Mental Health Nurse Academics UK

Mental Health Nurse Academics UK not reassured by CNO's letter on safe staffing

It is with some irony that the day after Jane Cummings, Chief Nursing Officer for England, attempted to reassure nurses on the safety and quality of NHS staffing[1], the Care Quality Commission report on crisis mental health care *Right here, right now*[2] concludes that "local providers and commissioners have to ask serious questions about whether the services they provide are safe".

The CNO's letter conflates safe staffing in mental health areas with multidisciplinary working and skill mix. This is a dangerous misunderstanding, particularly in acute mental health care where the professional status and specialist skills of staff are of paramount importance to safety. Of the professions the CNO lists as contributing to mental health care, we need to remind her that it is *registered mental health nurses* that have the main responsibility for the 24-hour, direct care of patients and service users. In addition, several of the "professions" she lists – healthcare assistants and activity leaders, for example – while important and valued members of the multidisciplinary team, do not have the necessary training and specialist skills for dealing with mental health crises. Devaluing the skills of mental health nurses is another irony given that we would expect our Chief *Nursing* Officer to be speaking up for *nurses*.

The CNO stresses that the decision to shift the work on safe staffing away from NICE is not about saving money yet the available evidence over the past few years suggests that costs do outweigh safety, otherwise we would not be seeing, from 2010-14, an 8% reduction in, and the downgrading of, qualified mental health nursing staff in England while there has been a concomitant 10% increase in mental health detentions over the same period[3].

Mental Health Nurse Academics UK is neither reassured by the CNO's letter nor is it confident that the Mental Health Taskforce will provide guidance on safe staffing that has the same degree of authority or independence as NICE, particularly since there is little detail about how the Taskforce intends to carry out this work. We agree that more research is needed into safe staffing in mental health areas but emerging evidence from the Care Quality Commission[2,4], the Royal College of Nursing[3] and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[5] suggests that many mental health areas are not safe *currently* and consequently action is needed *now* to ensure – as the CNO so confidently proclaims in her 6Cs manifesto – that "we have the right staff, with the right skills in the right place"[6].

The Francis Inquiry into events in Mid-Staffordshire[7] – the driver behind the current safe staffing and quality of care agenda – explicitly linked poor leadership, staffing policies and an overemphasis on costs to inadequate standards of care. Two years on, there is yet another irony in that a national nursing leader's letter purportedly focussing on the quality of care and bemoaning a lack of evidence for safe staffing appears to have conveniently sidestepped significant evidence of the causes of one of the biggest scandals ever to have affected British healthcare.

1. Cummings J. Ensuring the NHS is safely staffed. Letter to Directors of Nursing and other stakeholders. 11 June 2015. www.england.nhs.uk/wp-content/uploads/2015/06/cno-safe-staffing-letter-stakeholders.pdf

2. Care Quality Commission. *Right here, right now: People's experiences of help, care and support during a mental health crisis*. 12 June 2015. www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf
3. Royal College of Nursing. *Frontline First: Turning back the clock? RCN report on mental health services in the UK*. November 2014. www.rcn.org.uk/__data/assets/pdf_file/0004/600628/004772.pdf
4. Care Quality Commission. *Chief Inspector of Hospitals recommends Norfolk and Suffolk NHS Foundation Trust should be placed into special measures following Care Quality Commission inspection (press release).* 4 February 2015. www.cqc.org.uk/content/chief-inspector-hospitals-recommends-norfolk-and-suffolk-nhs-foundation-trust-should-be
5. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). *In-patient Suicide Under Observation*. March 2015. www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/ipobsreport.pdf
6. NHS England. How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability. November 2013. www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
7. The Mid Staffordshire NHS Foundation Trust Public Inquiry (Chair R Francis). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary*. January 2013. www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf