Leicestershire Partnership NHS Trust

Safe Staffing Policy

To outline a clear escalation process from frontline staff to board describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift/community team.

Key Words:	Safe staffing, Establishment Reviews, Acuity and Dependency, nursing staffing levels, roster management, Escalation process, Tipping points and Thresholds	
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Adopted by:	Trust Policy Committee	
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Name of responsible Committee:	Strategic Workforce Committee	
Please state if there is a reason for not publishing on website	N/A	
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Expiry date:	1 June 2024	
Target audience:	All staff involved in safe staffing on in-patient's wards and community-based nursing teams	
Type of Policy	Clinical *X*	Non-Clinical *X*
Which Relevant CQC Fundamental Standards?	CQC Regulation 18 Providers must provide sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (Description change and amendments)
Version 1	05/05/2022	

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1.0 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

1.1 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

2.0 Definitions that apply to this Policy

SOP	Standard Operating Procedure
NIC	Nurse In Charge
Planned	Established number and skill mix of staff per shift
Acuity	The measurement of the intensity of nursing care required by a patient
Dependency	The degree of patient dependency in relation to nursing care
DRA	Dynamic Risk Assessment
CHPPD	Care Hours Per Patient Day
OOH	Out Of Hours
OPEL	Operational Pressure Escalation levels
Establishments	The term used to describe the number of whole-time equivalents funded in the area, detailing the number of staff required per band for each shift. Includes an uplift (headroom) to cover Annual leave (AL), sickness, maternity pay, study leave and is individual to each ward/service/ community team
Skill Mix	Staffing levels of both registered and un-registered staff benchmarked against acuity and dependency scoring. Skill-mix is also conceptualised in three ways to mean: (1) the range of competencies possessed by an individual healthcare worker; (2) the ratio of senior to junior staff within a particular discipline; and (3) the mix of different types of staff in a team/healthcare setting
Competence	A bringing together of general attributes – knowledge, skills and attitudes. Skill without knowledge, understanding and appropriate attitude does not equate to competent practice. Thus, competence is 'the skills and ability to practice safely'
Delegation	The transfer to a competent individual, the authority to perform a specific task in a specified situation that can be carried out in the absence of the registered practitioner and without direct supervision

3.0 Purpose of the Policy

3.1 The purpose of this policy is to provide clear guidance on the Trust safe staffing standards to maintain safe and sustainable staffing levels in all our clinical services. This includes when and how clinical services review their budgeted establishments to ensure their staffing levels meet the needs of our patients and their families/ carer's.

3.2 It will also set out steps to be taken on our clinical areas where staffing levels are not adequate and or the planned staffing levels are insufficient to meet the patient's care needs safely and the escalation required to ensure clear decisions are taken to keep patients and staff and actions to mitigate the risks.

3.3 The policy supports and guides the operational management and deployment of nursing staff daily to ensure there is the right number of staff, with the right skills, in the right place to deliver safe and effective patient care. Safe staffing can be complex and takes account of multiple factors; patient acuity and dependency and skill mix as well as numbers.

3.4 The Developing Workforce Safeguards (2018) Clearly outline the requirements for all trusts with in-patient beds to publish their staff fill rates (actual versus planned) in hours, taking into consideration day and night shifts for both registered and non-registered staff. This information appears on the NHS choices website and the trust website.

3.5 Ensure each in-patient ward meets the required standards to publicly display staff numbers on a shift-by-shift basis, with 'welcome to the ward' boards being updated at the start of each shift by the nurse in charge. This should detail the nursing staffing numbers for the day and night shift.

3.6 This policy uses the term 'Nursing staff in order to achieve mandated safe staffing levels and patient to registered nurse ratios. The trust also considers Allied Health Professionals (AHP) and /Multi-disciplinary Team (MDT) members who are contributing to care delivery within the rotational shift pattern and as reported nationally in our monthly safe staffing reviews. (For the purposes of this policy both will be considered in the context of safe staffing)

4.0. Summary and scope of the Policy

4.1 This policy applies to all *Ward and community-based nursing teams*

Executive Director of Nursing, Allied Health Professionals and Quality	Accountable for • Ensuring that staffing levels are adequate to meet the needs of patients on each shift to assure the Trust board as to the safety of staffing levels. • Providing professional and strategic leadership to all nursing and AHP staff. • For ensuring that review of establishments is reviewed as set out in the NQB guidance • Ensure that establishments are safe, appropriate and in line with national benchmarks. • Presenting the findings and of establishment reviews to the Trust Board on a six-monthly basis.
Deputy Director of Nursing	Is responsible for • Ensuring that there are processes in place to maintain appropriate safety and quality for patients. • Provide professional and strategic leadership to all nursing staff. • Ensuring there is a process in place to support the review of clinical team's establishments and in Trust policy. • For Co-authoring (with Associate Director of Nursing and Quality) the 6 monthly board report and ensuring the content is reflective of establishment reviews which have taken place. • Supporting and deputising for the Director of Nursing, AHP and Quality
Heads of Nursing/Heads of Service/Associate Directors	Are responsible for • Ensuring that all wards/community teams within their directorate are safely staffed and all risks minimized • Ensuring that the Director of Nursing/Deputy Director of Nursing are informed of any actions to mitigate staffing risks • Ensuring that staff are deployed flexibly to meet patients' needs as required in support of Ward Managers/ Team Managers • For ensuring that establishment reviews have sufficient senior managerial and clinical oversight to validate the findings and implement changes as required and to submit to Director of Nursing for review and approval.
Deputy Heads of Nursing / Clinical Operational Managers/ Clinical Services Managers	Are responsible for • Ensuring all wards/teams within their service lines are safely staffed, and that all risks have been minimised and ensure the directorate Head of Nursing is informed of any staffing risks/mitigations • Ensuring that establishment reviews are undertaken and reviewed six monthly together with ward sister/Charge nurse and Matron

	• For coordinating the review process for their clinical area of responsibility and to ensure that anyone who has a delegated role within the review is clear about their responsibilities and is competent to undertake the role. • Are responsible and accountable for the day-to-day monitoring and deployment of staff within their clinical area to meet patients' needs
Matrons/ Ward sister /charge nurse and Operational Team Managers	Are responsible for • And accountable for the provision of safe staffing levels to meet patient needs and service demands. • assessing the factors that determine nursing staff requirements using a systematic approach when setting the establishment reviews in conjunction with the Matron and Deputy Head of Nursing • Ensuring that establishment reviews are undertaken in keeping with the standards and timelines as described within this policy. • Coordinating the review process for their clinical area of responsibility and to ensure that anyone who has a delegated role within the review is clear about their responsibilities and is competent to undertake the role. • The day-to-day monitoring and deployment of staff within their clinical area to meet patients' needs
Nurse in Charge	Are responsible for • reviewing staffing levels at the start of a shift for both the actual shift and oncoming shift. • Where the planned staffing levels are not in place and/or the planned staffing levels are insufficient to meet patient needs due to increased acuity and dependency The shift will be RAG rated using the thresholds and tipping points. As per daily operational staffing review in conjunction with Ward sister/charge nurse/ Matron /team managers. Have a responsibility to contribute to the review of establishments. Are responsible for working flexibly to meet patients' needs and for raising any safety issues which may arise from staffing levels

