

Safe Staffing Policy

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

Key words: Safe staffing, Establishment Reviews, Acuity and Dependency, nursing staffing levels, roster management, professional judgement, Escalation process, Tipping points and Thresholds

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Policy On A Page

SUMMARY & AIM

What is this policy for?

- The Developing Workforce Safeguards (2018) mandates all trusts to take the required actions to ensure staffing is safe, effective, and sustainable. LPT has ensured this guidance has been embedded into our safe staffing policy.
- The purpose of this policy is to provide clear guidance on the trust safe staffing standards to maintain safe and sustainable staffing levels in all our clinical services. This includes when and how clinical services review their budgeted establishments to ensure their staffing levels meet the needs of patients and their families/ carer's.
- The policy aims to support staff with ensuring we are consistent in our approach and have a clear framework for escalation and management of staffing models in our services for the best patient care.
- The policy is an overarching set of principles and guidance that guides people. It will then be adapted and locally standardised to operate in practice.

TARGET AUDIENCE:

Who is involved with this policy?

Clinical and non-clinical staff

TRAINING

What training is there for this policy?

Safer Nursing Care Tool, Community Nursing Safer Staffing Tool, E-Rostering, Annual Establishment Review Training.

KEY REQUIREMENTS

What do I need to follow?

- It is absolutely vital to have clear escalation processes for frontline staff to activate if staffing risks continue, increase or mitigation proves insufficient to ensure patient safety and care quality is maintained. The policy clearly describes key fundamental principles to ensure staffing is safe, effective, and sustainable such as:
 - Daily operational staffing review table
 - Annual establishment reviews
 - Roster management
 - Clear escalation of concerns
 - Red flag events/tipping points
 - Safe staffing decision tool and escalation framework
 - Dynamic Risk Assessment and process.

The Policy also describes the process we have within our trust for:

- safe staffing escalation
- safe staffing meetings and escalation routes
- monthly safe staffing review process,
- reporting, monitoring and governance and
- levels of accountability from nurse in charge, ward sister/community team leader to the Director of Nursing, AHP and Quality.

1.0 Quick look summary

Please note that the above is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
Version 1	05/05/2022	
Version 2	18/07/2022	Updated Summary and scope of the Policy – All staff table added. New DRA process added.
Version 3	March 2024	Update from planned review.

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Director	Dr Anne Scott (Executive Director of Nursing, AHP And Quality)
Author(s)	Elaine Curtin (Workforce and Safe Staffing Matron) Jane Martin (Assistant Director of Nursing and Quality) Emma Wallis (Deputy Director of Nursing and Quality)
Implementation Lead	Elaine Curtin (Workforce & Safe Staffing Matron)
Wider consultation	All LPT Staff Bands 7 and above, Senior Nurses and AHP leads, Trust Policy experts.
Head of Nursing	Saskya Falope (Head of Nursing Division of Mental Health)
Deputy Head of Nursing	Tracy Yole (Deputy Head of Nursing Adult Community Nursing) Jon Paul Vivers (Deputy Head of Nursing Division of Mental Health) Jacqui Newton (Deputy Head of Nursing Community Mental Health Services)

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Strategic Workforce Group	People and Culture Committee

1.4 Equality Statement

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

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

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

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

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

1.6 Definitions that apply to this policy.

SOP	Standard Operating Procedure
NIC	Nurse In Charge
Planned	Established number and skill mix of staff per shift
Acuity	The measurement of the intensity of nursing care required by a patient
Dependency	The degree of patient dependency in relation to nursing care
DRA	Dynamic Risk Assessment
CHPPD	Care Hours Per Patient Day
OOH	Out Of Hours
OPEL	Operational Pressure Escalation levels
Establishments	The term used to describe the number of whole-time equivalents funded in the area, detailing the number of staff required per band for each shift. Includes an uplift (headroom) to cover Annual leave (AL), sickness, maternity pay, study leave and is individual to each ward/service/ community team.
Professional Judgement	Is a recognised researched workforce planning method and forms part of the triangulated review of safe staffing establishments.
Clinical Professional Judgement	is a crucial element to interpret results from evidence-based tools, take account of local context such as ward, patient and staff factors and used to inform the skill mix of staff.
Evidence Based Tools	National evidence-based licensed decision support tools for use in clinical settings including Safer Nursing Care Tool, Mental Health Optimum Staffing Tool & Community Nursing Safer Staffing Tool providing recommended nursing establishment recommendations based on patient acuity and dependency assessment.
Skill Mix	Staffing levels of both registered and un-registered staff benchmarked against acuity and dependency scoring. Skill-mix is also conceptualized in three ways to mean: (1) the range of competencies possessed by an individual healthcare worker; (2) the ratio of senior to junior staff within a particular discipline; and (3) the mix of different types of staff in a team/healthcare setting.

