Safer Staffing Policy
Version: 3

Summary: This policy is to provide clarity on the monitoring and management of nursing and allied health professional staffing levels across SHFT services.

Keywords (minimum of 5): (To assist policy search engine)
Safer, staffing, nursing, staff, staffing levels

Target Audience: All Nursing and Allied Health Professionals.

Next Review Date: September 2019

Approved and Ratified by: Chief Nurse and Senior Team JCNC
Date of meeting:
08/02/2017
23/05/2017

Date issued: June 2017

Author: Sue Jewell, Safer Staffing Lead

Sponsor: Sara Courtney, Acting Chief Nurse
Version Control

Change Record

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<th>Version</th>
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<td>November 2015</td>
<td>Sue Jewell Safer Staffing Lead</td>
<td>One</td>
<td>4, 5, 6, 7</td>
<td>Amended and updated to reflect current processes and guidance.</td>
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<td>March 2016</td>
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<td>Two</td>
<td>All</td>
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<td>March 2017</td>
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<td>Three</td>
<td>5, 6, 9, 10</td>
<td>Amended and updated to reflect current processes to include flow chart posters</td>
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<tr>
<td>14/3/19</td>
<td></td>
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<td>Review date extended from June to September 2019</td>
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Reviewers/contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Version Reviewed &amp; Date</th>
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</thead>
<tbody>
<tr>
<td>Sara Courtney</td>
<td>Associated Director of Nursing</td>
<td>V1 October 2014</td>
</tr>
<tr>
<td>Della Warren</td>
<td>Director of Nursing</td>
<td>V1 October 2014</td>
</tr>
<tr>
<td>Paula Hull</td>
<td>Associated Director of Nursing</td>
<td>V1 October 2014</td>
</tr>
<tr>
<td>Tim Coupland</td>
<td>Associated Director of Nursing</td>
<td>V1 October 2014</td>
</tr>
<tr>
<td>Helen Ludford</td>
<td>Head of Quality Governance</td>
<td>V1 October 2014</td>
</tr>
<tr>
<td>Gina Winter-Bates</td>
<td>Head of Specialist Care Pathways</td>
<td>V1 October 2014</td>
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<tr>
<td>Sara Courtney</td>
<td>Acting Director of Nursing</td>
<td>V2 March 2016</td>
</tr>
<tr>
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<td>V3 February 2017</td>
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</tr>
<tr>
<td>A5</td>
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<td>15</td>
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</table>
Safer Staffing Policy

1. Purpose

The purpose of this policy is to provide clarity on the monitoring and management of nursing and allied health professional staffing levels across SHFT services.

2. Background

SHFT is committed to ensuring that levels of all non-medical clinicians both registered and unregistered, match the acuity and dependency needs of patients within clinical ward areas and clinical community caseloads across the Trust. This includes an appropriate level and skill mix of nursing staff and allied health professionals to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, and for inpatient units - “registered nurse to patient ratios”, the percentage skill mix ratio of registered staff to unregistered staff and the number of staff per shift required to provide safe and effective patient care.

There is a requirement for all Trusts with in-patient beds to publish their staff fill rates (actual versus planned) in hours, taking into consideration day and night shifts and Registered and Unregistered staff. This information appears on the NHS Choices website. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

For in patient areas, the ward establishment may include allied health professionals and other support staff (such as Pharmacists, Advanced Clinical Practitioners/Clinical Nurse Specialists), depending on the model of care being delivered. However it is important to ensure that other support staff that are included as part of the core establishment are both rostered on the ward team’s roster and are ward based. Staff who provide care on a defined number of session’s basis would not be considered as part of the ward core establishment.

Each inpatient ward is also required to publically display staff numbers on a shift by shift basis. The Ward Staffing Today poster is required to be updated at the start of each shift by the nurse in charge – detailing the number of expected staff on each shift together with the actual number of staff on each shift. Any shortfalls in numbers will be managed as per the identified process in section three of this policy.