4.2 This policy applies to nursing safe staffing levels across Leicestershire Partnership NHS Trust. including

- Planned nurse staffing levels e.g., roster management
- Thresholds and Tipping points
- Process for monthly review of nursing safe staffing
- Process for bi-annual review of nursing establishments
- Daily operational review, RAG rating and actions to mitigate risks
- Clear escalation process from Ward to Board

4.3 This document sets out the Trusts policy and clear guidance on the standards expected to maintain safe and sustainable staffing levels in all our in -patient wards and community nursing services. To ensure that area's that are at risk of falling below the planned safe staffing levels are identified utilising associated thresholds, tipping points and professional judgement and mitigation is implemented at ward, service, and directorate level. It also outlines a clear safe staffing escalation process for each directorate to implement and follow, supporting the operational management of nurse staffing levels daily to ensure there is a safe and consistent approach across the trust.

4.4 This policy also includes when and how our clinical services review their budgeted establishments to ensure their staffing levels meet the needs of our service users and their families/carer's.

5.0. Introduction

5.1 This policy has been developed in reference to the safe and sustainable staffing framework - 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place and the right time: Safe Sustainable and productive staffing, published by the National Quality Board (NQB) in July 2016 and NHS Improvement Developing workforce Safeguards (2018).

5.2 Both documents clearly outline the framework, expectations and recommendations required for safe staffing and workforce decisions and assessment of trusts compliance utilising the 'triangulated approach' to deciding staffing requirements.

5.3 LPT is committed to ensuring our service users receive high quality compassionate care and to ensure this is achievable there must be the right number of staff, with the right skills in the right place at the right time.

5.4 Nursing, Allied Health Professionals and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality compassionate care and excellent outcomes for patients and service users. There are established and evidenced links between outcomes and whether organisations have the right people, with the right skills, in the right place at the right time.

5.5 LPT have a number of mechanisms in place to ensure our in-patient wards and community teams are safely staffed to support safe and effective patient care the following principles support this expectation:

- The safety and well-being of patients and the health and wellbeing of staff is paramount, the Trust requires staff to work flexibly to meet these needs, within their scope of professional practice.
- All staff working on in-patient wards should ensure they use the Trust e-rostering system to enable the safe and efficient use of staff to meet service need.
- Annual Establishment Reviews must take place with a 6-month review for all inpatient wards and yearly for community teams using a triangulated approach the outcome being reported to Trust board. Establishments describe the number of whole-time equivalents funded in the area, detailing the number of staff required per band for each shift, including an

uplift to cover annual leave, sickness, maternity pay, study leave and is individual to each ward/service/ community team.

- Staffing levels will be reviewed on a minimum of shift-by-shift basis which will be undertaken by Ward Sister/Charge Nurses/Clinical operational managers/community team leaders and/or Matrons, Clinical Nurse Managers, Clinical Service Managers and Heads of Nursing (where staffing concerns escalated to ensure safety and effectiveness)
- Where concerns about safe staffing are made, we have a duty to investigate, respond and resolve in a timely way to maintain safety and provide feedback to those raising concerns.
- Weekly safe staffing meetings are held with Deputy heads of nursing, Workforce and Safe Staffing matron, Assistant Director of Nursing and Quality, workforce, and HR colleagues to exception report and forecast the oncoming week, mitigate, and escalate updates to Director of Nursing and AHP
- Monthly review process to monitor staffing levels are in place to publish in patient fill rates (externally to NHS England and Improvement and on the NHS choices/LPT's website) and reported to trust board bimonthly. Six monthly safe staffing reports including establishment reviews are also reported to trust board.
- Safe staffing measures are aligned to local managerial knowledge and Directorate operational management process of bronze, silver, and gold command across the trust. This is in addition to daily Operational Pressure Escalation Level (OPEL) reporting.

6.0 Daily Operational staffing review table(s)

6.1 The Nurse in Charge/community team leader is responsible for reviewing staffing levels at the start of a shift for both the actual shift and oncoming shift. The shift will be RAG rated using the thresholds and tipping points.

Level of Risk	RAG rating	Thresholds/Tipping Points	Actions to mitigate risk
Low Risk		• Planned staffing levels met • Ward teams are managing workload and associated patient acuity and dependency. • Minimum of two LPT employed registered nurses (substantive or bank) on shift.	Sudden changes in acuity and dependency are escalated by the NIC to the Ward Sister/Charge Nurse/Matron or On Call Manager Out of Hours (OHH)
Moderate Risk		• Planned staffing levels not met (less than 80%) • Skill mix is not met (less than 80%) • Increased patient acuity and dependency	• Ward Sister/Charge Nurse to work clinically • Matron or On Call Manager to review staffing levels and patient acuity and dependency across the

Level of Risk	RAG rating	Thresholds/Tipping Points	Actions to mitigate risk
		• Increased number of patients requiring increased levels of therapeutic observation or specialling • Greater than or equal to 50% of registered nurses on shift are employed by LPT • Increase in harms associated with Nurse Sensitive Indicators • The ward can be managed using the reduced staffing available •	service to identify staff who can be deployed to support area • Dynamic Risk Assessment (DRA) to be completed and discussed with Matron, On-Call Manger and Lead Nurse for an off-framework request • Staffing review with AHPs and other Ward based staff to identify patient care support
High Risk		• Planned staffing levels not met (less than 50%) • Skill mix is not met (less than 50%) • Only one registered nurse on shift (NICE Red Flag) • More than 50% of nursing staff are temporary workers • Serious Incident associated with Nurse Sensitive Indicators • Increased patient acuity and dependency	• Ward Sister/Charge Nurse and Matron to work clinically • Matron, Lead Nurse or On Call Manager to review staffing levels and patient acuity and dependency across the service to identify staff who can be deployed to support area • Staffing review with AHPs and other Ward based staff to identify patient care support • Consider taking staff off shifts following day and bring into work to cover the gap. • Request staff to start a shift early or finish a shift late. • Consider reviewing any planned admissions if patient safety is compromised • Liaise with Community teams for support • DRA to be completed and discussed with Matron, On-Call Manger and Lead

Level of Risk	RAG rating	Thresholds/Tipping Points	Actions to mitigate risk
			Nurse for an off-framework request
Unmitigated High Risk		High risk that has not been mitigated. Deputy Head and Head of Nursing to investigate and review	Such an assessment may require a decision to: • increase staffing numbers to meet patient demand • partially or fully close a ward or service for a determined period until the issues are resolved • temporarily reduce service delivery or take another demand-management approach to redeploy the available workforce to areas of critical need to sustain safe and adequate care delivery • close the service, facility, or model of care in the long term • implement business continuity plans.

