

Safer Staffing Policy

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1 Policy summary

The aim of the policy is to describe the process to be followed by managers or leaders to anticipate, plan, and manage the optimal staffing requirements (of a 24-hour roster).

The policy provides clear guidance to be followed when putting together a roster, ongoing actions to ensure it is safe, balanced, and efficient, action and governance structures required to support the dynamic management of a live roster, directions on how to escalate short term and re-occurring staffing shortfalls, and retrospective reviews by senior colleagues across each of the care groups.

This policy should be read in conjunction with the trust's [rostering policy and procedure](#).

1.1.Quick guide

Purpose

- The establishment review ensures that each clinical team within the trust has an agreed staffing establishment that enables deployment of the right colleagues with the right skills at the right place and time to remain safe, effective, and sustainable.

Conducting the review

- All clinical teams must undertake a full establishment review every 12 months.
- A lighter review for inpatient units must be completed within the following 6 months at a minimum.
- Increased frequency of review may be requested by the service.
- Evidence-based staffing tools should be utilised in the establishment reviews (where available).
- Mental health optimal staffing tool (MHOST) is used for inpatient mental health services.
- Safer Nursing Care Tool (SNCT) is used for physical health units.
- Community nursing safer staffing tool 2 (CNSST2) should be used for community district nursing (Physical health).

Finalising the review

- Deputy Chief Nurse, Care group director of nursing and safer staffing lead and NHSP relationship manager provide recommendations to the chief nurse and care group director.
- Agree on establishment changes to implement.
- Update e-roster templates, budgets.

Implementing change

- Formally authorise new establishment levels.
- Amend budgets and recruit as needed.
- Update, rosters, documentation.
- Complete quality impact assessments.

Governance and reporting

- Schedule mid-year interim review in 6 months.
- Report outcomes through governance structures.
- Feed outcomes into board reports.

2 Introduction and aim

The National Quality Board (NQB), within its 2016 publication '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' outlines key expectations of all NHS Trusts.

To supplement this, NHS England and Improvement produced the 2018 publication 'developing workforce safeguards'. These standards reinforce the expectations under the NQB. The standards provide a regulatory framework, requiring evidence-based staffing tools to be utilised (where they exist). The standards also set out the requirements for quality impact assessments to be undertaken when there are any changes to roles or skill mix.

Alongside these publications, safe staffing also forms part of the regulated activities under the Health and Social Care Act 2008 under regulation 18: Staffing. 1.4 Health and Social Care Act 2008, Regulation 18: Staffing states;

'Sufficient numbers of suitably qualified, competent, skills and experienced persons must be deployed to meet the requirements of this part. Persons employed by the service provider in the provision of regulated activity must:

- receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform
- be enabled where appropriate to obtain further qualifications appropriate to the work they perform
- regulated health or social care professionals must provide evidence to their regulator showing they meet professional standards
- these standards are required for their registration and ability to practice
- this evidence demonstrates the professional continues to be up-to-date and fit to practice

This policy aims to support team managers, ward managers, matrons, service managers, on-call managers, and registered nurses in charge of wards to ensure that the trust is meeting its obligations, and to support actions that are required when there are staffing concerns in clinical areas. This policy will also provide assurance to the trust board of directors that the trust has appropriate procedures in place for managing safer staffing.

The negative impact of inadequate staffing levels on patient care has been a consistent theme, identified in the reviews undertaken on patient care within NHS provider organisations. The full findings and outcomes of these reviews are referenced within the following reports:

- Francis Inquiry 2013, Report of the Mid Staffordshire NHS Foundation Trust public inquiry
- Keogh Overview Report 2013, Review into the Quality of Care and Treatment provided by 14 hospital trusts in England

- Berwick Report 2013, A promise to learn, A commitment to act: Improving the safety of patients in England
- Cavendish Review 2013, An independent review into healthcare assistants and support workers in the NHS and Social Care settings

In response to the above reports, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) is committed to ensuring the safety of patients, colleagues and the public by ensuring that the right people with the right skills are in the right place at the right time.

This policy provides guidance to employees with responsibilities for safe staffing decision-making on a shift-by-shift basis across all areas. The policy addresses:

- the safe staffing process for areas to follow, including establishment reviews, roster management (including changes to rosters), dynamic deployment, use of temporary staffing, including NHSP and extra shifts and escalation protocols
- how to determine adequate staffing levels through use of evidence-based tools, professional judgement, and quality indicators
- actions to take when there are insufficient staffing levels to meet patient needs safely, including the utilisation of bank and agency colleagues in line with governance requirements
- escalation protocols for reporting staffing concerns to appropriate individuals at the ward, care group, and trust-wide level
- monitoring of ward quality and safety performance through monthly retrospective reviews and reporting through governance structures
- Compliance with workforce regulations, including the Working Time Directive (WTD)
- the overall purpose is to ensure optimal staffing levels and skill mix are maintained to deliver safe, high-quality care that meets patients' needs

This policy applies to all clinical services across the organisation. The implementation of workforce (establishment) reviews within non-inpatient units is being considered.

For further information about responsibilities, accountabilities and duties of all colleagues, please see section 5.

3 Procedure or implementation

3.1 Establishment review

Each clinical team within the trust has an agreed staffing establishment. This forms the basis of their roster (and in most cases subsequent budget). This may also include other professional groups (such as occupational therapy, speech and language therapists, physiotherapists or social workers (SW)).

The purpose of the establishment review is to ensure that the agreed establishment remains able to deploy the right colleagues with the right skills at the right place and time to remain safe, effective and sustainable.