3. ‘Real Time’ management of staffing levels to mitigate risk

The SHFT definition of ‘safe’ levels is the agreed clinical establishment for registered and unregistered staff within the establishment for each area. This is reinforced by agreed ratios of registered versus unregistered staff.

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency requirements, the agreed staffing levels are reviewed and RAG rated (Red/Amber/Green) with escalation actions specified at each level.

- **Green shifts** are determined to be safe levels and would not require escalation as these constitute the levels expected through the agreed establishment

- **Amber shifts** are determined to be at a minimum safe level. The matron will be alerted, but no further escalation will be required. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any
changes to the acuity and dependence

- **Red shifts** are determined to be at an unsafe level with inadequate staffing to meet patient needs. The matron and Divisional Head of Nursing will be alerted. Mitigating actions will be taken, and documented, which may include:
  - The movement of staff – including temporary staff, allied health professionals and the wider clinical team from another ward or community care team to cover duties where appropriate.
  - Overtime may be offered at the Managers discretion.
  - Logging of the incident on Ulysses
  - Utilisation of supernumerary staff within the numbers where appropriate
  - By mutual agreement cancellation of leave, administration shifts, non-essential training, time owing and management days.
  - In exceptional circumstances activity could be reduced through reduction in the number of beds, or caseloads.

Completion of these actions may address / reduce the risk and reduce the shift to an amber rating. Red shifts are escalated via the Divisional Escalation Standard Operating Procedure (SOP), actions are monitored for effectiveness.

- If following the red shift actions staffing levels continue to be inadequate the Divisional Director will;
  - Review amber and red actions taken
  - Consider cancellation of appointment’s
- And in liaison with the Executive on call will;
  - Consider stopping admissions to caseloads or wards
  - Consider closing beds
  - Consider implementing critical incident/major incident plan
  - Inform the Chief Executive
  - Inform commissioners

A flow chart of the above process is included within Appendix 1

4. **Daily Process to manage staffing**

A flow chart of the following process is included within appendix 2

Safe staffing levels are managed on a daily basis by the Team Leader / Ward Manager. Consideration is given to bed capacity and operational activity within the Trust which may impact on safe staffing.

Amber and Red teams are escalated to the Matron. Actions are agreed to ensure that all areas are made safe, this may mean that a green rated ward/team becomes amber, due to the movement of staff to a ward/team that initially triggered red, usually as a consequence of short term sickness or other unplanned leave.

Red teams will be escalated by the Matron to the Associate Director of Nursing, Deputy Director of Nursing and the Chief Nurse and a Ulysses incident logged.

5. **Weekly Process to manage staffing**

Divisional staffing reviews take place at least on a weekly basis to ensure plans are in place to deliver safe staffing levels for the forthcoming week and to review escalations from the previous week.
Temporary staffing requests, absence and acuity and dependency levels are reviewed with team leaders / ward managers / Matrons to provide escalation reporting and to action and resolve known staffing issues.

The Trust Board has ultimate accountability for ensuring that SHFT is compliant to providing safe levels of staff. The shift fill and any concerns are raised through the weekly meeting held with the Professional Leads / Associate Directors of Nursing for each Division.

6. **Monthly Review Process to monitor Staffing levels**

Staffing levels are reviewed at Divisional Monthly Operational Meetings.

Inpatient fill rates are reported externally to NHS England via UNIFY2 and are published on NHS Choices website.

The Trust Executive Committee review published information on ward level staffing and exception reports which are produced in ‘heat map’ format.

7. **Quarterly Review Process to monitor Staffing levels**

Reports are provided by the Chief Nurse to the Trust Executive Committee / Board and the Workforce Committee.

Workforce plans are developed and reported through the Workforce Committee to plan recruitment priorities, skill mix reviews, training and development and the introduction of new roles.

8. **Six monthly Acuity and Dependency Measurements to inform Safe Staffing levels**

Acuity and Dependency measurements of inpatients and caseloads takes place on a six monthly basis using National evidence based tools and a professional judgment framework. A map of this process is included within Appendix 3a.