If all actions have been taken and the staffing level is deemed to be at an unacceptable level to complete a Dynamic Risk Assessment (DRA) Appendix 6 and escalate to Matron/Team manager /Lead Nurse in hours and Manager on Call Out of Hours.

6.2 Generic Principles of Safe Staffing for Community Services - *(Based on Operational Pressures Escalation Levels OPEL Rating Risk Scoring)*

Green Low risk/ OPEL one	**Amber Moderate Risk/OPEL Two**	**RED High Risk /OPEL Three**	**BLACK Unmitigated Risk High Risk/OPEL Four**
Able to accept new referrals and meet current caseloads and respond provide on-going care. Staffing available to match on going service need and provision of full-service delivery	Unable to meet planned visits on caseload Unable to respond to unscheduled service response times in one locality Unable to meet planned visits in one locality or more Service demand in a single locality outweighs the staff available.	Unable to guarantee non-urgent planned or unscheduled service response times in more than one locality Service demand in more than one locality outweighs the staff available	Unable to provide urgent and targeted interventions within response time across the service line. Cancelling routine clinic appointments to release staff. All community teams across all service lines and localities experiencing significant issues impacting delivery of safe care and provision of full-service delivery

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency the staffing levels are reviewed, and rag rated (GREEN/AMBER/RED/BLACK) with escalation actions at every level and OPEL risk assessment scoring for community teams. (See appendix 7 for OPEL Rating Risk Scoring for Directorates).

7.0 Annual Establishment Review

7.1 Each ward/community team has agreed planned staffing levels in line with their clinical establishments. Planned is the established number and skill mix of staff per shift and reinforced by agreed ratios of registered versus unregistered staff.

7.2 The agreed clinical establishment forms the basis of their roster (and subsequent budget). For inpatient services this involves the 24 – hour safe staffing nursing roster and Community teams this may also include the wider MDT.

7.3 All in patient wards must undertake a full establishment review every 12 months with a lighter review completed within the following 6 months

7.4 Establishment reviews must include the use of evidence-based staffing tools (where they exist). For Division of Mental Health, the trust has the license to use the Mental Health Optimal staffing Tool (MHOST). For In patient wards (Community Health Services) the trust has the licence for the Safer Nursing Care Tool (SNCT) and for learning disability services within Families, Young People and Children's directorate the trust utilises the Learning Disability Optimal Staffing

Tool (LDOST)

7.5 Community Nursing Teams will plan to implement the Community Nursing Safer Staffing Tool (CNSST) following national launch.

7.6 Establishment reviews must include professional judgement of the local contextual factors e.g., general workload and acuity, environmental factors and layout of a ward, skill mix of the team and patient/service user demographic to support decision making

7.7 Establishment reviews must include a review of Nurse sensitive indicators/outcomes (of previous 6 months) considering quality, patient safety experience and feedback.

7.8 Formal establishment reviews must be completed using the Annual Establishment Setting Review template (see appendix 8).

8.0 Roster Management

8.1 All staff working on in-patient wards /services must ensure that rosters are created in line with the Electronic (e) Rostering policy (appendix 9)

8.2 Rostering is built around the budgeted clinical establishments

8.3 Electronic (e) rostering is the electronic system used (by all in-patient wards/services) to prepare rosters at a minimum of 12 weeks in advance of the roster becoming live.

8.4 Ward Sisters/ Charge Nurses/team leaders are responsible and accountable for the provision of safe staffing levels to meet patient needs and service demands by preparing and managing the team roster

8.5 Matrons/community team leaders/team and operational managers are responsible and accountable for reviewing, overseeing and approving rosters for their area, adhering to the e rostering SOP (appendix 10) ensuring they are balanced and that staffing resources have been deployed effectively in order to meet the service needs

8.6 Directorate Management Teams to have oversight and scrutiny ensuring e-rostering sign off arrangements and business continuity plans are linked prior to and during peak times of annual leave/school holidays e.g., Mid-term school breaks, Easter, Christmas etc.

8.7 Directorate business continuity plans are refreshed and reviewed prior to peak holiday periods taking into consideration the following factors.

- clear understanding of in-patient ward/community team average % of absences and vacancies, to be considered at peak holiday periods and considered when % or number of staff off on annual leave has been confirmed
- Any late/last minute annual leave changes to be made and approved by matron/team manager
- Ward/community team reserve lists (of staff available and offering to work) to be formulated in readiness for ‘step up’ as needed
- Ensure e-rosters and staffing levels are being reviewed daily and any gaps are being escalated through Directorates with plans in place to ensure safe staffing levels during peak holiday periods

8.8 Effective Roster management is essential in supporting high quality patient care by optimising the skill mix and use of staff time enabling Managers to ensure that services are staffed in a consistent, safe, and cost-effective way

8.9 Efficient e rostering provides equity for all staff by enabling impartial allocation of shifts and with advanced planning of rosters allowing for enhanced health and wellbeing and greater work/life balance.

8.10 Nurse in charge is responsible for ensuring the roster is an accurate record of staff who worked each shift and to ensure care hours per patient day (CHPPD) reporting is accurate

9.0 Escalation of staffing concerns

9.1 Designating the nurse in charge for each shift is the responsibility of the Ward or Team Manager. The Ward or Team Manager must understand that they are delegating authority for the management of the ward/team for a span of duty in their absence. The Ward Manager/team manager needs to be sure that the person to whom they have delegated this responsibility is sufficiently competent, and that he/she will have sufficient knowledge of the service user needs and routines in order to manage the shift safely.

9.2 The Nurse in Charge of any shift should be a substantive member of LPT staff unless a regular member of bank staff has received additional training and supervision to undertake the nurse in charge role. This will be identified on the e rostering system. In the event of a last-minute shortage of staff, a substantive member of staff must be moved from another inpatient ward to cover the nurse in charge role.

9.3 The nurse in charge of a ward /community team leader is the designated professional responsible for the daily operational staffing review, identification of the staffing escalation position and the identification of any red flag staffing events.