Competence	A bringing together of general attributes – knowledge, skills and attitudes. Skill without knowledge, understanding and appropriate attitude does not equate to competent practice. Thus, competence is ‘the skills and ability to practice safely’.
Delegation	The transfer to a competent individual, the authority to perform a specific task in a specified situation that can be carried out in the absence of the registered practitioner and without direct supervision.

2.0 Purpose and Introduction

- 2.1 The purpose of this policy is to provide clear guidance on the trust safe staffing standards to maintain safe and sustainable staffing levels in all our clinical services. This includes when and how clinical services review their budgeted establishments to ensure their staffing levels meet the needs of patients and their families/carer’s.
- 2.2 It will also set out steps to be taken in our clinical areas where staffing levels are not adequate and or the planned staffing levels are insufficient to meet patient care needs safely. This will include the escalation required to ensure clear decisions are taken to keep patients and staff safe, including actions to mitigate the risks.
- 2.3 The policy supports and guides the operational management and deployment of nursing staff daily to ensure there is the right number of staff, with the right skills, in the right place to deliver safe and effective patient care. Safe staffing can be complex and takes account of multiple factors; patient acuity and dependency and skill mix as well as numbers.
- 2.4 The Developing Workforce Safeguards (2018) clearly outline the requirements for all trusts with in-patient beds to publish their staff fill rates (actual versus planned) in hours, taking into consideration day and night shifts for both registered and non-registered staff. This information appears on the NHS choices website and the trust website.
- 2.5 Ensure each in-patient ward meets the required standards to publicly display staff numbers on a shift-by-shift basis, with ‘welcome to the ward’ boards being updated at the start of each shift by the nurse in charge. This should detail the nursing staffing numbers for the day and night shift.
- 2.6 This policy uses the term ‘nursing staff’ in order to achieve mandated safe staffing levels and patient to registered nurse ratios. The trust also considers Allied Health Professionals (AHP) and /Multi-disciplinary Team (MDT) members who are contributing to care delivery within the rotational shift pattern and as reported nationally in our monthly safe staffing reviews. (For the purposes of this policy both will be considered in the context of safe staffing).
- 2.7 This policy should be considered in conjunction with LPTs Electronic Rostering Policy, Preceptorship and Probation policies.
- 2.8 This policy has been developed in reference to the safe and sustainable staffing framework - ‘Supporting NHS providers to deliver the right staff, with the right skills, in the right place and the right time: Safe Sustainable and productive staffing, published by the National Quality Board (NQB) in July 2016 and NHS Improvement

Developing workforce Safeguards (2018).

