Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Safe Staffing Escalation for In-Patient Areas Policy (Nursing & Midwifery)

This procedural document supersedes: PAT/PS 18 v.1 – Safe Staffing Escalation for In-Patient Areas Policy (Nursing and Midwifery)

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Target audience:	Nursing and Midwifery staff, Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	30 March 2022	• Review undertaken to reflect current Trust processes, Structure changes and operational flow changes • Update regarding escalation for temporary staff / agency process • Update of terminology regarding role titles • Full policy review planned to be completed by end of September 2022 to reflect planned change to utilise Allocate Safe Care tool	Marie Hardacre / Kirsty Clarke
Version 2	24 November 2015	• Update General Ward Escalation Process to reflect current processes • Update terminology - Matron on call altered to Duty Matron • Update processes to reflect current Operational Flow meeting • Update processes to reflect current temporary staffing planning and requests	Lib Jones
Version 1	27 November 2014	This is a new procedural document as a result of two pieces of major guidance from the National Quality Board and NICE, please read in full.	Lib Jones

Contents

Flowchart 1 General Ward Escalation Process if Sudden Acute Staffing Shortfall

Level 1 - YELLOW
Red Flag Triggered or Increased activity/dependency E.g. enhanced care needs sickness absence ACTION within 30 minutes at Ward level

IN HOURS
Consider:

1. Professional judgement of staffing needs
2. Utilise un-used hours
3. Realign rotas including skill mix needed, sharing of staff
4. Ring own part time staff
5. Ring Nurse bleep holder for unit support
6. Consider cancelling management time, training, students, time owing and short/long term leave plans
7. Contact NHSP for active contacting of bank workers
8. ACTION: Report via divisional bleep and Ops Meeting - exact shortage and plan
9. Report Red Flags using the incident reporting system

OUT OF HOURS
As above

Chief Nurse reports weekly to Executive Team and monthly to Board of Directors regarding exception and consequence

Review Meeting at Speciality / Divisional Level

Level 2 – AMBER

Risk assessment indicates inadequate staffing levels despite mitigation explored/ implemented Action within 60 minutes at Bleep Holder /Matron / CSM Level

IN HOURS

1. Escalate to Bleep Holder and / or Matron responsible for ward
2. Check Level 1 complete. Review plans and risks identified. Review staffing across level of responsibility
3. Consider other registered nurses who can support e.g. specialist nurses and educators
4. Ask other Divisional bleep holders / Matrons to review rotas and workload across sites
5. Consider short notice leave cancelled across speciality / Division site/organisation e.g. time owing, annual leave
6. Consider additional hours/overtime and check agency cascade triggered and consider Golden Key removal (by DDoN / HoN during hours)
7. ACTION: Report via Ops Meeting - exact shortage and plan
8. Escalate to Chief Nurse / Deputy for site wide management
9. Ensure outcome of decisions is shared to the relevant managers

OUT OF HOURS
Escalate Clinical Site Manager / Duty Matron. Check Level 1 &2 carried out if unresolved refer to DDoN/ Senior Manager On Call/Executive Director to consider golden key removal higher Tier

Review Meeting with Decision Makers
Chief Nurse / Deputy Chief Nurse
Chief Operating Officer or Deputy Chief Operating Officer (or deputy), Divisional Director of Nursing / Head of Midwifery, Exec On call

Level 3 – RED

Action by Matron / Head of Nursing within 1 hour. If issues continues chair Review Meeting in 60 minutes

IN HOURS
Consider:

- Review position relating to non-ward based nurses being allocated to areas of need – without impacting on patient safety
- Consider temporary reduction of beds in affected area / areas
- Consider stepping down of non-urgent inpatient activity / Out Patient activity to redirect staff to affected areas.
- Agency cascade in place and golden key for Higher cost agency considered and actioned
- Consider internal ED divert if clinical safety concerns relating to staff shortfalls
- Consider external ED divert if clinical safety concerns relating to staff shortfalls