All inpatient clinical teams must undertake a full establishment review every 12 months with an interim completed within the following 6 months at a minimum.

There may be times whereby an increased frequency of review is requested by the service or indicated within the trust wide safer staffing group. In these cases, the request will be treated as urgent, and a review convened at the earliest opportunity to support services in a timely manner.

Establishment reviews must include the use of evidence-based staffing tools (where they exist). They must include a review of locally defined outcomes measures. This should, at a minimum, include patient safety information, patient feedback or experience, operational performance, quality of care and key workforce information.

Establishment reviews must include the use of professional judgement to support the decision-making, considering local contextual factors. This may include the operational context, the environmental context, the team dynamic or skill mix and the patient demographics.

Establishment reviews must define the optimal staffing required, the minimum staffing required to maintain full operational functioning and define the staffing thresholds for business continuity plans to be implemented. For inpatient services, this should also include the acuity thresholds for enhanced observations (for example, how many should be included within the establishment).

Formal establishment reviews are to be overseen by the deputy chief nurse, although undertaking the reviews and associated data collection may be delegated to a trust workforce lead or another senior operational manager. The matron or ward manager (and where necessary the relevant professional and clinical leads representing the wider group of multi-disciplinary professions, including psychological professions, allied health professions (AHPs) and SW) must always be included within the establishment review and the outcomes or recommendations feedback to the clinical team (appendix D).

3.2 Evidence based staffing tools

NHS Improvement (2018) sets out the expectation that evidence-based staffing tools must be used (where they exist) as part of the establishment review process.

The trust is required to have and maintain a current licence for any evidence based safer staffing tools. This licence must be signed by the Chief Nurse. There is also a requirement for a main contact to be identified for all communication around the licence, this will be the trust workforce transformation lead.

All trust employees must adhere to the licencing conditions for the use of evidence-based staffing tools.

Colleagues using MHOST must follow the tool's terms of use and licencing requirements.

The licence states that the licensee shall:

- ensure that no one other than colleagues of the licensee working at the facilities of the licensee shall use or have access to the materials

- ensure that no detail of ownership, copyright statement, or other proprietary right statement connected with the materials is deleted or removed

The licence also states that the licensee shall not:

- sell, assign, licence (or sub-licence), hire, rent, lend, supply, gift, distribute, transmit, publish, or otherwise transfer, disclose, or make available the whole or any part of the materials to any third party.
- adapt, modify, translate, merge, or create any derivative work based on the whole or any part of, the materials, unless specifically agreed with Innovations and the clinical colleagues in writing and in advance.
- use the whole or any part of the materials:
 - for any commercial purpose
 - in any commercially sponsored research or other activity
 - to develop or create any product or service that may be used commercially

To ensure the integrity of the tools and the output of the tools, anyone undertaking use of these tools is required to have undergone training. Training can be sought via the trust Safer Staffing Lead and NHSP Relationship Manager.

For MHOST and SNCT, a minimum of 30 days of data collection is required.

The  deputy chief nursing officer is the accountable professional responsible for ensuring that this data collection is undertaken within their areas twice a year prior to the annual and bi-annual establishment reviews.

The chief operating officer is responsible for supporting local reporting processes at care group quality groups and care group delivery review meetings care group assurance meetings.

The trust's Safer Staffing Lead and NHSP Relationship Manager is the designated professional responsible for inputting the data from the data collection into the required tool and feeding back the outputs.

All outputs from any of the evidence-based staffing tools will be reported to board via quality committee or any other sub-board committee with no local manipulation as part of the annual establishment review board report.

3.3 Changes to the budgeted establishments

It is essential that all requests to change agreed establishments go through appropriate governance, in the form of formal establishment reviews, to ensure that requests or recommendations are safe, sustainable, and productive.

If the establishment review identifies that a change is recommended to the budgeted establishment, the care group nurse director, safer staffing lead and deputy chief nurse will confirm this recommendation. If the review was delegated to another professional, an additional scrutiny meeting will be commenced to confirm and scrutinise the recommendations. They will agree and document actions to be taken with the relevant local manager, plus timelines for the calculation of financial impacts through the relevant local finance representative.

The deputy chief nurse will brief the chief nurse, plus the care group director of the area reviewed, in a timely manner (immediately if urgent, use of clinical judgement is recommended), highlighting the findings of the review and the recommendations of what is required. They will agree the ongoing route of authorisation following one of the two approaches below.

If the change to establishment is significant and requires investment, an investment bid will be created and submitted at the next annual round, to request additional funding. The care group director will prepare a document explaining the need for change and financial implications in conjunction with the care group nurse director and deputy chief nurse. This report must include the use of evidence-based staffing tools and their recommendations (where available) without any local manipulation.

If the change to the establishment is manageable within the care group budgets, and the change can be actioned swiftly by the responsible care group director.

A quality safety impact assessment should be submitted as part of either process, highlighting the risks of implementing, or not implementing, the recommended amendments to the establishment.

Any changes to budgeted establishments will then be formally authorised and adopted. The e-rostering requirements, plus the minimum staffing documentation will be immediately changed to reflect the new establishment, and be distributed to care group directors, care group nurse directors and matrons, and to all clinical management teams.

Service and team budgets will be amended, and colleague recruitment or rotation actions will be immediately authorised and implemented within two weeks of the decision.

Any changes to the skill mix, service redesign of existing roles or introduction of new roles are required to have a quality impact assessment review as directed within [NHSE and I \(2018\) Developing Workforce Safeguards \(staff access only\) \(opens in new window\)](#).