- 2.9 Both documents clearly outline the framework, expectations and recommendations required for safe staffing and workforce decisions and assessment of the trust's compliance utilising a 'triangulated approach' to deciding staffing requirements.
- 2.10 LPT is committed to ensuring our patients receive high quality compassionate care and to ensure this is achievable there must be the right number of staff, with the right skills in the right place at the right time.
- 2.11 Nursing, Allied Health Professionals Psychology, medics, and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality compassionate care and excellent outcomes for patients and service users. There are established and evidenced links between outcomes and whether Organisations have the right people, with the right skills, in the right place at the right time.
- 2.12 LPT have a number of mechanisms in place to ensure our in-patient wards and community teams are safely staffed to support safe and effective patient care the following principles support this expectation.
- 2.13 The safety and well-being of patients and the health and wellbeing of staff is paramount, the trust requires staff to work flexibly to meet these needs, within their scope of professional practice.
- 2.14 All staff working on in-patient wards should ensure they use the Trust e- rostering system to enable the safe and efficient use of staff to meet service need.
- 2.15 Annual Establishment Reviews must take place with a 6-month review for all inpatient wards and yearly for community teams (where there is a validated evidence-based tool), using a triangulated approach the outcome is reported to Trust board. Establishments describe the number of whole-time equivalents funded in the area, detailing the number of staff required per band for each shift, including uplift to cover annual leave, sickness, maternity pay, study leave and is individual to each ward/service/ community team:
- Staffing levels will be reviewed on a minimum of shift-by-shift basis which will be undertaken by Ward Sister/Charge Nurses/Clinical operational managers/community team leaders and/or Matrons, Clinical Service Managers and Heads of Nursing (where staffing concerns escalated to ensure safety and effectiveness)
 - Where concerns about safe staffing are made, we have a duty to investigate, respond and resolve in a timely way to maintain safety and provide feedback to those raising concerns.
 - Safe staffing measures are aligned to local managerial knowledge and Directorate operational management process of silver, and gold command across the trust. This is in addition to daily Operational Pressure Escalation Level (OPEL) reporting.
 - Monthly review process to monitor staffing levels are in place to publish in patient fill rates (externally to NHS England and Improvement and on the NHS choices/LPT's website) and reported to trust board bimonthly. Six monthly safe staffing reports including establishment reviews are also reported to trust board.

3.0 Policy Requirements

- 3.1 This policy applies to all *Ward and community-based nursing teams*.
- 3.2 This policy applies to nursing safe staffing levels across Leicestershire Partnership NHS Trust including:
- Planned nurse staffing levels e.g. roster management.
 - Thresholds and Tipping points
 - Process for monthly review of nursing safe staffing
 - Process for bi-annual review of nursing establishments
 - Daily operational review, RAG rating and actions to mitigate risks.
 - Clear escalation process from Ward to Board.

4.0 Duties within the Organisation

Deputy Directors of Nursing and Quality

Are responsible for:

- Ensuring that there are processes in place to maintain appropriate safety and quality for patients.
- Provide professional and strategic leadership to all nursing staff.
- Ensuring there is a process in place to support the review of clinical team's establishments and in Trust policy.
- For co-authoring (with Associate Director of Nursing and Quality) the 6 monthly board report and ensuring the content is reflective of establishment reviews which have taken place.
- Supporting and deputising for the Director of Nursing, AHP and Quality.

Heads of Service

Are responsible for:

- Ensuring that all wards/community teams within their directorate are safely staffed and all risks minimised
- Ensuring that the Director of Nursing/Deputy Director of Nursing are informed of any actions to mitigate staffing risks
- Ensuring that staff are deployed flexibly to meet patients' needs as required in support of Ward Managers/ Team Managers
- For ensuring that establishment reviews have sufficient senior managerial and clinical oversight to validate the findings and implement changes as required and to submit to Director of Nursing for review and approval.

Senior Managers

Are responsible for:

- Ensuring all wards/teams within their service lines are safely staffed, and that all risks have been minimised and ensure the Directorate Head of Nursing is informed of any staffing risks/mitigations.
- Ensuring that establishment reviews are undertaken and reviewed six monthly together with ward sister/Charge nurse and Matron.
- For coordinating the review process for their clinical area of responsibility and to ensure that anyone who has a delegated role within the review is clear about their

- responsibilities and is competent to undertake the role.
- Are responsible and accountable for the day-to-day monitoring and deployment of staff within their clinical area to meet patient's needs.
- Decision to escalate staffing and discussion regarding extraordinary escalation meeting.

Matrons and Team Leads

Are responsible for:

- The provision of safe staffing levels to meet patient needs and service demands.
- assessing the factors that determine nursing staff requirements using a systematic approach when setting the establishment reviews in conjunction with the Matron and Deputy Head of Nursing
- Ensuring that establishment reviews are undertaken in keeping with the standards and timelines as described within this policy.
- Coordinating the review process for their clinical area of responsibility and to ensure that anyone who has a delegated role within the review is clear about their responsibilities and is competent to undertake the role.
- The day-to-day monitoring and deployment of staff within their clinical area to meet patients' needs.
- Ensuring that roster management/ approval and finalisation process is adhered to especially regarding timeliness with operational and clinical oversight.
- Chairing of daily huddle to discuss staffing, highlight any patient safety concerns, contingency planning, and identification of escalation.