Ensure outcome of decisions is shared to the relevant managers

1. INTRODUCTION

Nursing, Midwifery and Care Staff, working as part of a multi-disciplinary team, play a critical role in delivering safe, high quality care to patients and service users. The Doncaster and Bassetlaw Teaching Hospitals NHS Trust Strategy puts patients at the heart of all that we do. There is strong evidence from a range of recent reports (Hard Truths Department of Health 2013, Francis 2013, Keogh, 2013, Berwick, 2013) that having the right number of staff delivering care in the right place impacts positively on both clinical outcomes and patient experience. Addressing these issues ensures that we prioritise the safety and experience of our patients and staff.

The global pandemic has had an enormous impact on the workforce and has been the most challenging times for those providing care. The health and wellbeing of our teams and the ability for the workforce to recover and restore is paramount to ensure the safety and experience of our patients is maintained.

In November 2013, the National Quality Board clearly articulated 10 expectations which require all NHS Trusts to ensure that nursing and midwifery staffing levels are safe and optimal at all times and across all areas. Central to these expectations is the requirement to publish staffing information in the public domain and to ensure that the roles and responsibilities of those with responsibility for responding to gaps in staffing establishments are clearly outlined. This guidance remains and Care Hands per shift / UNIFY data is required to be submitted monthly.

In July 2014 the National Institute for Health and Care Excellence (NICE) published Safe staffing for nursing in adult inpatient wards in acute hospitals. It makes recommendations on safe staffing for nursing in adult inpatient wards in acute hospitals. It also identifies organisational and managerial factors that are required to support safe staffing for nursing, and indicators that should be used to provide information on whether safe nursing care is being provided in adult inpatient wards in acute hospitals.

2. PURPOSE

The purpose of this policy is to provide effective support to those staff who have responsibility for safe staff decision making on a shift by shift basis. It addresses the following questions:

1 - How do we know that there are enough staff deployed?
2 - What do we do when there are not enough staff?
3 - How and to whom is it escalated when there are concerns?

The person in charge of the relevant area is responsible for assessing that staffing numbers are as expected on the rota and the ward / team is assessed as being safely staffed taking into consideration workload, patient acuity, dependency and skill mix.

3. DUTIES AND RESPONSIBILITIES

3.1 Chief Nurse

Report bi monthly staffing information to Board of Directors on planned vs. actual numbers of staff on duty on a shift by shift basis.

Provide assurance to the Board that there are effective nursing and midwifery workforce plans in place for all patient care pathways or identify where shortfalls are predicted and plans to mitigate.

Hold Divisional Directors of Nursing / Director of Midwifery to account for having appropriate staffing capacity and capability on a shift by shift basis.

Agree with Divisional Directors of Nursing / Director of Midwifery the changes in planned staffing levels as part of annual budget setting and adhoc changes.

Where staffing issues occur, ensure Datix; Trusts incident reporting system is completed to reflect staffing concerns and actions taken throughout the use of the Escalation Process if sudden day by day Acute Staffing Shortfall (see flowchart 1 on page 4).

With Chief Operating Officer, be part of Decision Making meeting at Level 3, chaired by Chief Nurse or assigned deputy.

Chief Nurse / Executive on call /Divisional Directors of Nursing to review situation and whether first and second Tier agency requests following review of situation and having fully escalated to NHSP. Follow cascade in place for the 1st Tier agencies in level 1 & 2. Remove the Golden Key for Higher cost agency shifts as per cascade in place at that time and if sufficient evidence to support the need for higher cost agency. Golden keys for removal to be escalated to Chief Nurse (or designated deputies – deputy chief nurse, Divisional Directors of Nursing) or executive on call out of hours.

3.2 Head of Nursing Workforce

Develop the nursing and midwifery leadership teams so that they can demonstrate an understanding of the principles of workforce planning and can use evidence based tools informed by professional judgement to develop workforce plans and make decisions about staffing safely.

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix. Support the Director of Nursing, Midwifery and Quality to report accurate and timely data to the Board of Directors.