3.4 Dynamic deployment of colleagues

All rosters will be authorised by matrons for each ward 6 to 8 weeks before they go live.

Within inpatient services, as part of this authorisation process, matrons must chair a formal Confirm and Challenge meeting, supported by the safer staffing lead and e-rostering team. This process will include a detailed review of agreed key performance indicators, including (but not limited to) complaints, incidents, falls, pressure ulcers, fill rates, roster quality and other locally agreed workforce metrics in line with national guidance. The purpose of the meeting is to provide assurance that rosters are safe, effective and efficient, identify areas of risk, and agree actions required before the roster is finalised.

All actions arising from the Confirm and Challenge meeting must be recorded on the standard documentation and will inform the ward manager's roster planning over the following 6 to 8 weeks. The completed documentation must also be shared with the relevant operational management team to ensure visibility of workforce risks, agreed mitigations and outstanding actions.

All rosters must comply with the Trust Rostering Policy and associated procedures. Within both inpatient and community services, patient acuity, dependency and service demand are dynamic and can change rapidly. Staffing deployment must therefore remain flexible and responsive to ensure safe, effective and productive services are maintained at all times.

All clinical areas are expected to continually review their staffing requirements throughout the day and adjust staffing levels where appropriate in response to changes in patient acuity, enhanced observations, admissions, discharges, leave status, skill mix or other operational pressures.

The decision to increase or reduce staffing should be made following discussion between the nurse in charge or clinical leader and the appropriate matron or operational manager, using professional judgement supported by available workforce and patient acuity information. Ward managers and matrons are expected to discuss staffing requirements daily to proactively identify actual and anticipated risks. Outside of normal working hours, decisions should be supported through the clinical matron or on-call manager.

Redeployment of colleagues across wards and services is an expected component of the Trust's safer staffing model and should be considered whenever there is an imbalance between staffing resource and clinical demand. Redeployment decisions must be based on patient safety, colleague competence, skill mix, familiarity with the clinical area where possible, and the overall operational needs of the organisation.

Where redeployment is required:

- the receiving and releasing Nurse in Charge must communicate directly to agree the deployment and ensure it is safe and appropriate;

- the colleague must receive an appropriate handover, be made aware of local risks and expectations, and be provided with appropriate support and supervision throughout the shift;

- consideration must be given to the individual's competence, experience and wellbeing, ensuring colleagues are not expected to undertake duties beyond their scope of practice;

- any concerns regarding the safety or appropriateness of a redeployment must be escalated immediately to the matron or Operational Manager for review.

All temporary staffing requirements, including increases in establishment arising from changes in patient acuity or dependency, must be accurately recorded within the e-roster to ensure it reflects the true staffing requirement. This enables accurate reporting of staffing demand, supports workforce planning and provides assurance regarding unmet need.

Ward managers must ensure that, prior to finalising the roster, all shifts accurately reflect the planned staffing deployment, including any additional requirements and any known unfilled duties.

Following second-level approval, or as soon as a staffing gap is identified, all unfilled duties must be released to NHS Professionals to maximise opportunities for fill. Requests should include the correct colleague group, skills and competencies required, together with sufficient information to justify the request in line with patient acuity and service need. Urgent requests should be clearly identified and followed up by telephone on the same day where necessary.

Where shifts remain unfilled, services must follow the Trust escalation process. This includes reviewing opportunities for internal redeployment, temporary movement of colleagues from areas with surplus capacity, the offering of additional shifts to substantive colleagues where appropriate, and timely escalation through the operational management and on-call arrangements where safe staffing cannot be achieved.

3.5 Daily or weekly staffing reviews and forecasting

As staffing requirements, unplanned colleague absence and service need can dynamically change between the date the roster is created and the live day, staffing is required to be reviewed at regular intervals to ensure that services remain safe, sustainable and productive.

All services must ensure that there is a weekly dynamic review of staffing at a minimum. For inpatient services and areas where staffing requirements are anticipated to change rapidly, the frequency of these reviews should be daily.

The dynamic staffing reviews must include a review of the required staffing compared to the actual staffing, a review of the skill mix on duty compared to the patient needs, a consideration of colleague wellbeing and fatigue (including compliance with the Working Time Directive requirements) and a decision made on the staffing escalation position using agreed thresholds and professional judgement. For inpatient services, this needs to include and consider the number of enhanced observations or escorts out of hospital, high dependency patients and any red flag staffing events which may occur or be at risk of occurring.

The escalation position should fall into one of four states:

- optimal staffing
- suboptimal staffing, operational minimum
- suboptimal staffing, reduced clinical activity
- suboptimal staffing, unsafe staffing

The suboptimal staffing positions may interchange, with a ward or team moving from one position to another dependent on interventions undertaken, and how the situation develops. As such special consideration should be given to this, the risks of this occurring, and should be detailed in the escalation position.

Table 1. Staffing escalation position definition

Ratings	Level	Explanation
1	Optimal staffing	The agreed staffing establishment within the team or ward, this will normally be agreed at the annual staffing review and is usually the staffing designated within the e-roster template
2	Suboptimal staffing, operational, minimum	The minimum number of colleagues required to maintain all operational functioning of the team or ward without patient care or experience of care being affected
3	Suboptimal staffing, reduced clinical activity	The minimum safe level of staffing which can be achieved with some reorganisation or temporary postponement of none safety critical activity or urgent clinical activity, this may be linked to the business continuity plans
4	Suboptimal staffing, clinically unsafe staffing	Once staffing has gone beyond the ability to implement business continuity and emergency or urgent clinical activity can no longer be maintained and patients are at risk of harm

Careful consideration should be given to the length of time each area has been within any suboptimal staffing states. Areas may be able to maintain a high quality of care and safety for short periods of time within suboptimal staffing states, but prolonged, may have negative outcomes for patients or colleagues.