Nurse in Charge

Are responsible for:

- Reviewing staffing levels at the start of a shift for both the actual shift and oncoming shift.
- Where the planned staffing levels are not in place and/or the planned staffing levels are insufficient to meet patient needs due to increased acuity and dependency the shifts will be RAG rated using the thresholds and tipping points, as per daily operational staffing review in conjunction with Ward sister/charge nurse/ Matron /team managers. Have a responsibility to contribute to the review of establishments.
- Working flexibly to meet patients' needs and for raising any safety issues which may arise from staffing levels.
- Completion of an E-iRF for staffing, skill mix issues, including missed care.

Responsibility of Clinical Staff

Are responsible for:

- Meeting patient needs safely and effectively.
- Working within their scope of competence and skill set.
- Carrying out delegated duties to deliver safe patient care.
- Working flexibly to meet patients' needs and for raising concerns around safer staffing at the point of identification.
- Escalating to team manager/ nurse in charge
- Book annual leave in advance as per Trust Policy
- Input health roster rota requests in a timely manner.

5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

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

6.0 Daily Operational Staffing Review Table

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

Level of Risk	RAG rating	Thresholds/Tipping Points	Actions to mitigate risk
Low Risk		<ul style="list-style-type: none"> • Planned staffing levels met. • Ward teams are managing workload and associated patient acuity and dependency. • Minimum of two LPT employed registered nurses (substantive or bank) on shift. 	Sudden changes in acuity and dependency are escalated by the NIC to the Ward Sister/Charge Nurse/Matron or On Call Manager Out of Hours (OHH)
Moderate Risk		<ul style="list-style-type: none"> • Planned staffing levels not met (less than 80%) • Skill mix is not met (less than 80%) • Increased patient acuity and dependency 	<ul style="list-style-type: none"> • Ward Sister/Charge Nurse to work clinically. • Matron or On Call Manager to review staffing levels and patient acuity and dependency across the

Level of Risk	RAG rating	Thresholds/Tipping Points	Actions to mitigate risk
		<ul style="list-style-type: none"> • Increased number of patients requiring increased levels of therapeutic observation or specialling • Greater than or equal to 50% of registered nurses on shift are employed by LPT. • Increase in harms associated with Nurse Sensitive Indicators • The ward can be managed using the reduced staffing available 	<ul style="list-style-type: none"> • service to identify staff who can be deployed to support area. • Dynamic Risk Assessment (DRA) to be completed and discussed with Matron, On-Call Manger and Head/Deputy Head of Nursing for an off-framework request. • Staffing review with AHPs and other Ward based staff to identify patient care support
High Risk		<ul style="list-style-type: none"> • Planned staffing levels not met (less than 50%) • Skill mix is not met (less than 50%) • Only one registered nurse on shift (NICE Red Flag) • More than 50% of nursing staff are temporary workers. • Serious Incident associated with Nurse Sensitive Indicators • Increased patient acuity and dependency 	<ul style="list-style-type: none"> • Ward Sister/Charge Nurse and Matron to work clinically. • Matron, Head/Deputy Head of Nursing or On Call Manager to review staffing levels and patient acuity and dependency across the service to identify staff who can be deployed to support area. • Staffing review with AHPs and other Ward based staff to identify patient care support. • Consider taking staff off shifts following day and bring into work to cover the gap. • Request staff to start a shift early or finish a shift late. • Consider reviewing any planned admissions if patient safety is compromised. • Liaise with Community teams for support. • DRA to be completed and discussed with Matron, On-Call Manager and Head /Deputy Head of Nursing for an off-framework request

Unmitigated High Risk		High risk that has not been mitigated. Deputy Head and Head of Nursing to investigate and review	<p>Such an assessment may require a decision to:</p> <ul style="list-style-type: none"> • increase staffing numbers to meet patient demand. • partially or fully close a ward or service for a determined period until the issues are resolved. • temporarily reduce service delivery or take another demand- management approach to redeploy the available workforce to areas of critical need to sustain safe and adequate care delivery. • close the service, facility, or model of care in the long term. • implement business continuity plans.
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If all actions have been taken and the staffing level is deemed to be at an unacceptable level to search for 'Stopping use of Thornbury Registered Nurse Agency and guidance to ward manager/operational and clinical leader' and follow the Dynamic Risk Assessment (DRA) process which can be found on staff net and escalate to Matron/Team manager / Lead Nurse in hours and Manager on Call Out of Hours.