3.3 Divisional Director's of Nursing and Director of Midwifery

Develop a Divisional workforce plan for nursing and midwifery to respond to vacancies and provide the required resource to fill them. The Divisional Directors of Nursing / Director of Midwifery will ensure that the Divisional workforce planning process forecasts the future nursing workforce requirements, taking into account changes to service, the acuity of patients accessing the services, matched to the bed plan, skill mix and will take into account the training, sickness and absence and existing vacancy rate. The Divisional Directors of Nursing / Director of Midwifery will work with the Chief Nurse, Deputy Chief Nurse, Workforce lead P&OD and Workforce Head of Nursing to develop and deliver strategic workforce planning.

Develop local processes that ensure staff work safely within the limits of their competency.

Approve prospective staffing plans with the Chief Nurse.

Reallocate staff across areas of responsibility to ensure safe levels throughout where the matron has been unable to do so.

Daily / Weekly / Monthly (depending on situation) workforce planning across Divisions to ensure staff are distributed according to clinical need.

Chair the Review Meeting at level 3 as delegated by the Chief Nurse or Deputy. This includes ensuring the correct people are involved to ensure appropriate decision making.

Where necessary, review clinical activity on the wards and consider use of non-ward based nurses e.g. corporate teams, educators; cancellation of all training, the cancellation of in-patient planned activity and closure of beds in collaboration with the Chief Operating Officer and Chief Nurse. Request for release to second Tier Agency will also be considered via the golden key cascade.

Communicate use of corporate nurses through the chief nurse and consider the cancellation of training and use of educators via Deputy Director of Education.

Identify with the corporate communication team and usual operational channels, a communication plan to ensure all staff are aware of decisions and how it will affect them.

Undertake risk assessment for staffing issues, including vacancies, sickness and absence, excessive demands and document these on the Divisional / Speciality Risk Register. The risk assessments and risk register entries must be under regular review to mitigate the risk, using the Red Flags reported and other quality indicators, such as patient experience contacts, surveys and the Quality Metrics for the departments concerned.

3.4 Out of Hours Senior Manager on-Call – Silver on call

Review the actions taken to date by the Clinical Site Manager and Duty Matron and suggest any additional measures that may be taken to support the safety of patients.

Contact the executive director on call if unable to resolve the risks to patient safety or to request escalation to higher tier agency via golden key removal.

Feedback outcome to staff involved in the escalation.

3.5 Matrons

Ensure effective and efficient use of nurse staffing resources, including 21% headroom, to support safe, effective, fair staffing planned in advance by reviewing, revising and authorising the monthly roster.

Proactive daily / weekly / monthly workforce planning across patch to ensure staff are distributed according to clinical need. Including daily to weekly utilisation of RAG rated assessment of staffing in ward areas.

Reallocate staff across area of responsibility to ensure safe levels throughout using the Escalation Process if Sudden Acute Staffing Shortfall (see flowchart 1 on page 4). This includes deployment of non-ward nurses.

Monitor red flag triggers and respond to these as part of on the day, short term and long term workforce planning.

Escalate to Tier 1 agency where NHSP are unable to fill shifts.

Escalate to DDoN / Heads of Nursing/Midwifery, informing where areas of concerns are and if higher tier agency needs consideration.

Feedback outcome to staff involved in the escalation.

3.6 Clinical Site Management Team/ Bronze Rota (out of hours/ weekend)

On a shift by shift basis the Clinical Site Manager will have an overview of staffing and patient acuity across the whole organisation. This information will shared via bleep holders, Divisional Matrons, face to face reviews, information flow from digital systems and information on the live bed management system.

At the Operational Flow Meeting out of hours (Between 6pm and 8am Monday to Friday) and over the full weekend period the site manager will be responsible for escalating staffing issues to the Bronze Rota personnel. The Clinical Site Management Team will be responsible for ensuring that all actions pertinent to staffing shortage agreed with the Bronze Rota personnel are enacted through direct action or delegation to speciality bleep holders.