3.6 Escalation of staffing concerns

The management of the staffing resource is a dynamic one, which requires significant focus to assess the current and impending acuity of the patient population, alongside the treatment program, general task allocation, central to the smooth running of each ward or team.

It is essential therefore, that each service adopts the processes identified in the previous section, to plan well in advance, recognise changing demands and react dynamically and mitigate the risk.

There are times however, when despite proactive interventions and review, staffing may not be safe, effective and sustainable. As such, a formal escalation process is required to ensure that risks are identified, escalated and actions taken to mitigate.

Any situation whereby the escalation status is within reduced clinical activity or clinically unsafe must be escalated as a matter of urgency for immediate action or oversight. The same principal applies for any red flag staffing event which may have occurred or be at risk of occurring within inpatient services.

The nurse in charge of a ward is the designated professional responsible for the identification of the staffing escalation position, and the identification of any red flag staffing events within inpatient services.

In non-inpatient teams, the most senior professional on duty is the designated professional responsible for the identification of the staffing escalation position, and the identification of any red flag staffing events within the service.

There must be a daily designated professional responsible for the oversight of staffing and the designated contact for any staffing escalation and support. This is usually a senior nurse such as a matron or nurse director in hours, or patient flow duty manager out of hours.

Staffing escalations should be clear in terms of what the shortfall is (skill mix, number of colleagues, experience, high amount of bank or agency), what the current staffing position is, what the risk towards patient care or safety is, and what actions have already been taken.

Where local actions have proven to be insufficient to mitigate the risk, and the ability to deploy safe staffing comprised, then further escalation must occur to directorate management teams, then if mitigations prove insufficient to care group senior leadership teams. Should mitigations prove insufficient at this point, escalation is to a trust wide level utilising all staffing resources where available. Out of hours this will following the on-call management structure, escalating first to the patient flow duty manager, who will escalate as required to the senior manager on call, and if required escalation to the director on call. Appendix C details the staffing escalation framework.

Inpatient wards must have systems in place for the identification of these specific events occurring or if they are likely to occur, processes to escalate these events and systems in place to learn from them.

The specific inpatient red flag events within Rotherham, Doncaster and South Humber NHS Foundation Trust are:

- 50% or less of the planned qualified nurse deployed
- agency use is a third of the clinical workforce covering the working hours or shifts
- preceptorship nurse working without a second qualified nurse, or without adequate supervision
- missed clinical or therapeutic observations due to staffing levels
- colleagues unable to take breaks for the duration of a clinical shift
- cancellation of planned therapeutic activities or clinical activity due to staffing
- inpatient area unable to respond to clinical emergency due to staffing

All inpatient red flag staffing events must be reported via the trust's incident reporting systems under 'staffing related incidents' and escalated either at the time they occur or are identified as at risk of occurring. Please see [incident management policy](#).

There may be occasions, following a dynamic risk assessment, that actions are not required if an area is within a suboptimal staffing escalation state, or red flag staffing events occurring. On these occasions, it is essential that there is senior oversight of the ward or team, as the risk may change rapidly, and a swift response may be required.

All staffing escalations should be monitored locally by the care group nurse director or matron with the aim of learning lessons and reducing the risk of them occurring again.

3.7 Governance

Due to the dynamic nature of safer staffing, effective and responsive governance frameworks are required to ensure that controls in place to mitigate risk associated with staffing are working effectively and provide timely escalation and oversight of emerging risks.

Oversight of staffing, escalation of risks and the escalation status of each area must be maintained locally by the operational teams.

Confirm and Challenge Meetings

As part of the governance framework, monthly Confirm and Challenge meetings will be undertaken in each inpatient ward area by ward manager (or delegate) matrons, and the safer staffing lead. These meetings provide an opportunity to review roster performance, staffing establishments, temporary staffing utilisation, sickness, vacancy levels, WTD compliance, and any significant roster changes made following second-level approval.

The purpose of the Confirm and Challenge process is to provide assurance that rosters are aligned to agreed establishments, staffing resources are being utilised effectively, and risks are identified and addressed at the earliest opportunity. Where concerns are identified, actions and management plans will be agreed and monitored through subsequent meetings.

Monthly safer staffing meetings. A monthly safer staffing report will be created for each inpatient area, these will be discussed at the monthly safer staffing meeting and be critiqued by the care group nurse director with the aim of developing cogent management plans to support hot spot ward areas. Other areas may be defined by the local team as hot spot areas, despite being within the agreed establishments, and will be raised by the care group nurse director or matrons to the safer staffing lead and NHSP relationship manager, or deputy chief nurse.

All hot spot areas will be reported via the monthly safer staffing Meeting with additional triangulation of nurse sensitive indicators (for example, complaints, incidents, falls, fill rates, pressure ulcers etc) and trust wide themes. This information will also be reported bi-monthly to board (or sub board) via safer staffing reports and the iQPR, and the bi-annual safer staffing paper.

These exception reports should be triangulated by the care group nurse director and matrons using patient safety information, care quality information, patient feedback and colleague feedback to monitor any adverse effects due to staffing.

Governance processes will include oversight of temporary staffing utilisation (including NHSP and additional shifts), monitoring of compliance with WTD requirements, and review of any significant deviations from agreed rosters following second-level approval. This is to ensure that staffing risks, including over reliance on temporary staffing, excessive hours, and unplanned roster changes, are identified, escalated, and managed appropriately.