10.0 Red Flag Events /Tipping points

10.1 Red flags are those circumstances stipulated NICE (JULY 2014) which maybe an indicator that quality of care has declined, and patients are being made vulnerable. The red flags outline ‘tipping factors and thresholds that would ‘tip’ the risk rating to a high/red risk from a moderate/amber risk.

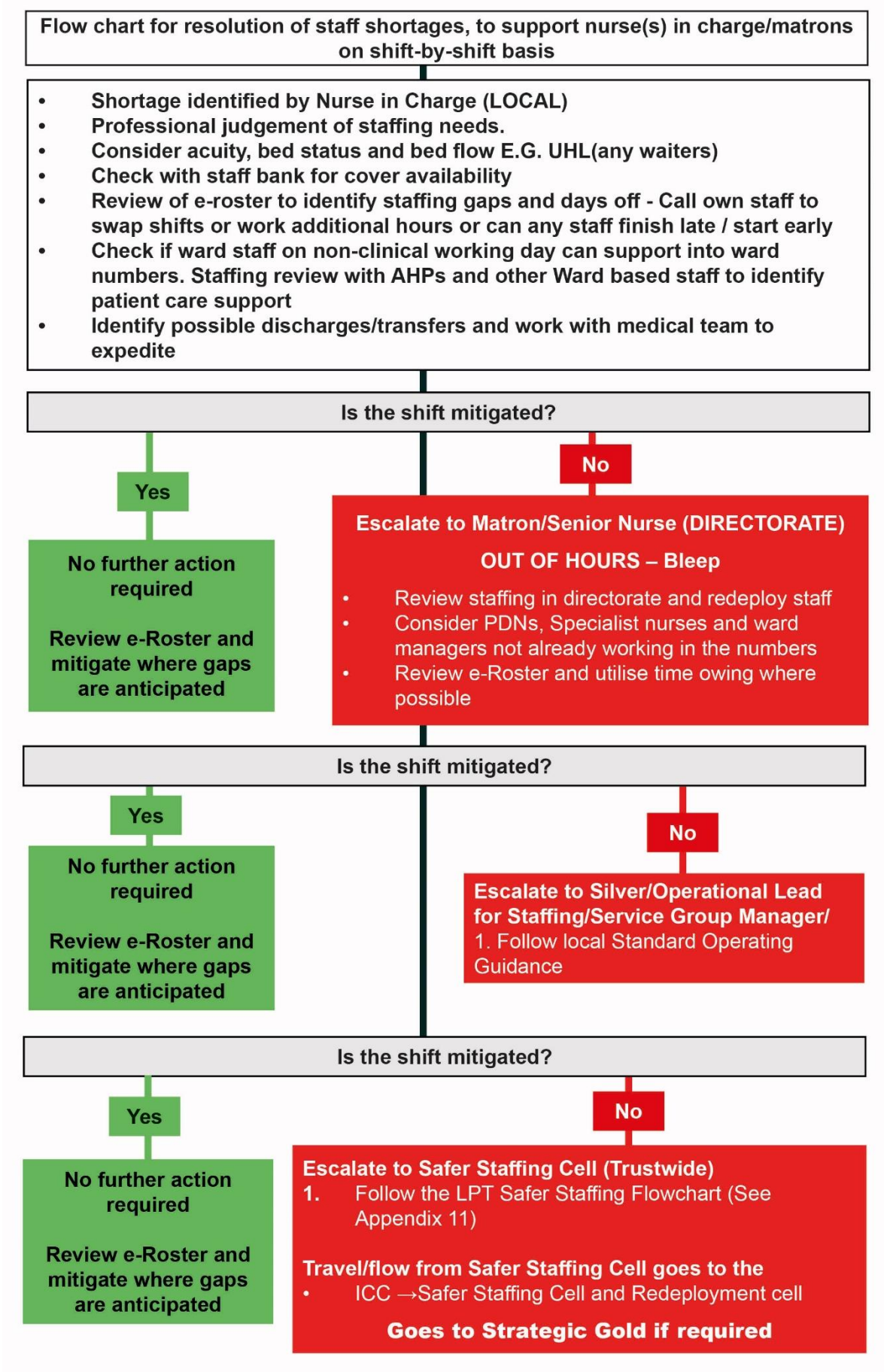
10.2 Should any of these occur or is identified as being at risk of occurring, it should prompt immediate escalation by the registered nurse in charge to the ward manager/matron and investigation and complete an e-irf. As staffing levels may need to be increased on the basis of these events, actions may include full or part closure of a service or reduced provision e.g., Wards, beds and teams’ realignment or change to skill mix.

- Less than 2 RN per shift – e.g., only 1 nurse where 2 were required (in patients)
- >50% temporary staffing utilisation
- Fill rates below 80%
- Care Hours Per Patient Day (CHPPD) below service average = less care hours
- More than 1: 8 RN to patient ratio (is linked to poorer outcomes and mortality)
- Increase in nurse sensitive indicator harm
- Missed care – tasks, therapeutic intervention
- Serious incidents – staffing as a contributory factor
- Increased complaints
- Missed breaks - staff
- Mental health – Detained patients unable to be offered fresh air at least once a day

- Prioritised assessments/visits are not carried out or cancelled

10.3 In the event of when operational staffing has been reviewed and despite proactive interventions the risk remains high, the safe staffing escalation framework is required to ensure that risks are identified, escalations and actions are taken to mitigate the risks.

11.0 Safe Staffing Decision Tool and Escalation Framework for In-patients



11.1 In the event whereby Directorate Staffing & Safety review identifies High risk (Red) staffing depleted or unmitigated high risk (Black) then support, and action is escalated to the trust wide Safer Staffing cell (Appendix 11). The Staffing and Safety huddle is convened and staffing, and safety assurance template completed (Appendix 12). The Trust wide bed closure SOP can also be found in appendix 13.

11.2 The management of safe staffing is dynamic with unplanned workforce challenges. It is essential therefore that each directorate adopts the overarching principles and guidance identified in this policy, including the daily operational staffing review and safe staffing escalation framework to recognise changes in demand and react dynamically to mitigate the risk. It is acknowledged the overarching principles and guidance will be adapted and locally standardised to operate in practice E.G. CHS in-patient Safe Staffing SOP (Appendix 14).