Out of hours escalate to senior manager on call where actions (by Clinical Site Management Team / Bronze Rota) to triggered Red Flags identified in section 4.3 are insufficient.

Out of hours, Clinical Site Manager / Bronze Rota personnel escalates the requirement of higher tier* Agency to the Executive on Call (request to release the Golden Key) or Divisional Director Nursing (if Silver on call) having assessed the situation for Escalation to 2nd Tier* Agencies.

Feedback outcome to staff involved in the escalation. *This includes escalation of any HCA shifts to any level of agency.

3.7 Unit Bleep Holders

On a shift by shift basis the unit bleep holder will collect and hold an overview of staffing and patient acuity and dependency within their area of responsibility. This will be collated four times a day as a minimum in preparation for the four times a day site operational meetings.

Review staffing rosters within their unit of responsibility and consider using staff from other areas to support patient care. Provide hands per shift information to inform RAG assessment.

Close liaison with Divisional / Speciality Matron and other Divisional / Speciality bleep holders.

Relay information to the Divisional Matron 'in hours' and Clinical Site Management Team / Bronze rota personnel (Duty Matron) out office hour period (between 6pm and 8am Monday – Friday and 24/7 over weekend / bank holiday periods).

Feedback outcome to staff involved in the escalation.

3.8 Ward Manager/Charge Nurse/Ward Clinical Co-ordinator

Respond to unplanned changes to staffing e.g. Sickness, carers leave.

Respond to changing patient acuity/dependency.

Monitor and respond to red flag triggers.

Escalate to Matron or out of hour's Clinical Site Manager / Bronze rota personnel where inadequate staffing levels vs. patient needs still exist.

Complete incident reporting via datix as safe staffing issues arise – to include mitigation and escalation undertaken.

Complete ward / department risk register entry via datix for prolonged staffing shortfall issues – including mitigation and escalation undertaken.

Produce monthly staffing roster in line with e roster guidance.

Utilise E Roster / NHSP interface as part of effective E Roster management.

Request NHSP replacement where nursing/midwifery shortages in planned rosters are identified using NHSP interface in approval of each roster and complete adhoc shift requests as required.

Escalate to Tier 1 agency and Tier 2 agency as per the escalation process in place at the specified time period.

3.9 All Staff

To ensure patient safety all staff must be aware that they may be moved to work within another clinical area if required, this includes across the three Trust sites. This includes all staff who work for NHSP or with an agency.

Report episodes where staffing falls below plan to the Sister/nurse in charge/team leader.

Report absence as soon as possible via the Trust absence line and always to the person in charge of the ward/team at the earliest opportunity.

Incident reporting should be used to highlight when there is any actual harm caused by a shortfall of staff, or where there is a high risk identified that cannot be mitigated through the management actions taken through the escalation process. These types of incidents may be prompted from the examples in the Red Flags list in section 4.3.

4. PROCEDURAL INFORMATION

4.1 General Ward Escalation Process if Sudden Acute Staffing Shortfall

4.1.1 See flowchart 1 on page 4.

4.1.2 Use of Operational Flow Meeting

The Operational Flow Meeting will be chaired on a rota basis by the Senior Manager on Call (SMOC) or Clinical Site Senior Nurse. Data will be updated throughout the day. A review of staffing and patient acuity and dependency by ward will take place prior to (by the bleep holder) and after the operational meeting (SMOC, Divisional Senior nursing team – matron, ward sisters, bleep holder, DDoN). The meeting will comprise of the SMOC, clinical site manager (DRI 8am to 4pm), divisional representatives (Bleep holder and / or associated speciality / divisional flow matron), Bronze Rota Personnel (from 15:30 and 6pm meeting) to enable decision making.

Decisions relating to staffing will remain responsibility of the Division during Business as Usual hours Monday 8am to Friday 5pm with escalation as per flowchart on page 4. Out of hours decisions will be supported by Bleep holders, Bronze Rota Personnel /Clinical Site Manager and Senior Manager on call.

