent at times depending on clinical time and activities on the wards. Teams were aware of the Critical Incident Stress Debrief meetings when a serious incident occurs.

We were told that restrictive practices are discussed during shift handover, which is attended by all of the incoming team. Some staff spoke more eloquently than others and there were discrepancies about the understanding of blanket restrictions. Some staff were not aware if they had any on their ward, whilst others were clear about the process and communication.

We observed a variation in length of stay on all wards, from 1 day to the longest current stay on the ward of over 11 months. The extended stays were attributed to social issues such as housing. All teams had an up-to-date Purposeful In Patient Admission (PIPA) board which contained good clinical intelligence and was clearly acting as a prompt to ensure clinical activity was updated daily.

Staff spoke about the range of activities and activity spaces available to them. They showed a good understanding of the preferences of their service users and there was an activity co-ordinator on each ward. Staff told us that each day tends to be planned in the morning service user meeting where people choose what they would like to do. Staffing issues can sometimes impact on the ability of staff to support patient to go off the ward to do activities.

Staff on all wards reflected that visiting for friends and families had been limited due to the covid-19 pandemic. They talked about the alternatives used during that time, such as the use of phones and video chats. Staff told us that patients and staff were pleased about the opening up of the café and canteen on the ACMH site. Many staff described how patients prefer to leave the ward for visits with family and friends.

The Assurance Team Observed:

There was good evidence of care planning and person-centred approaches through the Systm1 care plan audit. There were inconsistencies in daily meetings on the wards to plan daily activities. Staff told us this depended on the Activity Coordinator to organise.

4. **Training and supervision:**

Staff were asked if they felt they had the right training and supervision to support them in their role.

What staff said:

Staff said that permanent staff get access to supervision and training, but there is no supervision for bank or agency staff. If staff are involved in or report an incident, someone will contact them to discuss this, but they told us that is usually by email.

Bank and Agency Staff told us that they did not get invited to team meetings and were not offered clinical supervision or management supervision. Opportunities for education, training and development were reported to be limited for bank staff and non-existent for agency workers.

All staff told us that they felt equipped for working on the ward but acknowledged that there was inconsistent awareness of the skills required to complete roles on each shift. However, on further investigation, all registered staff knew what was expected of them. Wards appeared to have good allocation of roles against skill sets. This was tested out by exploring who responded to alarms and if staff knew who was Intermediate Life Support (ILS) and Basic Life Support (BLS) trained on shift. Substantive and Bank workers reported it was difficult if staff had not been trained in BDCFT Management of Violence and Aggression (MVA) the training provided by agencies has some different techniques taught, although they are minor anomalies.

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The Assurance Team Observed:

It was apparent that staff were committed and wanted to develop, learn, and access training for progression. However where they choose to work on bank or for an agency for the flexibility people are placed in a difficult position with limited choice as they are not supported to have both.

5. **Leadership:**

Staff were asked if senior staff are visible on the wards and whether they felt they were being led by example and aware of changes/activity in the Trust.

What staff said:

Staff said there was a lack of senior visibility at night. Those people who worked rotational shifts stated there were senior staff present during the days. Staff highlighted the high number of senior staff on the wards who are perceived to have limited experience in terms of years in the job. The views of staff were that this needs to be harnessed and valued.

Agency Staff told us they felt they should be recognised and supported when they are motivated and enthusiastic and be given the same support as their permanent colleagues specifically in terms of management and clinical supervision. Staff told us that equitable access to training and Employee Health and Wellbeing support should be given to agency workers as permanent staff..

Assurance Team Observed:

There is a clear disparity between the level of senior leadership accessible during night shifts compared to days. The impact of this is that staff on nights report feeling less valued, do not have as much opportunity to access supervision and have fewer opportunities for learning and reflection. All staff were very keen to speak with us and were grateful that we were there to listen to them, which emphasises that they do not normally get this opportunity. All teams reflected they would appreciate more opportunities for night staff to meet with senior leaders.

6. **Incidents, Complaints and Learning:**

Staff were asked if concerns are recognised and acted upon and whether debrief/support is offered after incidents

What staff said:

Staff consistently said they were aware of how to report incidents and didn't have any direct issues; however they felt that learning and support could be improved with regular contact with senior staff and regular supervision. Some staff told us that in the past involvement in investigations was long with little feedback and staff were left not knowing what was happening, which they found difficult. However they also told us that recently there have been improvements in this and they have felt supported and been kept up to date.

Staff told us that if bank staff have been named in an incident report (IRE), they are now contacted by the staff bank team. Some staff told us that they felt this offered good debrief and support, however others felt less supported and told us that they may be asked if they are ok but not much else afterwards.

Agency staff reported the immediate response on shift by the team following an incident was consistently stated to be very good and very supportive, however we were told that there is no formal follow up or debrief offered after that by managers. Critical Stress Debrief is offered after every serious incident but this is not offered outside of that process. Some staff told us that in other organisations bank and agency staff get support from clinical leaders even when working for the agency they report this does not happen in BDCFT.