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

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

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency the staffing levels are reviewed, and rag rated (GREEN/AMBER/RED/BLACK) with escalation actions at every level and OPEL risk assessment scoring for community teams. (See appendix 6 for OPEL Rating Risk Scoring for Directorates and Community Teams).

8.0 Annual Establishment Review

- 8.0 Each ward/community team has agreed planned staffing levels in line with their budgeted establishments. Planned staffing is the established number and skill mix of staff per shift and reinforced by agreed ratios of registered versus unregistered staff.
- 8.1 The agreed budgeted establishment forms the basis of rosters (and subsequent budget). For inpatient services this involves the 24 – hour safe staffing nursing roster and Community teams this may also include the wider MDT.
- 8.2 All in patient wards must undertake a full establishment review every 12 months with a lighter review completed within the following 6 months.
- 8.3 Establishment reviews must include the use of evidence-based workforce planning tools (where they exist). For Division of Mental Health, the trust has the license to use the Mental Health Optimal staffing Tool (MHOST). For In patient wards (Community Health Services) the trust has the license for the Safer Nursing Care Tool (SNCT) and for learning disability and autism services within Families, Young People and Children’s directorate, the trust utilises the Learning Disability Optimal Staffing Tool (LDOST).

- 8.4 Community Nursing Teams (Adult Physical Health) are progressing with the implementation of the Community Nursing Safer Staffing Tool (CNSST) following national launch.
- 8.5 Establishment reviews must include professional judgement of the local contextual factors e.g., general workload and acuity, environmental factors and layout of a ward, skill mix of the team and patient/service user demographic to support decision making.
- 8.6 Professional judgement is a recognized and researched workforce planning method and forms part of the triangulated review of safe staffing establishments. Clinical professional judgement is a crucial element to interpret results from evidence-based tools, take account of local context such as ward, patient and staff factors and are used to inform the skill mix of the staff. They are also used at all levels to inform real time decisions about staffing taken to reflect changes in case mix, acuity, dependency, and activity.
- 8.7 Staffing establishments should take account of the need to allow clinical staff the time to undertake non-direct care such as mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship, and supervision roles, including the support of preregistration and undergraduate students. Some of which is included in Headroom/uplift but not all is reflected.
- 8.8 Professional judgement is critically important when applying review of nursing staff factors/activities other than direct patient care including:
 - 8.9 Communication with relatives and carers, MDT, discharge planning
 - 8.10 Management of the team and ward, nurse in charge duties, team leader
 - 8.11 Supervising, mentoring and assessing staff.
 - 8.12 Incident management, staff appraisal, audits, care reviews
- 8.13 Establishment reviews must include a review of Nurse sensitive indicators/outcomes (of previous 6 months) considering quality, patient safety experience and feedback.
- 8.14 Formal establishment reviews must be completed using the Annual Establishment Setting Review template (see Appendix 7).

9.0 Roster Management

- 9.1 All staff working on in-patient wards /services must ensure that rosters are created in line with the Electronic (e) Rostering policy.
- 9.2 Rostering is built around the budgeted clinical establishments.
- 9.3 Electronic (e) rostering is the electronic system used (by all in-patient wards/services) to prepare rosters at a minimum of 12 weeks in advance of the roster becoming live.
- 9.4 Ward Sisters/ Charge Nurses/team leaders are responsible and accountable for the provision of safe staffing levels to meet patient needs and service demands by preparing and managing the team roster.
- 9.5 Matrons/community team leaders/team and operational managers are responsible and accountable for reviewing, overseeing and approving rosters for their area, adhering to the e rostering SOP ensuring they are balanced and that staffing

resources have been deployed effectively in order to meet service need and patient safety.