12.0 Core Standards

Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CQC Regulation 18 Providers must provide sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations	Fill rate against planned staffing – in-patients Annual establishment setting Bi-annual establishment reviews
National Quality Board standards M**ust** deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively	Fill rate against planned staffing – in-patients Annual establishment setting Bi-annual establishment reviews

13.0 Training Needs

13.1 There are training requirements relating to e-rostering management and Annual Establishment Reviews identified within this policy and it is important that staff are made aware of the thresholds, red flags and tipping points and clear escalation process as part of the policy implementation

14.0. Duties within the Organisation

14.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

14.2 The Trust Policy Committee is mandated on behalf of the Trust Board to adopt policies.

14.3 Strategic Workforce Committee have responsibility for the policy

14.4 Divisional Directors and Heads of Service are responsible for: ensuring that this

policy and any supporting policies and guidelines are built into local processes and ensure maintenance of compliance

14.5 Managers and Team leaders are responsible for: ensuring that all staff involved in outlined tasks and duties described in this policy are fully aware of their individual responsibilities.

14.6 Responsibility of Staff
All staff whether permanent, temporary, or contracted who are responsible for the tasks and duties described in this policy are fully aware of their roles and responsibilities and comply with these on a day-to-day basis

14.7 Responsibility of Clinical Staff and consent.

- *Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.*
- *In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:*

- *Understand information about the decision*
- *Remember that information*
- *Use the information to make the decision*
- *Communicate the decision*

15.0. Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Annual establishment resetting with 6 monthly updates	Six-monthly safe and effective reports Section 5.5	QAC & Trust Board work plan	Assistant Director of Nursing & Quality	Bi-annual
	Safe staffing reviews	Monthly Section 5.5	Trust Board	Assistant Director of Nursing & Quality	Monthly

16.0 References and Bibliography

The policy was drafted with reference to the following:

Birmingham and Solihull Mental Health NHS Foundation trust, Safter staffing policy (August 2021)

Developing workforce safeguards supporting providers to deliver high quality care through safe and effective staffing, NHS Improvement (October 2018)

LPT Optimising Electronic Rostering at LPT (Dec 2020)

LPT Trust wide Decision-Making process for Bed closures (Nov 2021)

Nottinghamshire Healthcare NHs Foundation trust, In-Patient Safe Staffing – Essential Guidance to Defining and Managing Nurse Staffing Resources (August 2021)

National Quality Board (2013) how to ensure the right people, with the right skills, are in the right place at the right time – A guid to Nursing, midwifery and care staffing capacity and capability

North Devon Healthcare NHS trust Nursing Safer Staffing Policy (May 2019)

Nursing Workforce standards supporting a safe and effective nursing workforce (May 2021) Royal College of Nursing

Staffing Assurance Framework For winter 2021 Preparedness (Nov 21)

Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time, Safe sustainable and productive staffing, National Quality Board (July 2016)

Appendix 1: **Training Requirements**
Training Needs Analysis

Training topic:	e-rostering and Annual Establishment Reviews
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☑Role specific ☐ Personal development
Division(s) to which the training is applicable:	☑ Adult Mental Health & Learning Disability Services ☑ Community Health Services ☐ Enabling Services ☑ Families Young People Children ☐ Hosted Services
Staff groups who require the training:	*Please specify…*ward managers, charge nurses, team leaders, matrons
Regularity of Update requirement:	One time only
Who is responsible for delivery of this training?	E -rostering training is via workforce team and the Annual Establishment Review training will be rolled out to all ward managers as part of the Annual establishment review (by acting Assistant Director for Nursing and Professional Practice and workforce and safe staffing matron)
Have resources been identified?	Within the JD of the roles identified
Has a training plan been agreed?	E-rostering is provided on a bespoke basis Yes as part of the Annual establishment reviews (one time only)
Where will completion of this training be recorded?	☐ ULearn ☑ Other (please specify) – as per Annual establishment review
How is this training going to be monitored?	As part of the Annual Establishment Review process and in line with the essential to role requirements of ward sister/charge nurse/clinical team leader

Appendix 2: The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☑
Respond to different needs of different sectors of the population	☑
Work continuously to improve quality services and to minimise errors	☑
Support and value its staff	☑
Work together with others to ensure a seamless service for patients	☑
Help keep people healthy and work to reduce health inequalities	☑
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☑

Appendix 3: Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Louise Evans	Interim Assistant Director of Nursing and Quality
Emma Wallis	Interim Deputy Director of Nursing and Quality

Circulated to the following individuals for comment

Name	Designation
Core members	Strategic Workforce Committee
Fiona McGuigan	Clinical ICC lead
Catherine Holland	Clinical ICC lead
Val Dawson	Staff Side Representative
Jane Lavelle	Staff Side Representative
Core members	Staff Side
Margot Emery	Head of Nursing CHS
Simon Guild	Deputy Head of Nursing - MHSOP
Saskya Falope	Deputy Head of Nursing – Urgent care
Jane Martin	Deputy Head of Nursing - DMH
Claire Armitage	Deputy Head of Nursing – DMH Community
Michelle Churchard Smith	Deputy Director of Nursing/ Head of Nursing - DMH
Bernadette Cawley-Nash	Deputy Head of Nursing – FYPC.LD
Carmella Senogles	Deputy Head of Nursing – FYPC.LD
Zayad Saumtally	Head of Nursing – FYPC.LD
Sarah Latham	Deputy Head of Nursing – CHS inpatients
Tracy Yole	Deputy Head of Nursing – CHS Community

Appendix 4: Due Regard Screening Template

Section 1	
Name of activity/proposal	Safe staffing policy
Date Screening commenced	05/05/2022
Directorate / Service carrying out the assessment	Nursing Corporate team
Name and role of person undertaking this Due Regard (Equality Analysis)	Elaine Curtin, workforce, and safe Staffing Matron
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of the policy is to outline a clear escalation process from frontline staff to board describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift/community team. To ensure that by providing a structure and process for carrying out establishment reviews that planned staffing for registered and non-registered nursing match the acuity and dependency needs of patients. The skill mix and capability of the workforce is of an appropriate level to provide high quality safe and compassionate care. Service users and staff will benefit from this policy.	
OBJECTIVES: Ensure there is a clear escalation process in place and staff are able to escalate their safe staffing concerns from ward to board. All nursing staff clearly understand the policy and procedures within it to enable the safety of patients and the health and wellbeing of the workforce.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	The policy supports safe staffing levels for all service user's and staff and there is no evidence it will disproportionally have an impact.
Disability	As above
Gender reassignment	As above
Marriage & Civil Partnership	As above
Pregnancy & Maternity	As above
Race	As above
Religion and Belief	As above
Sex	As above
Sexual Orientation	As above
Other equality groups?	As above

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor	Elaine Curtin	**Date**	6.5.22
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Emma Wallis	**Date**	

Appendix 5: DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Safe Staffing Policy**		
Completed by:	**Elaine Curtin**		
Job title	**Workforce and Safe Staffing Matron**		**Date**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		no	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		no	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		no	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		no	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		no	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		no	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		no	
8. Will the process require you to contact individuals in ways which they may find intrusive?		no	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:			
Date of approval			

Acknowledgement: This is based on the work of Princess Alexandra Hospital NH

Appendix 6: Dynamic Risk Assessment (DRA)

AMH/LD – INPATIENT AND COMMUNITY SERVICES

STAFFING DYNAMIC RISK ASSESSMENT DECISION TOOL

The checklist below will aid the decision-making process when risk assessing the ward or team in the event of a staffing shortage / emergency / increased patient acuity to look at alternative factors which can be deployed.