The results of the acuity and dependency measurements will be discussed in a face to face meeting between the clinical team and the review team. The review team membership will be multidisciplinary and will include as a minimum;

- Team manager
- Representative involved in delivering direct care
- Finance representative
- Workforce and staff side
- Service user or carer attending
- Safer Staffing Lead
- A Senior Clinical lead (8a or above) should chair the review

Before the meeting the review chair will access the self-assessment document (see appendix 3b). This will provide assurance that the team is cross-checking data using evidence-based guidance and presenting a rounded view of staffing requirements to support professional judgements and decisions about delivering high quality, safe care to patients. The discussion will review all budgeted establishments/teams to identify any resource variances.
Results are presented via the Chief Nurse to the Trust Executive Board for discussion and approval prior to establishment changes. This report will also be available to commissioners.

Following the second measurement in November and agreement of establishment levels, e-roster templates will be updated, locked and budgets re-set in line with the new financial year.

9. ‘Safer Staffing Information Packs’ to support safe staffing levels

Safer Staffing Information Packs are located within each ward, department and available on the intranet– providing guidance upon ‘good rostering’ practice, temporary staff booking procedures and a copy of this policy. Staff members should ensure that they are familiar with the location and content of these Information Packs, and that the policy within it is the most up to date version and contacting their line manager for further guidance if required.

10. Red flags

Red flags are those occurrences stipulated by NICE (July 2014) which maybe an indicator that the quality of care has declined and patients are being made vulnerable. Should any of these occur, escalation to the service Matron 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 Ulysses Safeguard Incident Reporting System and the management of the situation must then follow the route as stipulated in section 3 if the area is deemed to be unsafe.

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - **Pain**: asking patients to describe their level of pain level using the local 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 the 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*.

*It is noted that the NICE guidance is presently only applicable to Acute Hospitals and that this specific red flag will not be applicable to all of the SHFT services.

Additional nursing red flags specific to SHFT, which may not be applicable to all services are:-

- Observations of patients’ mental state/ behaviour that are not completed.
- Delays in response to alarms or urgent situations.
- Delays in meeting care needs which have led to an increase in behaviours' which challenge (e.g. activity, therapeutic intervention, implementation of behavioural support plans).
- Delays in essential clinical documentation being produced within Trust Policy timescales (e.g. clinical risk assessments, care plans, nursing reports) which have led to a delay in care or process.
- Delayed admission including delay of receipt and scrutiny of Mental Health Act admission.
- Excessive prolonged working hours to complete a process of care e.g. admission to a service, review of treatment, seclusion, response to increase in violence or behaviours' which challenge services.
- Delay or cancellation of essential appointments/patient visits due to reduced staffing levels.
- Inadequate levels of available staff with PRISS training.

11. Other feedback

If a staff member has any concerns about the levels of staffing, they should raise this first with their line manager. If for any reason they don’t think this is appropriate or have not have concerns sufficiently addressed they can refer to the SHFT Whistleblowing Policy. Alternatively they can contact the SHFT Freedom to Speak Up Guardian (Contact details to be found on the SHFT Intranet). Should any concerns be raised about safe staffing levels through the formal speak up process this will be investigated by the Associate Directors of Nursing and the findings discussed with the Deputy Director of Nursing and Chief Nurse.

12. Training Requirements

Nil training requirements

13. Monitoring Compliance

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
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<tbody>
<tr>
<td>Safer staffing levels in each division.</td>
<td>Amanda Beaumont and Sue Jewell</td>
<td>Monthly Safer Staffing Data</td>
<td>Monthly</td>
<td>Reported to QID and the Trust Board.</td>
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<tr>
<td>Red flag events</td>
<td>Sue Jewell</td>
<td>Ulysses incidents, red flag weekly report, Monthly Ulysses flash report</td>
<td>Weekly/Monthly</td>
<td>Reported to Chief Nurse and Deputy Directors of Nursing. Reported to CCG’s via Divisional Quality reports</td>
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<tr>
<td>Incidents, risk and complaints related to staffing levels</td>
<td>Each Professional Lead</td>
<td>Tableau</td>
<td>Weekly</td>
<td>Reported and Investigated Divisionally</td>
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<tr>
<td>Bank and Agency usage Data</td>
<td>Workforce Information Team/ Finance</td>
<td>Tableau</td>
<td>Weekly</td>
<td>Bank and Agency Group</td>
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14. Policy Review

Will be undertaken every two years or when there is a change in national guidance by the Safer Staffing Lead or Chief Nurse and Senior Nursing team.