Staff told us that the cumulative impact of incidents is not addressed and that low-risk incidents reported on an IRE do not get acknowledged. People reported that they could have been on several shifts with lots of incidents and these are not looked at in terms of the overall impact on wellbeing

Staff told us that support and debrief was reserved for 'serious' incidents or those with a moderate plus level of harm. They described how facing regular near miss/low harm (e.g., violence and aggression, verbal abuse) on a regular basis sometimes had just as much or more impact on their wellbeing.

The experience of racial abuse towards staff members by service users, particularly from service users who presented with capacity, was raised across many wards. There was a feeling from staff members that although they were encouraged to report incidents to the police, there was little in the way of action taken and more support could be offered to them by the trust post incident.

Staff talked about the importance of being recognised if they received a compliment. They told us that when staff have had this recognised in BDCFT this adds to them feeling valued. Staff spoke about being professional and respected and how the need for kindness impacts on how they work and treat their patients.

The Assurance Team Observed:

There was inconsistency across the staff group relating to the level of support and debrief offered following incidents. This varied depending on if staff were agency, bank, or substantive. This is an area that needs some development to understand how the good examples could be mirrored across all staff groups and wards.

We observed the importance of a consistent response to the raising of incidents and the impact this had on staff wellbeing. We saw that staff could be equally impacted by multiple low level harm events as much as by a more significant but singular event but that this was not consistently recognised in the way leaders supported their staff.

7. **Care planning and handover:**

Staff were asked if they felt confident with the information from the handover and able to direct the shift.

What staff said:

Staff told us that handovers happen at the start and end of every shift and include safety and risk discussions. Staff were able to tell us about PIPA and daily huddles, but many told us they didn't actually attend them, stating this is just for the senior clinical team. This was typical across all of the wards.

Staff reported that occasionally information gets missed during handovers but that it was better than it used to be and is more focused. Staff reported anyone joining the shift late gets a briefing in the office rather than joining halfway through to ensure they receive the full handover. Some staff felt the handover wasn't long enough to accommodate the high number of service users and high level of risk and needs. Staff were well briefed on their roles relating to increased levels of observation, and this was typical across all wards.

The Assurance Team Observed:

Staff were confident they had the right information about their patients to work safely, however the possibility of rushing due to time constraints raises a question about how thorough that information might be. This was tested out and people could articulate their role and the reasons for increased observations. They were able to articulate who was at increased risk and why, what their role was and what to report to the Nurse in charge. Some staff said they would benefit from longer handover

8. **Improvements to make this the best ward to be/work:**

Staff were asked what they would do to make the ward better.

Staff Said:

Staff resoundingly shared the need for regular staff who knew the wards and the patients. They cited improved therapeutic relationships and improved patient engagement when there is a consistent workforce, making the ward easier to manage and keeping patients safe.

The high use of bank and agency were not deemed a patient safety risk if they were regular staff. The concerns arose when they weren't regular workers. Bank staff spoke about support and equal opportunities for development for regular bank staff e.g., Open university nurse training / band 4 associate practitioner roles. The teams spoke specifically about retention of staff and avoidance of burnout if the Employee Health and Wellbeing (EHW) and support is right. All staff said knowing who they are working with makes them feel safe, and this has a positive impact on the patients.

Some agency workers stated that access to SystmOne to review and complete documentation can be an issue and some said they were told they should sort this for themselves when on shift. They told us how this can be difficult if they didn't know the systems and the IT teamwork in daytime hours. Some staff felt others avoided getting access to SystmOne to avoid having to complete documentation and that this makes the balance on shifts unfair. They also raised concerns about whether records were accurate and reflective of what had happened if there was only one nurse completing records. All staff felt the access to SystmOne for all staff on shift is essential to improve how it feels to work at BDCFT and for patient care.

Staff told us they would feel more valued and able to fulfil their role if they had access to regular clinical supervision and additional training opportunities

The Assurance Team Observed:

There was a positive attitude from staff and some good suggestions for improvement.

9. **Service User Feedback:**

The Involvement Partners attended a series of community meetings (during the daytime) on the wards and asked question around five areas:

- Feeling safe,

- Caring environment
- Respectful team,
- Effective care and experience and
- Well led wards.

Visits were planned for all 13 wards in the two-week timeframe, however due to a variety of reasons, including Covid outbreaks and disruption on the wards, only 5 wards engaged in the process. The number of respondents ranged from three to five people.

Patients Said:

Most people said they felt safe on the ward. Many said the staff are overworked and don't get time to sit and chat. Many people were concerned about the wellbeing of the staff team. People were happy with the cleanness of the ward. They were complimentary of the food, stating it was better than other hospitals, however, they said that the menu doesn't change and is on a three-week rotation. One person said there were not enough healthy options on the menu.

One person said he didn't feel safe on the ward and described overhearing people in the courtyard speaking about how changes need to happen on the ward, and that they are unhappy about the ward. Another patient stated at the morning meeting when the ward manager attended that this was unusual and implied it was because there were visitors on the ward.