The meeting will use the information provided by the bleep holder and from the electronic bed management board in order to support staffing decisions for the following 12 hours. This will include reviewing escalation from bleep holders and where significant shortfalls flagged even with mitigation:

- Actual staffing against plan for each ward area
- Specific ward based situations e.g. increased capacity due to Winter Pressures that may require additional staff
- Wards where a Red Flag has been triggered

If level 2 and 3 are triggered then the above information will be utilised as part of decision making at level 2 and presented in the staffing brief meeting held as a result of level 3 being triggered.

A documented plan of actions recommended in the operational flow meeting will be recorded as part of the four daily operational meetings.

In hours any actions are the responsibility of the Matron of the area.
Out of hours any actions are the responsibility of the Clinical Site Management Team / Duty Matron.

To maintain communication Trust wide, variance is reported to the Operational Flow Meeting.

4.1.3 Safe Staffing levels for Midwives

The Policy for Safe Staffing levels for Obstetricians, Midwifery and Support Staff (MSG181) includes The Maternity Services Escalation Plan and Suspension of Services Guidance can be found on the intranet (last reviewed July 2015).

4.1.4 Safe staffing levels Adult Critical care areas

DCC / ITU nursing teams to work within GPIC's and refer to the Critical care nursing plans when there is a requirement to work outside of these.

4.2 Application to Practice – How do we know enough staff are deployed?

4.2.1 Use of E Roster - Planning Ahead

The Trust Allocate E Roster tool, is used to provide a prospective overview of staffing per shift per ward. Each ward has pre-determined threshold levels of staff, against which current staff levels are reviewed. These thresholds are reviewed on a quarterly basis and adjusted as necessary.

The purpose of the four weekly Fully Approve and Analyse Process is to provide an overview and status at a glance report of the actual number of staff rostered per shift against the number planned. It is completed by the matron every four weeks.

Matrons should flag these for review by the HoN/DDoN/DOM if any indicators are red and / or as part of the confirm and challenge process at a Divisional Level. It provides a means of initiating response to identified staffing gaps in a timely and proactive way.

The Speciality matron will review the staffing summary with their ward / department managers and where staffing numbers fall below plan will undertake:-

- Review all duty rotas across all clinical areas and consider using staff from other wards to support patient care.
- Assessment of overall skill mix of nursing, midwifery and support staff and utilise appropriately.
- Ensure that the NHSP interface has been enacted to support appropriate use of temporary staff.
- Ensure that NHSP have been contacted to request that additional staff are requested on an adhoc basis.
- Ensure that Part–time staff, who have indicated that they are willing to work additional hours have been contacted at ward level or via NHSP.
- Review with ward managers all planned study/ annual leave and step down / reschedule if risk assessment supports.
- Review the distribution of nurse specialists and non -ward based nurses/midwives/staff.

Where these actions have not resolved the staffing deficit the Matron will:-

- Approve overtime and agency use as is considered professionally required in conjunction with DDoN/DoM/ HoN/HoM
- Refer to the DDoN/DOM who will review and distribute staff across the Division so that the whole Division has safe staffing levels or will escalated to the Chief Nurse and a Datix incident report will be completed.

4.2.2 Use of ward based staffing boards

The purpose of the ward based staffing boards is to enable staff numbers to be displayed publically on each ward on a shift by shift basis. White boards and electronic boards have been placed at the entrance to all ward areas and must be updated by the nurse/ midwife in charge at every shift change.

In order to ensure a consistent approach to the use of Ward Staffing Information Boards a Standard Operating Procedure is to be used.

At the same time as the Ward Staffing Information Board is updated, the hours on each shift must be recorded on the Actual Staffing Template, to collate actual hours of staff in clinical practice.