15. Supporting References

NICE guideline SG1 July 2014 Safe staffing for nursing in adult inpatient wards in acute hospitals http://www.nice.org.uk/Guidance/SG1

SHFT 2014 Safer Staffing Board Reporting
Appendix 1 – “Real Time” Management of Staffing Levels poster

**Green Shift**
- Shift determined to be safe. No escalation Required

**Amber Shift**
- Shift determined to be at a minimum safe level
- Matron to be alerted
- Use professional judgement to prioritise need and adjust workload throughout shift accordingly
- Seek additional staffing
- Continual review of any changes to acuity and dependency

**Red Shift**
- Staffing inadequate to meet patient need
- Matron and Divisional Head of Nursing to be alerted
- Log incident on Ulysses
- Review Amber shift actions
- Mitigation actions will be taken and documented. These can include;
  - Movement of staff including AHP/wider clinical team to cover duties where appropriate
  - Utilisation of supernumerary staff within numbers where appropriate
  - Discressionary overtime
  - By mutual agreement cancellation of leave, administration shifts, non essential training, time owing and management days
  - In exceptional circumstances activity could be reduced through a reduction in bed numbers or caseloads

**Senior Level Actions**
- The Divisional Director on call will;
  - Review amber and red actions taken
  - Consider cancellation of appointments
  - in liaison with the Executive on Call will;
  - Consider stopping admissions to caseloads or wards
  - Consider closing beds
  - Consider implementing critical incident/major incident plan
  - Inform the Chief Executive
  - Inform Comissioners
Daily process to manage staffing
Managed by team leader/ward manager
Amber and red teams escalated to Matron
Actions agreed to ensure that all areas are made safe
Red teams are escalated by the Matron to the Associate Director of Nursing, Deputy Director of Nursing and Chief Nurse

Weekly process to manage staffing
Divisional staffing reviews weekly to ensure plans are in place and review escalations from previous week
Temporary staffing requests, absence and acuity and dependency levels reviewed with team managers to provide escalation and resolve known staffing issues
Concerns raised to Chief Nurse through the fortnightly Professional leads/Associate and Deputy Directors of Nursing meeting

Monthly review process to monitor staffing levels
Staffing levels are reviewed at the Divisional Monthly Operational Meetings
Inpatient fill rates are reported externally to NHS England via UNIFY2 and are published on NHS choices website
The Trust Executive Committee review ward level staffing and exception reports
Appendix 3a – Acuity and Dependency Establishment Review Process
# Appendix 3b – Strategic Clinical Team Establishment Review Template

## Strategic Clinical Team Establishment Review Template

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<th>RAG</th>
<th>Action Required</th>
<th>Review Date</th>
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### Expectation 1: Right Staff

- There is continuity in the multi-professional team
- Continuity of team leadership with sufficient allocated time for managerial activities
- Caseload within evidence-based recommendations/clustering data
- Administration support is available
- Benchmark data for an equivalent team
- Positive staff experience measures
- Team budget meets requirements, including a review of headroom

### Expectation 2: Right Staff

- Technology to support team function
- Effective appraisals are conducted
- Mandatory training standard met
- CPD plan for all staff in place
- Staff supervision/reflective practice processes in place
- All staff have had an appropriate induction (including temporary staff), including evidence of implementation
- Skill mix data reflects need