This checklist **must** be completed:

- If the SOP for bank and agency staff has been followed and all conditions cannot be met and the gaps cannot be filled.
- For any shift booked on the day of requirement.
- For any outstanding shifts 24 hours prior to the shift commencement.
- When a shift is operating below the usual agreed staffing levels.

Please complete one form per shift required

Inpatient area (ward and site)	

Date of Shift(s) Required	Time of Shift (E/L/LD/N)	Type of Nurse (RN/HCSW)	Band	Booking Reference Number	Reason for Agency Request e.g. sickness/vacancy/observation levels/risks

Risk consideration **To help inform your decision making if the ward or team can operate safely with less than agreed usual staffing levels.**	**Yes**	**No**	**N/A**	**How Many?**
COMPLETE FOR INPATIENT AREAS ONLY				
Number of patients on the ward				
Are there sufficient RNs to meet safer staffing requirements for your area?				
Are there any empty beds?				
Is this a single site?				
Are there any planned discharges?				
Are there any patients who are well enough to consider home leave?				
Are there any planned admissions?				
Number of patients on level 1 observations (1:1)				
Number of patients on level 1 observations (req. more than one staff member)				
Number of patients on level 2 observations				
Number of patients requiring escort				
Seclusion, de-escalation or extra care suite currently in use?				
Any patients with additional complex physical health requirements?				
Any patients that require extra care?				
Any patients with communication needs requiring additional care?				
Any patients in source isolation?				
Number of patients subject to MHA (1983)?				
Any support available from other members of the wider MDT? (e.g. OT, TLW)				
Has attendance at all non-essential training been reviewed?				
Has the CDM reviewed nursing support being offered in other clinical areas?				
Number of patients requiring support at A&E or similar				

Risk consideration To help inform your decision making if the ward or team can operate safely with less than agreed usual staffing levels.	Yes	No	N/A	How Many?
COMPLETE FOR COMMUNITY TEAMS ONLY				
Are there sufficient CPNs to meet patient needs within your team?				
Has support available from Centralised Staffing been reviewed?				
Has support available from other members of the wider MDT been reviewed?				
Are there delays in responding to referrals and undertaking assessments?				
Have alternative ways of working been reviewed, e.g. patient attendance at base, telephone contact etc.				
Has attendance at all non-essential training been reviewed?				

COMPLETE AS PER STANDARD OPERATIONAL PROCEDURE:
Any problems gaining support contact relevant AMH/LD on-call Manager via LPT Switchboard: 0116 2256000

Please complete your decision and rationale below for requiring additional or less than usual staffing levels.

Date	Actions/Control measures	Decision made & rationale	Name & Signature

Assessment of decision taken:

Tick as appropriate: Shift(s) Required ■ Shift Not Required ☐ Off Framework Request ☐

Discuss with your Head of Service / Head of Nursing (Out of hours Manager on call). If an off framework request is required, they will forward this completed form to the below for authorisation:

Mon – Fri 9-5pm AMH/LD Director or Out of Hours – Director On call

If authorised by AMH/LD Director/On call Director, they will forward to: centralisedstaffingsolutions@nhs.net and cc to the Head of Nursing michelle.churchard@nhs.net and Head of Service helen.perfect@nhs.net or jules.galbraith@nhs.net

Form completed by: Name _____

Designation _____

Contact number _____

Date_____

Form Authorised by: Name _____

Designation _____

Contact number _____

Date_____

1.28

COMMUNITY HEALTH SERVICES – INPATIENT SERVICE LINE

STAFFING RISK ASSESSMENT DECISION TOOL

The checklist below will aid decision making when dynamically risk assessing the ward to see if skill mix can be diluted (i.e. additional HCA cover) or shifts unfilled dependant on the patient acuity and dependency.

This checklist **must** be completed following:

- The implementation of the SOP for bank and agency and when all conditions cannot be met and the gaps cannot be covered.
- For any shift booked last minute and any still outstanding 48 hours prior to the start of the required shift as per the 9am report

Hospital: **Ward:**

Date of Shift Required	Time of Shift (E/L/LD)	Type of Nurse (RN/HCA)	Band	Booking Reference Number	Reason for Agency Request e.g., sickness/vacancy/specialing

Risk consideration	Yes	If Yes; How Many?	No
Is this a single site?			
Are there any planned discharges			
Are there any planned admissions			
Are there any empty beds			
Number of patients (acutely ill requiring intervention or unstable with a potential to deteriorate?)EWS Score 3 or above.			
Patients on IV antibiotics			
End of life care patients			
Patients with naso gastric tubes			
Number of patients who have fallen in the previous 6 hours.			
Patients requiring two hourly turns/pressure area care			
Confused patients whom are restless and wandering?			
Number of patients in source isolation			
Number of patients requiring complex wound care in the shift period requiring cover.			

Control measures to consider:
Redirect admissions to other areas
Consider delaying planned admissions
Unscheduled care/ night nursing support for IV medications, End of Life care patients
Consider use of Bank RMN nurse with the skill mix to support patients with dementia or challenging behaviour
Additional HCAs to support with nursing needs

Date	Actions/control measures	Decision made & rationale	Name Signature

Tick decision taken

SHIFT REMOVED	SHIFT STILL REQUIRED

Form completed by: Name _____

Delegation _____

Contact number _____

- **ONCE COMPLETED SEND COPY OF RISK ASSESSMENT EMBEDDED/ATTACHED TO DIRECTOR SIGN OFF FORM TO CSS via centralisedstaffingsolutions@nhs.net**
- **COPY TO MATRONS PAs**