- 9.6 Directorate Management Teams to have oversight and scrutiny ensuring e-rostering sign off arrangements and business continuity plans are linked prior to and during peak times of annual leave/school holidays e.g., Mid-term school breaks, Easter, Christmas etc.
- 9.7 Directorate business continuity plans are refreshed and reviewed prior to peak holiday periods taking into consideration the following factors.
 - 9.7.1 clear understanding of in-patient ward/community team average % of absences and vacancies, to be considered at peak holiday periods and considered when % or number of staff off on annual leave has been confirmed.
 - 9.7.2 Any late/last minute annual leave changes to be made and approved by matron/team manager.
 - 9.7.3 Ward/community team reserve lists (of staff available and offering to work) to be formulated in readiness for 'step up' as needed.
 - 9.7.4 Ensure e-rosters and staffing levels are being reviewed daily and any gaps are being escalated through Directorates with plans in place to ensure safe staffing levels during peak holiday periods.
- 9.8 Effective Roster management is essential in supporting high quality patient care by optimising the skill mix and use of staff time enabling Managers to ensure that services are staffed in a consistent, safe, and cost-effective way.
- 9.9 Efficient e-rostering provides equity for all staff by enabling impartial allocation of shifts and with advanced planning of rosters allowing for enhanced health and wellbeing and greater work/life balance.
- 9.10 The Nurse in charge is responsible for ensuring the roster is an accurate record of staff who worked each shift and to ensure care hours per patient day (CHPPD) reporting is accurate.

10.0 Factors to consider when monitoring /reviewing your planned nurse staffing levels

- 10.1 Newly qualified registered nurse (preceptee) in Preceptorship period requires a period of supernumerary time e.g., 150 hours (4 to 6 weeks pro rata) when the Preceptee is not in the planned staffing levels/numbers and is extra to staffing to allow the Preceptee to work under the supervision of another registered practitioner.
- 10.2 New member of Staff currently working within the 6-month Probation period e.g., Return to Practice nurse.
- 10.3 Internationally Educated Nurses within the preceptorship period
- 10.4 Registered Nursing Associates (RNA)
- 10.5 Under-graduate Students.

11.0 Escalation of Staffing Concerns

- 11.1 Designating the nurse in charge for each shift is the responsibility of the Ward or Team Manager. The Ward or Team Manager must understand that they are delegating authority for the management of the ward/team for a span of duty in their absence. The Ward Manager/team manager needs to be sure that the person to

whom they have delegated this responsibility is sufficiently competent, and that he/she will have sufficient knowledge of the service user needs and routines to manage the shift safely.