### Expectation 3: Right place and time

- Care Hours per patient day data (inpatient)
- Fill rate data reflects requirement
- Team environment is appropriate
- Staff sickness within trust threshold
- Use of bank/agency within trust threshold
- Staff turnover measures
- Shift patterns match patient need
- Therapeutic activity matches persons needs and is consistently delivered
- Quality dashboard trend data
- Escalation processes and review of escalated events
- Dependency/acuity data using evidence based tools
- Escalation plans in place
- Feedback from regulators
- Patient experience measures
- Student feedback considered
- Staff feedback considered
- Incident data
- Bed occupancy
- Organisational clinical handover standards are met

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<th>RAG</th>
<th>Expectation 3: Right place and time</th>
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<td>Red</td>
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<td>Amber</td>
<td>Partial/requires improvement</td>
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<td>Green</td>
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Appendix 4 - LEaD (Leadership, Education & Development) Training Needs Analysis

If there are any training implications in your policy, please make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance Manager on 02380 874091) to complete the TNA before the policy goes through the Trust policy approval process.

<table>
<thead>
<tr>
<th>Training Programme</th>
<th>Frequency</th>
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</table>

- **Title and Level (if appropriate) of your training programme**

  - How often will the target audience need to attend this course?
  - How long will the programme run (April – April?) and how long will each course take (3 hours?)
  - How and where do you intend delivering this programme (face to face, e-learning, Essential Training Days)?

<table>
<thead>
<tr>
<th>Training Programme</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
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<td>Corporate Services</td>
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<tr>
<th>Directorate</th>
<th>Service</th>
<th>Target Audience</th>
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</table>

- **Strategic & Operational Responsibility**

  - Who do you anticipate recording attendance?
  - Who is accountable for this training strategically and who is operationally accountable?
Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team

<table>
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<tr>
<th>Name of policy/service/project/plan:</th>
<th>Safer Staffing Policy</th>
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<tr>
<td>Policy Number:</td>
<td>SH CP 176</td>
</tr>
<tr>
<td>Department:</td>
<td>Nursing and Allied Health Professionals Directorate</td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Helen Ludford</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>29th October 2014</td>
</tr>
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</table>

1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe purpose of the policy including</td>
<td>This policy is to provide clarity on the monitoring and management of nursing and midwifery staffing levels across SHFT services.</td>
</tr>
<tr>
<td>▪ How the policy is delivered and by whom</td>
<td></td>
</tr>
<tr>
<td>▪ Intended outcomes</td>
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Safer Staffing Policy
Version: 3
June 2017
2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong> What is the equalities profile of the team delivering the service/policy?</td>
<td>Senior nursing team to deliver. No equalities.</td>
</tr>
<tr>
<td><strong>2.2</strong> What equalities training have staff received?</td>
<td>SHFT training – induction &amp; updates.</td>
</tr>
<tr>
<td><strong>2.3</strong> What is the equalities profile of service users?</td>
<td>Not directly related to service users.</td>
</tr>
<tr>
<td><strong>2.4</strong> What other data do you have in terms of service users or staff? (E.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?</td>
<td>No, national driven policy for safer staffing levels.</td>
</tr>
<tr>
<td><strong>2.5</strong> What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff</td>
<td>Staff aware of the national guidance for safer staffing.</td>
</tr>
<tr>
<td><strong>2.6</strong> What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations</td>
<td>Nil however external request that the Trust has such a policy.</td>
</tr>
</tbody>
</table>
In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this:

<table>
<thead>
<tr>
<th>Positive impact (including examples of what the policy/service has done to promote equality)</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Disability</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Reassignment</td>
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<tr>
<td>Marriage and Civil Partnership</td>
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<tr>
<td>Pregnancy and Maternity</td>
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<td>Race</td>
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<tr>
<td>Religion or Belief</td>
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<tr>
<td>Sex</td>
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<tr>
<td>Sexual Orientation</td>
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</tr>
</tbody>
</table>

**Sign Off and Publishing**

Once you have completed this form, it needs to be ‘approved’ by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equality and Diversity Team who will publish it on the Trust website. Keep a copy for your own records.

**Name:**

**Designation:**

**Signature:**

**Date:**