Any wards which have maintained exceptionally high (greater than 120% of planned staffing) or exceptionally low (less than 80% of planned staffing) staffing deployment for a sustained period of time (greater than 3 months) should also have a management plan developed to ensure that effective oversight and actions are taken to mitigate the risk of harm to patients.

Advice and guidance for management plans is available via the safer staffing lead and NHSP relationship manager and, or deputy director of nursing via the exception reporting procedure.

The exception reports, and associated management plans, will be discussed at a monthly safer staffing meeting.

If the management plan in place is not having the desired impact or is assessed by the group to be insufficient to resolve the staffing challenges, a bespoke establishment review will be scheduled to carry out an in-depth analysis in support of the operational team and should be escalated to the executive director of nursing and AHPs.

Bespoke establishment review process is section 5.2 of this policy and will be prioritised by all parties.

4 Responsibilities

On an inpatient ward safe staffing is everyone's responsibility. In this respect it is everyone's responsibility to report any instances where there are staffing concerns to the ward management team and on an incident report. Medical, allied health professionals and psychological therapies disciplines can all contribute to safe staffing numbers with wrap around support. For example, an allied health professional may support the activities of daily living assessment or a recreational group which contributes to the safe staffing numbers on the ward.

4.1 Chief nurse

The Chief Nurse is responsible for:

- providing assurance to the trust board that there are effective nursing workforce plans in place for all patient care pathways
- ensuring that ward establishments are safe, appropriate and in line with national benchmarks
- providing professional and strategic leadership to all nursing colleagues and all senior nurses or matrons adhering to this manual

4.2 Deputy Chief nurse

The deputy director of nursing is accountable and responsible on behalf of the Chief Nurse for:

- ensuring all wards have a clear reporting and escalation process in place for ward leaders reporting their safe staffing levels
- reviewing the clinical establishments ensuring they are safe, appropriate and in line with national benchmarking
- ensuring the bi-monthly safe staffing report is provided to sub-board (quality committee) with any risks, improvement or concerns actioned by care groups

4.3 Safer Staffing and NHSP Relationship Manager Lead

The safer staffing and NHSP Relationship lead is responsible for:

- providing strategic expert guidance and advice for tools to support operational implementation in the care groups to ensure the optimal safe staffing of inpatient wards, for example, this policy, guidelines, implementations, safer staffing tool, expertise, and training for colleagues
- provide guidance and oversight of the process to monitor compliance with the CQC regulation 18 and will review the monthly optimal safe staffing figures (fill rates)
- ratify and add narrative to the bi-monthly report data with the care group nurse directors, the report includes concerns improvement, or actions required or being across the care groups, risks and mitigations
- sharing in-patient workforce planning with the wider Integrated care system (ICS) and to share or escalate any insights or opportunities or impacts on recruitment, retention and wider trust strategies

4.4 Care group nurse directors or deputy care group directors

Care group nurse directors or deputy care group directors are responsible for:

- ensuring there are regular daily local meetings held by the matron with the ward managers for their responsible wards
- monitoring and providing strategic workforce planning for responsible areas and ensuring the wards are safely staffed on a shift-by-shift basis, this includes the authorising and monitoring the usage of agency colleagues
- any staffing concerns or incidences to be escalated by the matron and to coordinate actions to mitigate the concerns
- attending the monthly safe staffing meeting and ensure exception reporting takes place with actions on where necessary for their responsible wards
- providing local reporting processes at care group quality steering groups and care group delivery review meetings to share in-patient workforce planning with the wider integrated care system (ICS) and to share or escalate any insights or opportunities or impacts on recruitment
- supporting the care group strategic thinking around staffing for all areas and overarching planning to support the safe staffing program
- reviewing the care group operational risk register related to in-patient safe staffing and provide the updates on the actions, and controls related to these risks
- dip test audits on the quality of the e-roster completion

- ensuring this information is also to be shared at the daily on-call handover meetings, and weekend planning meetings, so any staffing challenges are shared with on call and out of hours services

4.5 Matrons

Matrons are responsible for:

- authorising the monthly roster in advance and ensure the rotas support safe, effective, and fair staffing
- leading on daily workforce planning and where necessary chair local meetings and check shift coverage and any gaps, with a forecast plan for the forthcoming days
- redeploying their resources where necessary to support the cover of red wards for their clinical areas as per escalation process
- where concerns about safe staffing are made including from incident reporting, the matrons have a duty to investigate, respond and resolve in a timely way to maintain safety and provide feedback to those raising concerns
- the daily oversight and triangulation of quality indicators on staffing including patient safety incident reports, clinical audits, rostering checklist or audit, ward sickness, agency or bank usage, complaints, structured judgement reviews, serious incidents, ward acuity, vacancies, seclusions, 136 suite impacts, and the number of supportive therapeutic observations and patient needs (for example, level of complexity), ward environment or design. The matrons will act and, or escalate concerns where necessary if the level of staffing is inappropriate for the patient cohorts or acuity or dependency
- escalating to the care group nurse director the request and requirement for external agency resources
- attending the monthly safe staffing meetings and oversee the exception reporting for delegated wards
- along with the ward managers will support the completion of the annual review template and will also progress the actions for the 6 monthly safe staffing reviews

4.6 Service Manager

Service Managers are responsible for:

- providing overall operational oversight and assurance that staffing establishments, deployment and workforce utilisation support the delivery of safe, effective and high-quality care across their services
- ensuring staffing resources are managed within agreed budget allocations and taking appropriate action to address variances, overspends, agency expenditure and workforce inefficiencies
- reviewing workforce performance, expenditure and establishment data to ensure services operate within financial controls whilst maintaining safe staffing levels and quality standards
- supporting matrons and ward managers to identify and implement workforce improvement plans, including recruitment, retention, sickness reduction, roster optimisation and skill mix reviews
- ensuring robust governance arrangements are in place for the monitoring, escalation and management of staffing risks, including workforce shortages, recruitment challenges and sustained staffing pressures

- overseeing the effective implementation of the safer staffing policy and ensuring compliance with workforce planning, rostering, SafeCare Live, acuity and dependency tools, and associated governance processes
- providing scrutiny and challenge regarding staffing decisions, workforce utilisation and deployment, ensuring resources are used effectively and in line with organisational expectations
- escalating significant staffing risks, workforce pressures and financial concerns to the Care Group Nurse Director and other senior leaders as appropriate
- ensuring lessons learned from incidents, complaints, patient safety events, workforce data and quality indicators are reviewed and acted upon to improve workforce planning and patient care
- attending monthly safer staffing meetings and providing assurance regarding workforce performance, staffing risks, mitigation plans and budgetary impacts within their areas of responsibility
- supporting the completion of annual establishment reviews and six-monthly safer staffing reviews, ensuring workforce recommendations are evidence-based, financially sustainable and aligned to service need
- ensuring workforce plans support organisational priorities, national workforce standards, quality objectives and the delivery of safe and compassionate care.

4.7 Ward managers

Ward managers are responsible for:

1. ensuring the e-roster is completed in time with a fair and robust staffing plan and will escalate concerns to the matron as per escalation process
2. requesting bank coverage where there are nursing shortages in planned rosters, and these cannot be covered by redeploying existing nurse resources
3. responding and acting on changing patient acuity or dependency or needs
4. completing and reviewing incident reports where staffing risk was not mitigated
5. reviewing incidents and triangulate the quality indicators on staffing for their wards and will ensure workforce plans are in place, escalating concerns with plans or actions to mitigate any concerns
6. Ratifying the monthly safe staffing report, providing feedback on workforce plans around recruitment and retention

4.8 Nurse in charge

Nurse in charge is responsible for:

- ensuring the staffing levels meet ward acuity or dependency and to act on any required changes, this includes escalating to the ward leadership team for approval additional staffing
- escalating staffing concerns for the shift to the ward leadership team or on call including training need or gaps
- any failures in patient care because of staffing or where staffing was a contributory factor
- completing any incident reports where safe staffing has not been met

4.9 In-patient registered nurse

In-patient registered nurse is responsible for:

- complying with their NMC code of conduct regarding patient safety
- escalating staffing concerns to the ward leadership team (ward manager or deputy ward manager) and, or patient flow duty manager
- requesting additional bank colleagues where there are unplanned nursing shortages and will escalate from checking the roster any further impacts the unplanned colleague shortages may have to the ward leadership team or out of hours team
- completing an incident report where staffing risk was not mitigated
- raising any safeguarding concerns related to safe staffing
- raising any concerns around patient safety issues related to staffing to the ward leadership team, including any training or learning needs for colleagues
- where necessary to ensure patient care is not compromised and will provide support outside their usual clinical ward

4.10 Qualified nursing associates

Qualified nursing associates is responsible for:

- contributing to the core work of the shift including acting as responsible second qualified to free up the registered nurse to focus on more complex clinical care
- raising any safeguarding concerns related to safe staffing
- completing incident reports where staffing risk was not mitigated
- acting in accordance with the NMC code of professional standards including recognising and report any factors that may adversely impact safe and effective care
- where necessary to ensure patient care is not compromised and will provide support outside their usual clinical ward within their parameters of roles and responsibilities
- the qualified nurse associate provides additional nursing support to the registered nurse and should work within their jurisdiction, not under any circumstances should the qualified nurse associate take on the role and responsibilities of a registered nurse to support staffing challenges

4.11 Nonregistered colleagues

Non-registered colleagues are responsible for:

- escalating staffing concerns for the shift to the nurse in charge or Ward Management team
- completing incident reports where safe staffing was not met
- reporting any patient safety concerns where staffing has been a contributory factor to the Ward Management team or nursing in charge
- where necessary to ensure patient care is not compromised to provide support outside their usual clinical ward

4.12 Out of hours

The patient flow duty manager is responsible for supporting ward areas resolving ward staffing challenges or concerns. The patient flow duty manager will escalate to silver on-call where there are staffing concerns which require further considerations or actions or approval.

This includes where the ward team have been unable to provide safe staffing in in-patient areas. The silver on-call will support decision around staffing concerns and

where necessary will escalate to gold on-call for support or approval. This could include decisions around 136 suite closures to support staffing issues or challenges.

The staffing concerns or issues are recorded on an on-call decision log and information is communicated and shared with the relevant operational or on-call teams the following day.

5 Training implications

Colleagues responsible for using evidence-based tools must receive appropriate training, information is available via the workforce transformation lead.

As a trust policy, all colleagues need to be aware of the key points that the policy covers. Colleagues can be made aware through a variety of means such as:

- one to one meetings or supervision
- continuous professional development sessions
- special meetings
- intranet
- team meetings
- local induction

5.1 Evidence-based staffing tools training, colleagues responsible for using evidence-based tools like MHOST

- How often should this be undertaken: Initial and refresher as needed.
- Length of training: Up to 60 minutes.
- Delivery method: Peer to peer.
- Training delivered by whom: Any colleagues competent in the application of the tool.
- Where are the records of attendance held: ESR.