4.2.3 ‘Real Time’ management of staffing levels to mitigate risk

The ward sister/charge nurse or their deputy will use their professional judgement to manage nurse/midwifery staffing levels on a day to day, shift by shift basis. They will use judgement to

determine if the activity/ acuity of the ward is matched by the skill mix and levels of staff present in order to ensure safe effective care. This will include:

Patient factors

- Individual patients nursing needs (acuity and dependency) – further detail can be found in Table 1 below
- Holistic assessment of nursing needs taking into account specific nursing requirements and disabilities – further detail can be found in Table 2 below.

Ward factors

- Expected patient turnover (including planned, unscheduled admissions, discharges and transfers
- Ward layout and size

Nursing staff factors

- Nursing activities and responsibilities, other than direct patient care e.g. communicating with relatives and carers, managing the nursing team and ward, professional supervision and mentoring, communicating with and providing nursing clinical support to healthcare staff involved with the care of patients on the ward and undertaking audit, performance reviews, staff appraisals.

These activities and responsibilities may be carried out by more than one member of the nursing team.

Support from non-nursing staff e.g. the medical team, allied health professionals and administration also needs to be taken into account.

Table 1: Ongoing Nursing Care Activities that Affect Nursing Staff Requirements

	Routine Nursing Care Needs	Additional Nursing Care Needs (about 20-30 minutes per activity)	Significant Nursing Care Needs (more than 30 minutes per activity)
Care Planning	Simple condition and care plan	Complex condition or care plan (such as multiple comorbidities)	Attending multidisciplinary meetings
Direct Contact and Communication	Providing information and support to patients, including all emotional and spiritual needs	Complex multiple health needs	Difficulties with communication including sensory impairment or language difficulties
Eating and Drinking	Ensuring food and drink provided and consumed	Assistance with eating and drinking	Parenteral nutrition
Fluid Management	8-hourly IV fluids	IV fluids more frequently than 8 hourly or blood components	Complex fluid management (such as hourly or requiring monitoring in millilitres)
Management of Equipment	Simple intermittent (such as catheters, IV access)	Central lines, drains, stomas	Multiple lines, drains, ventilator support
Medication	Regular oral medication	IV medication or frequent PRN medication	Medication requiring complex preparation or administration, or 2 nursing staff
Mobilisation	No assistance needed	Assistance needed (such as post-op or during out of hours periods)	Mobilisation with assistance of 2 nursing staff
Observations	4–6 hourly	2–4 hourly	More frequent than 2 hourly
Oral care	No assistance needed	Assistance needed	Intensive mouth care needed (such as patient receiving chemotherapy)
Skin and Pressure Area Care	Less frequent than 4 hourly	2–4 hourly	More frequent than 2 hourly or requiring 2 nursing staff
Toileting Needs	No assistance needed	Assistance needed	Frequent assistance or 2 nursing staff needed
Washing or Bathing and Dressing	Minimal assistance with washing, dressing and grooming	Assistance with some hygiene needs by 1 member of the nursing staff	Assistance with all hygiene needs, or needing 2 nursing staff
Abbreviations: IV, intravenous; PRN medication, medication administered as needed Note: these activities are only a guide and there may be other ongoing activities that could be considered			

Table 2 – One-off Nursing Care Activities that Affect Nursing Staff Requirements

	Routine Nursing Care Needs	Additional Nursing Care Needs (about 20-30 minutes per activity)	Significant Nursing Care Needs (more than 30 minutes per activity)
Admission		Admission assessment	Complex admission assessment
Care after death			Arrangements after the death of a patient, including support for relatives and carers
Discharge Planning	Simple follow-up and transfer home	Coordination of different services	Organising complex services, support or equipment
Patient and Relative Education and Support	Routine teaching about condition, routine post-op care	Teaching about a significant new condition (such as diabetes, heart disease or cancer)	Teaching about a new complex or self-managed condition (such as dialysis, colostomies), or to patient or their carers or relatives who have difficulties with communication including sensory impairment or language difficulties
Patient Escorts	Routine escorts or transfers for procedures	Escorting a patient off a ward for 20-30 minutes	Escorting a patient off a ward for more than 30 minutes
Procedures and Treatments	Simple wound dressings, specimen collection	Catheterisation, nasogastric tube insertion, multiple wound dressings	Complex wound dressings (such as vacuum-assisted closure), tracheostomy care
Note: these activities are only a guide and there may be other one-off activities that also could be considered			

This judgement will be recorded by the ward sister, charge nurse and matron on the daily staffing sheet and collated by the Duty Matron on behalf of the Clinical Site Management Team in order to establish a site wide view of all the wards.