One person described being restrained and how the restriction had made him feel intimidated and 'ganged up on.' He could not recall having a debrief following the incident.

Patients engaged in the conversations with Involvement Partners. The majority of people said they felt safe, they received good care and had been involved in planning their care. Most people knew how to make a complaint, and some spoke about advocacy. People knew about Mental Health Act sections and were able to speak with their named nurses if they had concerns. People enjoyed using the facilities with the Occupational Therapists and also the café and canteen at ACMH, where some people had visitors. Some patients spoke positively about being supported in their discharge plans and felt confident about their discharge.

People knew about their rights and said that staff were respectful and caring. People said they got an opportunity to have discussions with their named nurse, however some said it wasn't enough. People said they like the community meetings and some people said they would like them to happen more often.

Involvement Partners Observed:

A music therapy session was taking place; people said they thoroughly enjoyed these sessions and enjoyed listening to different genres of music that people choose. The therapist was observed to really engage with the patients in the sessions and the Involvement Partner stated it was the first time all morning they had seen patients coming together and having a good time. During the session, all patients were in good spirits and were singing, laughing, and joking between one and another. It was a very relaxed and calmed environment. The session started with 1 or 2 patients and by the end of the session there were 4 patients present.

Another Involvement Partner observed respectful engagement between staff and patients. He said the ward was very friendly and welcoming and he was introduced to several patients. The general impression obtained by the involvement Partner was that patients were well treated on the ward and were allowed to have reasonable boundaries of personal freedom (for example one patient was allowed to carry a radio around with him for personal use). Patients reported very positive feedback and the Involvement Partner said he would like to come back and work on the ward in future if possible.

At the coffee morning in the activities room the Involvement Partner was impressed by the facilities and the way the occupational therapist and physiotherapy staff engaged with patients. They were playing pool and card games together and it seemed to be a good ward.

10. **Patient Record Audit:**

A review of individual records on SystmOne was completed for all thirteen inpatient wards. This focussed on:
- The individual's health and wellbeing,
- Mental Health,
- Quality of life,
- Discharge planning,
- The person, personalisation of their care and treatment plans,
- Safety, and
- Whether people's rights are being upheld and promoted.

Method: Five sets of notes where randomly selected from each ward. 65 sets of notes were reviewed in total.

Assurance rating: Full assurance 100% significant assurance 90 – 99%, moderate assurance 61- 89%, limited assurance 40 – 60%, no assurance < 40 %.

Summary of findings: From the 65 records audited there were no potential breaches identified.

Full assurance 100%:
- All wards have access to independent advocacy support.
- For those people in hospital where they have an extended admission there is evidence of MDT working to identify solutions to meet their needs and promote discharge.
- There was no evidence of segregation in the records reviewed.
- Informal patients were permitted to leave the following in line with the policy.
- Person centred approaches were evident in the record.
- Blanket restrictions are reviewed, monitored, and documented on care plans.
- Learning Disability services (LD) are fully implementing 'Stopping Over Medication of People with Learning Disabilities (STOMP).
- There was evidence of reasonable adjustments being implemented to meet mental health needs.
- There was evidence of regular medication reviews involving the person and MDT.
- 100 % of all recorded incidents of abuse on the wards had been discussed with Safeguarding.
- Older peoples and LD service provided good practice examples of people being supported to stay in touch with their relatives and carers.

Significant assurance:
- People were encouraged to participate in meaningful activities.
- 98% of medical interventions were carried out in the least restrictive manner appropriate (1 record of no offer of oral medication prior to IMI medication given under restraint).
- 98% of Care plans and Risk assessments were regularly reviewed.

- 94% of patients had their Rights Read under the Mental Health Act (MHA) or informally.
- 92 % of Care plans included discharge planning (noted 8% of acute wards did not include).
- 92 % of Consent to Share Information were completed or Mental Capacity Assessment (MCA) to ascertain capacity to make this decision.

Moderate assurance:

- 82 % of people were involved in the development of their care plans.
- Peoples care plans are personal but do not always seem to show their choices or decisions. Care plans should include what gives the person joy or meaning in life, this wasn't seen consistently.
- 71 % of people's assessment of capacity to consent to care and treatment had been certified by their Registered Clinician (RC).

11. **Recommendations:**

- Regular random audits of patient records should be carried out against the Closed Culture key lines of enquiry
- The trust should conduct an audit of debrief following patient restraint to gain wider assurance of the process
- The Trust should audit the quality of daily ward meetings, and community meetings
- A programme of night-time visits should be organised across a 12-month cycle to develop leadership visibility and ensure that closed cultures are not developing
- The Trust should conduct a review of supervision and support for Bank and Agency workers
- The Assurance Team should hold feedback sessions with the participants to demonstrate they have listened
- A business case is currently being developed to support the introduction of a senior leader on every night shift. This should continue.
- The Trust should review current staffing contracts and consider all flexible options including night contracts to support recruitment and retention to substantive posts.
- The Trust reviews how it supports staff experiencing low level harm from incidents with specific regard to how the cumulative effect of this is identified and mitigated.