Colleagues are also reminded to keep up to date with their MAST compliance.

6 Monitoring arrangements

6.1 Safer staffing performance

- How: Monthly reports detailing safer staffing metrics, triangulated date alongside rostering performance metrics
- Who by: Created by Safer staffing team, confirmed and ratified by ward managers, Care group nurse directors and modern matrons.
- Reported to: Safer staffing meeting.
- Frequency: Monthly.

6.2 Compliance with evidence-based staffing tools for example, mental health optimal staffing tool (MHOST)

- How: Review of data collection frequency and use of tools like MHOST.
- Who by: Deputy Chief Nurse and Safer Staffing Lead
- Reported to: Trust board via Quality Committee.
- Frequency: Annually.

6.3 Establishment review completion

- How: Review of establishment review completion and recommendations.
- Who by: Workforce transformation lead.
- Reported to: Deputy Chief Nurse and Safer Staffing Lead
- Frequency: Bi-annually.

6.4 Monitoring of staffing escalations

- How: Staffing escalations will be monitored locally.
- Who by: Care group director of nursing and matron for each ward.
- Reported to: Outcomes will be reported to the monthly Safe staffing meeting.
- Frequency: Monitoring will be ongoing, with outcomes reviewed monthly at the safe staffing meeting and will be administrated in the care groups.

6.5 Quality of e-roster completion

- How: Conducting periodic dip test audits on the quality of e-roster completion.
- Who by: The care group director of nursing.
- Reported to: Outcomes of the audits would be reported to the safe staffing meeting and appropriate ward managers.
- Frequency: Dip test audits should be conducted periodically, such as quarterly.

7 Related documents

- [Rostering policy and procedure](#)
- [Ball, J. and Saville, C. \(2020\) What difference have safe-staffing policies made to NHS hospitals? Nursing Times, 116\(8\), pp. 31 to 32. NHS \(2022\) Safer staffing: nursing and midwifery \(accessed September 2023\) \(opens in new window\)](#)
- [Gilburt, H. \(2018\) Funding and staffing of NHS mental health providers: still waiting for parity \(accessed September 2023\) \(opens in new window\)](#)
- [Gilburt, H. \(2019\) Securing money to improve mental health care but no staff to spend it on \(accessed September 2023\) \(opens in new window\)](#)
- Griffiths, P. et al. (2020) Nursing workload, nurse staffing methodologies and tools: A systematic scoping review and discussion, International Journal of Nursing Studies, 103, pp. 103487
- [Health Education West Midlands \(2015\) Mental Health Staffing Framework \(accessed September 2023\) \(opens in new window\)](#)
- [Mental Health Act 1983, c. 20 \(accessed September 2023\) \(opens in new window\)](#)
- [Mental Capacity Act 2005, c. 9. \(accessed September 2023\) \(opens in new window\)](#)
- [National Quality Board \(2016\) 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 \(accessed September 2023\) \(opens in new window\)](#)

- [National Quality Board \(2018\) Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals \(accessed September 2023\) \(opens in new window\)](#)
- [NHS Improvement \(2018\) Developing workforce standards: Supporting providers to deliver high quality care through safe and effective staffing \(accessed September 2023\) \(opens in new window\)](#)
- Royal College of Nursing (2020) A safety representative's resource: Staffing for safe and effective care
- Skills for Care (2018) Guide to safe staffing (accessed September 2023) (opens in new window)
- [The Human Rights Act 1998, c. 42 \(accessed September 2023\) \(opens in new window\)](#)

8 Appendices

8.1 Appendix A Inpatient red flag staffing event framework

Red flags are those occurrences which may be an indicator that the quality of care has declined, and patients are being made vulnerable. Should any of these occur, escalation for investigation should follow immediately. It could be necessary to increase staffing levels on the basis of these events. This should be recorded on the incident reporting system, and the management of the situation must then follow the route as stipulated in appendix B. The actions to be taken are not extensive and as such should be taken as a guide, and the use of local managerial knowledge should be utilised to mitigate the risks.