Each ward has pre-determined threshold levels of staff, against which current staff levels are reviewed to identify if action is required. These will be monitored against the Red Flags. If any Red Flag is triggered, the escalation process as outlined in Flow Chart 1 will be activated.

4.3 THE RED FLAGS

Red Flags are triggers to escalate clinical concerns and report incidents when there is a risk to quality and patient safety. They are summarised below:

- Unplanned omission in providing patient medications within 1 hour.
- Delay of more than 30 minutes in providing pain relief
- Patient vital signs are not assessed or recorded timely as outlined in the care plan
- Inability to undertake regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. This is often referred to as 'intentional rounding' and involves checks on aspects of care such as the following:

    - Pain: asking patients to describe their level of pain level using the pain assessment tool
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration
    - Placement: making sure that items a patient needs are within easy reach
    - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised

- Less than 2 registered nurses present on a ward during any shift.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift e.g. if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

5. ABBREVIATIONS

DoM – of Midwifery
DDoN – Divisional Director Nursing
RM – Registered Midwife
RN – Registered Nurse
NHSP - National Health Service Professionals

6. REFERENCES

Berwick (2013*) A Promise to learn-a commitment to act, Improving the Safety of Patients in England.* National Advisory Group on the Safety of Patients in England

Francis (2013) Report *of the Mid-Staffordshire NHS Foundation Trust Public* Enquiry London. The Stationary Office

Keogh Review (2013) *into the quality of care and treatment provided by 14 hospital Trusts in England.* NHS England

National Quality Board (2013) *How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability.* NHS England

NICE (2014) *Safe staffing for nursing in adult inpatient wards in acute hospitals.* NICE

7. ASSOCIATED DOCUMENTATION

Roster Policy (Nursing and Midwifery) – CORP/EMP 35

Doncaster & Bassetlaw Hospitals NHS Foundation Trust - Escalation Plan and Suspension of Services Guidance 78 (v 12 last reviewed August 2014).

Doncaster & Bassetlaw Hospitals NHS Foundation Trust - Standard Operating Procedure for Ward Staffing Information Boards.

Doncaster & Bassetlaw Hospitals NHS Foundation Trust - The Policy for Safe Staffing levels for Obstetricians, Midwifery and Support Staff (MSG181).

Doncaster and Bassetlaw Hospitals NHS Foundation Trust - Strategic Direction 2013-2017.

Clinical Site Management Team Operational Policy - PAT/PA 33

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

Director of Nursing, Midwifery and Quality
Deputy Director of Nursing, Midwifery and Quality
Heads of Nursing / Midwifery Matrons
Ward Sisters/ Charge Nurses
Director of Operations Team
Deputy Director of Nursing, Midwifery and Quality Team
Deputy Director of Quality and Governance Team
Head of Employee Services and Team

9. APPROVAL AND RATIFICATION OF THE DOCUMENT

This document was approved by the Professional Nurse Advisory Group and ratified by the Policy Approval and Compliance Group.

10. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

11. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every 2 years unless such changes occur as to require an earlier review.

Chief Nurse (or delegated deputy) is responsible for the review of this document.

12. DISSEMINATION AND COMMUNICATION PLAN

The dissemination of this policy will be the responsibility of the Workforce Head of Nursing with the support of:

- Chief Nurse
- Divisional Director of Nursing
- Communications and Engagement Department

13. IMPLEMENTION AND TRAINING PLAN

Implementation will be the responsibility of the Chief Nurse with the support of the Deputy Chief Nurse, Divisional Director of Nursing and Director of Midwifery via the Matrons and Department managers. The Deputy Chief Nurse and the Workforce Head of Nursing have a key role in the implementation of the policy.