Appendix 7: OPEL Rating Risk scoring for Directorates

Action Levels			
Community Health Services			
Triggers			
Level 1 Normal Working	**Level 2 – Moderate Pressure**	**Level 3 – Severe Pressure**	**Level 4 – Extreme Pressure**
Community Hospital Beds	**Community Hospital Beds**	**Community Hospital Beds**	**Community Hospital Beds**
Bed capacity is 15 beds or more with discharges planned. No operational issues. Staffing meets demand. Availability outweighs demand. Good spread of gender and geography availability	Bed capacity is less than 15 beds available. Discharges are planned for same day Availability outweighs demand and discharges planned within 24 hours. Service area experiencing staffing issues	Bed capacity is less than 7 beds available. Availability less then demand with discharges planned in the next 24 hours Service line experiencing staffing issues	No beds available No discharges planned in the next 24 hours CHS experiencing staffing issues across all service lines
Community Services	**Community Services**	**Community Services**	**Community Services**
Able to accept referrals and provide on-going care. Staff able to fully engage in community hospital board rounds and proactively identify patients to discharge into the service. Staffing hours available match on going service need	Unable to guarantee non-urgent planned or unscheduled service response times in one locality. Staff unable to participate in community hospital board rounds, to proactively identify patients to discharge into the service. Service demand in a single locality outweighs the staff available.	Unable to guarantee non-urgent planned or unscheduled service response times in more than one locality Staff unable to participate in community hospital board rounds to proactively identify patients to discharge into the service Service demand in more than one locality outweighs the staff available	Unable to guarantee urgent and non-urgent unscheduled and planned service response times across the service line. Cancelling routine clinic appointments to release staff. CHS experiencing staffing issues across all service lines

Directorate Mental Health			
Triggers			
Level 1 Normal Working	**Level 2 – Moderate Pressure**	**Level 3 – Severe Pressure**	**Level 4 – Extreme Pressure**
DMH Hospital Beds	**DMH Hospital Beds**	**DMH Hospital Beds**	**DMH Hospital Beds**
Bed capacity is 15 beds or more with discharges planned. No operational issues. Staffing meets5 or more beds available Availability outweighs demand. Staffing meets demand No operational issues Central Access Point (CAP) managing all referrals demand. Availability outweighs demand. Good spread of gender and geography availability	Minimum 2 triggers required:- In-patient bed availability less than 5 beds. Discharges are planned for today. No operational issues but monitored closely CAP managing all referrals but assessments slots filling for next 24hrs No pressure from admissions expected in next 24hours. OOA beds available but use not expected. Difficult to manage single sex accommodation compliance.	Minimum 2 triggers required:- In-patient bed availability less than 3 beds. Discharges are not planned for today. Availability less than demand OOA beds available and may be used. Increased demand for assessments through the CAP, limited assessment slots Staffing needing review to meet increased demand Leave beds in use Considering use of contingency capacity (PSAU) Single sex walk through breaches.	No inpatient bed capacity Discharges not planned to today. Patients on waiting list and or unable to place OOA beds not available No patient identified for EDP Hospital beds in use Ward rounds completed and no additional predicted activity CAP taking high volumes demand exceeds capacity, impacting on capacity of Crisis to support home treatment. Contingency capacity open (PSAU) open.

Families Young People Children & Learning Disabilities			
Triggers			
Level 1 Normal Working	**Level 2 – Moderate Pressure**	**Level 3 – Severe Pressure**	**Level 4 – Extreme Pressure**
FYPC&LD Hospital Beds and Community services	**FYPC&LD Hospital Beds and Community services**	**FYPC&LD Hospital Beds and Community services**	**FYPC&LD Hospital Beds and Community services**
Wards have all available commissioned beds open to admissions All acute faced community services are working BAU Staffing capacity meets demand Active demand and capacity monitoring are in place Regular reporting to system partners – CYP subgroup	Patients waiting for community support prior to discharge. Workforce is at lower levels but sufficient to maintain services Capacity issues with specific professional groups e.g. medical cover, psychologists	Community capacity is full, demand exceeds capacity Unexpected significant reduced staffing levels significant use of emergency bank agency staff Closed to admissions due to reduced staffing or needing to provide cover to acute provision due to no beds available for transfer. Having to divert resources from other community services to support urgent referrals from acute wards for discharge, support to A&E or prevention of admission	As OPEL 3 but mitigation is not enough to ensure patient safety and prevention of harm

Appendix 8: Annual Establishment Review Template

NHS Improvement Developing Workforce Safeguards (2019) recommend establishment setting must be done annually, with a mid-year review, and should take account of:

- patient acuity and dependency using an evidence-based tool (as designed and where available)
- activity levels
- seasonal variation in demand
- service developments
- contract commissioning
- service changes
- staff supply and experience issues
- where temporary staff have been required above the set planned establishment patient and staff outcome measures.

Trusts must ensure the three components below are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes.

The template below will help align and shape the establishment review and subsequent setting.

Ward
Current FTE staffing and planned staffing per shift
Primary establishment - Ward based roles Skill mix – Registered versus non-registered Planned staffing per shift
Professional judgement
Consider general workload & acuity Ward factors – environment & layout, line of sight In your professional judgement what should the staffing levels and skill mix be for each shift Discussion with Ward team
Acuity & Dependency
Name of tool e.g. MHOST, LDOST or Keith Hurst ADL Date of 20 day data collection Outline the results; FTE total number of staff and suggested planned staffing and CHPPD

Service developments or changes
Outline any service developments/changes and impact to staffing
Outcomes
Review of last 6 months Nurse Sensitive Indicators (monthly safe staffing) Quality, Patient Safety & Experience Does the data suggest a need to increase staffing? Or reduce
Temporary staff use
Agency usage above 6% *Shifts whereby 50% are substantive* *Fill rates and temporary worker utilization*

Skill mix and new roles
Nursing Associates *Medication Administration Technicians* *AHP – Therapy liaison roles* *QIA for any new role*
Proposed staffing
Planned staffing per shift *Financial cost* *Impact assessment*