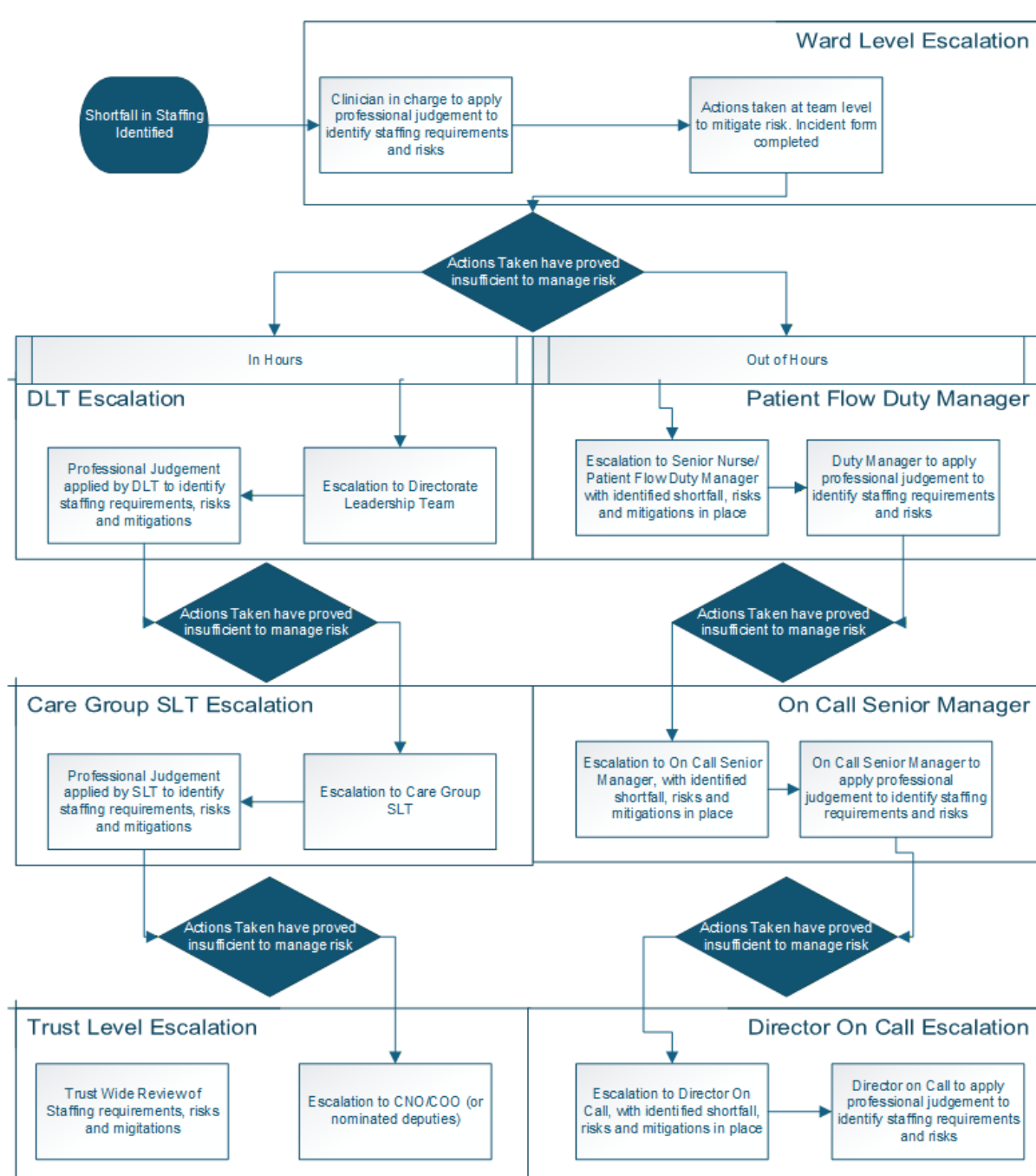
Hospitals need to have a system in place for nursing red flag events to be reported by any member of the nursing team, patients, relatives, or carers to the registered nurse in charge of the ward or shift. The nurse in charge of the ward should have a knowledge of what these events are and how to escalate these if they occur or are at risk of occurring.

If a nursing red flag event occurs or is identified as being at risk of occurring, it should prompt an immediate escalation response by the registered nurse in charge.

8.1.1 Red flag staffing events to be escalated

- 50% or less of the planned qualified nurse deployed.
- Preceptorship Nurse working without a second qualified nurse or without adequate supervision.
- Missed observations due to staffing levels.
- Colleagues unable to take breaks for the duration of a clinical shift.
- Cancellation of planned therapeutic or clinical activity due to staffing.
- Inpatient area unable to respond to clinical emergency due to staffing.

8.1.2 Inpatient staffing escalation framework



1. Shortfall in staffing identified.
2. Nurse in charge undertake professional judgement to identify staffing requirements and risks.
3. Actions taken at ward level to mitigate risk and report as an incident on the incident reporting system.
4. Actions taken have proved insufficient to mitigate risks.
5. Escalation to directorate leadership team (DLT) in hours, or patient flow duty manager out of hours with identified shortfall, risks.
6. DLT or patient flow duty manager to contact the ward and use professional judgement to identify shortfall and associated risks.

7. Actions taken at service level to mitigate risk.
8. DLT or patient flow duty manager to revisit actions taken at ward level.
9. Actions taken have proved insufficient to mitigate risks.
10. Escalation to Care Group Senior Leadership Team (SLT) in hours, or senior manager on call on call out of hours with identified shortfall, risks and actions taken.
11. SLT or senior manager on call to identify the risks and impact of previous actions to mitigate.
12. Additional actions taken to mitigate risk
13. All previous actions to be revisited.
14. Actions taken have proved insufficient to mitigate risks.
15. Chief Nurse and Chief Operating Officer (COO) to be contacted in hours, director on call out of hours Gold on call to be contacted and made aware of the staffing situation, the risks identified and actions taken.
16. Additional trust wide considerations by the CNO/COO/director on call, in line with relevant emergency planning, preparedness and response guidance and policies.

8.2 Appendix B Inpatient establishment review

- [Appendix F inpatient establishment review \(staff access only\) \(opens in new window\)](#)

8.3 Appendix C Ward to board information flow

The purpose of this process is to ensure robust governance and clear information flow.

Information flow between:

- trust board
- quality committee
- quality and safety group
- monthly safe staffing meeting
- Care Group and Directorate governance meetings
- Confirm and challenge meetings
- operational daily huddles
- team huddles or daily ward meetings

The monthly safe staffing meeting is summarised in a report to quality and safety group, and then quality committee. This summary report provides the overarching detail covered in the monthly safe staffing meetings or local governance meetings and ward level meetings.

Patient flow and acuity are provided also in the narrative as well as mitigations on fill rates which fell below safe staffing levels. The data is triangulated to give an overall picture. As well as this staffing incidences are checked for mitigations and any further actions required.

Trust board assurance is provided at trust board via the quality committee report around safe staffing.

Annual review and 6-month declaration is reported to Quality Committee and Board of Directors. The annual review is reported to quality committee and board of directors.