Training will be by dissemination and training within the Division structure and Clinical Site Management Team.

14. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

14.1 Process for Monitoring Compliance and Effectiveness

Audit/Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Roles & Responsibilities	Monthly audit of Datix reports to determine escalation process being utilised	Chief Nurse Head of Nursing Workforce	Monthly	Board of Directors DDoNs Matrons	DDoN DoM
Reporting of compliance with staffing against plan	Monthly audit of Datix reports and Nurse Staffing UNIFY return	Director of Nursing, Midwifery and Quality Head of Nursing Workforce DDoN and DoM	Monthly	Board of Directors DDoN DoM HoN HoM Matrons	Accountability Meetings DDoN DoM HoN HoM
Reporting compliance with public display of nurse/midwife staffing information	Monthly audit	Matrons	Monthly	Available on Hard Truths data	DDoN DoM

14.2 Standards/Key Performance Indicators (KPIs)

1. Staffing Red Flags triggers must be escalated
2. All staffing deficits when there is a risk to quality and patient safety must be reported thorough the Trust reporting mechanism.
3. Monthly staffing deficit will be reported as a percentage against plan
4. Daily publication of staffing information on ward display boards.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Safe Staffing Escalation for In-Patient Areas Policy (Nursing & Midwifery)	Director of Nursing, Midwifery and Quality - Nursing Directorate	Head of Nursing Workforce	Existing Policy	23.10.2015

1) **Who is responsible for this policy? Head of Workforce Design,** Nursing Directorate

2) **Describe the purpose of the service / function / policy / project/ strategy?** The intended outcome is to ensure Safe Staffing in all nursing inpatient departments

3) **Are there any associated objectives?** The policy is written in line with national documents including Hard Truths and subsequent guidance by NQB and NICE

4) **What factors contribute or detract from achieving intended outcomes?** – Appropriate establishments, appropriate availability and deployment of available staff, escalation of concerns to appropriate level and feedback of outcomes for future learning

5) **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** Details: [see Equality Impact Assessment Guidance] - no

- **If yes, please describe current or planned activities to address the impact**

6) **Is there any scope for new measures which would promote equality?** no

7) **Are any of the following groups adversely affected by the policy?**

Protected Characteristics	Affected?	Impact
a) Age	no	
b) Disability	no	
c) Gender	no	
d) Gender Reassignment	no	
e) Marriage/Civil Partnership	no	
f) Maternity/Pregnancy	no	
g) Race	no	
h) Religion/Belief	no	
i) Sexual Orientation	no	

8) **Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box**

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: November 2017

Checked by: Lib Jones Date: 23 October 2015

Service/Function/Policy/Project/Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Safe Staffing Escalation for In-Patient Areas Policy (Nursing & Midwifery)	Chief Nurse	Head of Nursing Workforce DDoN Surgery	Existing Policy	20.1.2022

9) Who is responsible for this policy? Head of Workforce Design, Nursing Directorate

10) Describe the purpose of the service / function / policy / project/ strategy? The intended outcome is to ensure Safe Staffing in all nursing inpatient departments

11) Are there any associated objectives? The policy is written in line with national documents including Hard Truths and subsequent guidance by NQB and NICE

12) What factors contribute or detract from achieving intended outcomes? – Appropriate establishments, appropriate availability and deployment of available staff, escalation of concerns to appropriate level and feedback of outcomes for future learning

13) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - no

- **If yes, please describe current or planned activities to address the impact**

14) Is there any scope for new measures which would promote equality? no

15) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
j) Age	no	
k) Disability	no	
l) Gender	no	
m) Gender Reassignment	no	
n) Marriage/Civil Partnership	no	
o) Maternity/Pregnancy	no	
p) Race	no	
q) Religion/Belief	no	
r) Sexual Orientation	no	

16) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: January 2023

Checked by: Marie Hardacre / Kirsty Clarke Date: 28 February 2022