Appendix 9: **Electronic Rostering Policy**

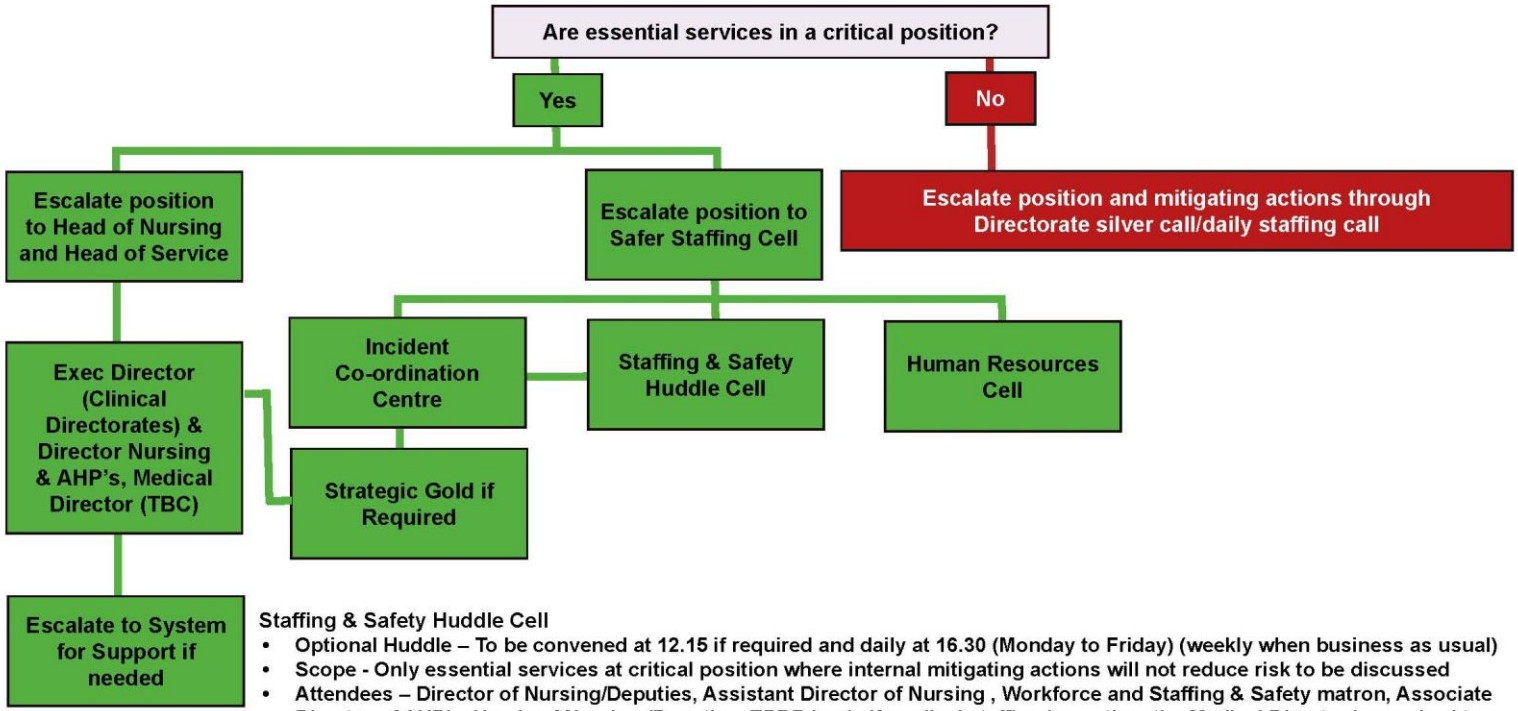
www.leicspart.nhs.uk/wp-content/uploads/2020/04/Electronic-Rostering-Policy-exp-Sep-22.pdf

Appendix 10: **Optimising Electronic Rostering at LPT**

www.leicspart.nhs.uk/wp-content/uploads/2020/04/HealthRoster-SOP-v12.pdf

Appendix 11: **Trust wide Safer Staffing Cell diagram**

Directorate Staffing & Safety review identifies High risk (Red) staffing depleted or unmitigated high risk (Black)



Staffing & Safety Huddle Cell

- Optional Huddle – To be convened at 12.15 if required and daily at 16.30 (Monday to Friday) (weekly when business as usual)
- Scope - Only essential services at critical position where internal mitigating actions will not reduce risk to be discussed
- Attendees – Director of Nursing/Deputies, Assistant Director of Nursing , Workforce and Staffing & Safety matron, Associate
- Director of AHP's, Heads of Nursing /Deputies, EPRR lead . If medical staffing issue then the Medical Director is required to attend
- Process – Any areas for escalation beyond acceptable risk levels to be discussed risks and actions escalated to the ICC and Redeployment cell to be reviewed in conjunction with the priority service list and agreed action for redeployment of staff.
- Outcome – Decision as to whether existing situation is safe or what mitigating actions are needed and what those actions are in line with the prioritised service list and in line with system extreme surge plans
- Governance – The outcomes of the discussions to be shared with ICC and Clinical Reference Group (TBC) for logging of decision and communicated to Strategic Gold. Please note that any significant change to service remaining should also be agreed at Strategic Gold.

Out of Hours – In an out of hours situation the discussion and decisions to be taken with the Director and Managers on Call. If a strategic gold decision is needed then this should be arranged by the Director on call.

Appendix 12:
CHS Community ONLY

Staffing and Safety Assurance templates

	Directorate:	Date:	Representative:
Dropdown option (Cells: B9, C9, D9, B21, B22, B23)			
	Drop down box: B9	*Drop down box: C9*	*Drop down box: D9*

Information required:		
Safe staffing areas to note under planned levels - shift and staff required		*Free text box*
Levels of staffing risk		*Free text box*
Quality and safety concerns		*Free text box*
<u>For Community ONLY</u> **Red flags would include essential visits not covered. Workload reprioritised. Clinics / Visits cancelled.**		*Free text box*
Clinical mobilisation		*Free text box*
Analysis of incidents / emerging themes and impact on patient safety		*Free text box*
Actions taken to date and what further action is required		*Free text box*
Community areas to highlight		*Free text box*
Grading of current risk		*Drop down box: B21* *Please refer to Guidance tab for explanations*
Opel Level		*Drop down box: B22* *Please refer to Guidance tab for explanations*
Action Level		*Drop down box: B23* *Please refer to Guidance tab for explanations*
Staff feedback regarding their Health and Wellbeing		*Free text box*

DMH/FYPC.LD/CHS inpatients

	Directorate:	Date:	Representative:
Dropdown option (Cells: B9, C9, D9, B14, B21, B23, B24)			
	Drop down box: B9	*Drop down box: C9*	*Drop down box: D9*

Information required:		
Safe staffing areas to note under planned levels - shift and staff required		*Free text box*
Beds available		*Drop down box: B14*
Quality and safety concerns		*Free text box*
Red flags would include essential visits not covered. Workload reprioritised. Clinics / Visits cancelled		*Free text box*
Levels of acuity / dependency		*Free text box*
Analysis of incidents / emerging themes and impact on patient safety		*Free text box*
Actions taken to date and what further action is required		*Free text box*
Highlight: Impact of any outbreak		*Free text box*
Grading of current risk		*Drop down box: B21* *Please refer to Guidance tab for explanations*
Inpatient areas above RAG rating *Where area is an exception to overall reporting*		*Free text box*
Opel Level		*Drop down box: B23* *Please refer to Guidance tab for explanations*
Action Level		*Drop down box: B24* *Please refer to Guidance tab for explanations*
Staff feedback regarding their Health and Wellbeing		*Free text box*

Appendix 13 – Please refer to StaffNet: Trust wide Bed Closure Standard Operational Procedure

Appendix 14 – Please refer to StaffNet: CHS Safe Staffing SOP