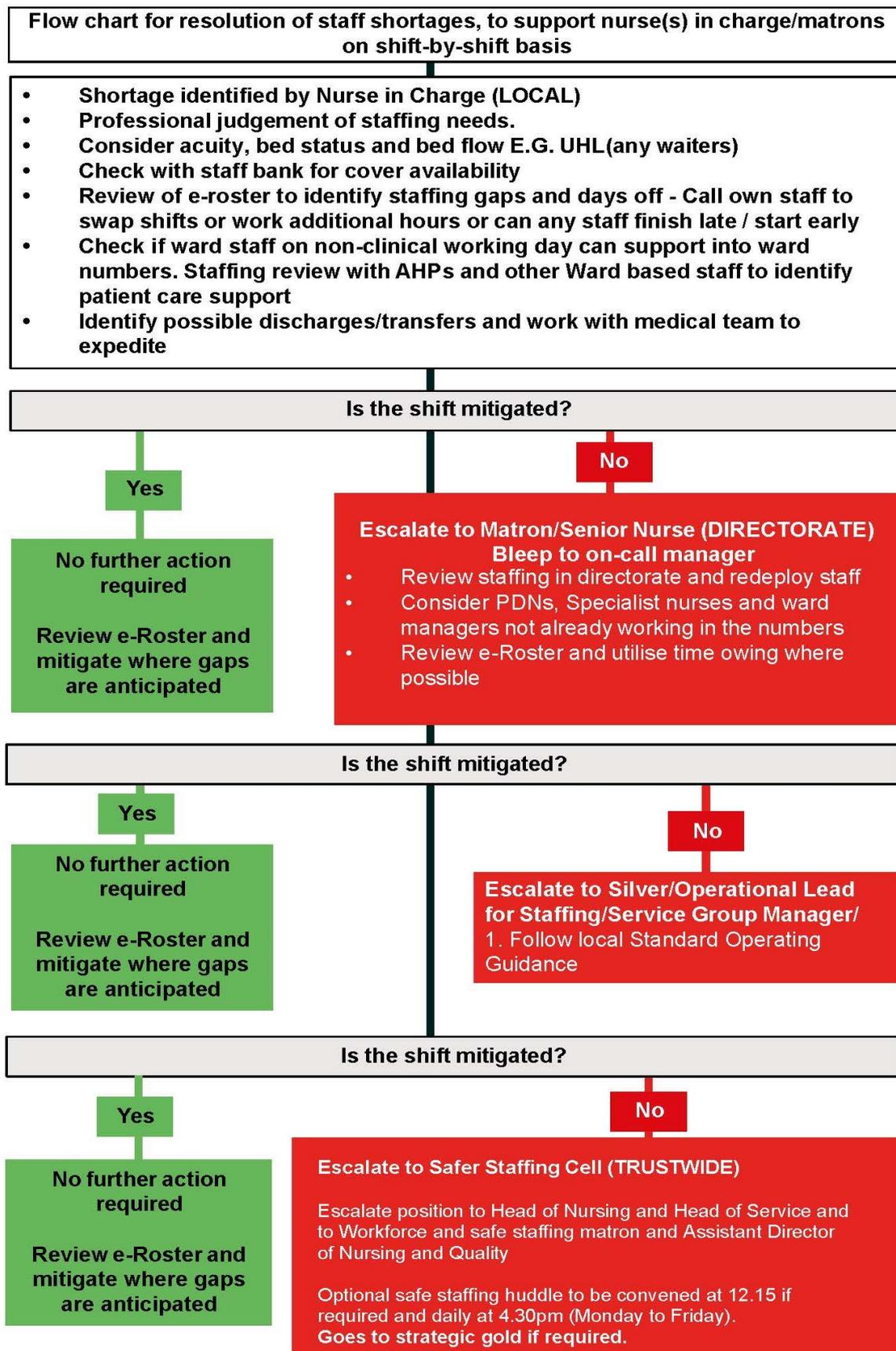
- 11.2 The Nurse in Charge of any shift should be a substantive member of LPT staff unless a regular member of temporary staff has received additional training and supervision to undertake the nurse in charge role. This will be identified on the e-rostering system. In the event of a last-minute shortage of staff, a substantive member of staff must be moved from another inpatient ward to cover the nurse in charge role.
- 11.3 The nurse in charge of a ward /community team leader is the designated professional responsible for the daily operational staffing review, identification of the staffing escalation position and the identification of any red flag staffing events.

12.0 Red Flag Events /Tipping points

- 12.1 Red flags are those circumstances stipulated NICE (JULY 2014) which maybe an indicator that quality of care has declined, and patients are being made vulnerable. The red flags outline 'tipping factors and thresholds that would 'tip' the risk rating to a high/red risk from a moderate/amber risk.
- 12.2 Should any of these occur or is identified as being at risk of occurring, it should prompt immediate escalation by the registered nurse in charge to the ward/community team leader and to the matron who will investigate and complete an e-iRF and follow the steps appendix 6 and progress through directorate processes.
- 12.3 Red flags/tipping points:
 - 12.3.1 Less than 2 RN per shift – e.g., only 1 nurse where 2 were required (in patients)
 - 12.3.2 >50% temporary staffing utilisation
 - 12.3.3 Fill rates below 80%
 - 12.3.4 Care Hours Per Patient Day (CHPPD) below service average = less care hours
 - 12.3.5 More than 1: 8 RN to patient ratio (is linked to poorer outcomes and mortality) based on the needs of the service.
 - 12.3.6 Increase in nurse sensitive indicator harm.
 - 12.3.7 Missed care – tasks, therapeutic intervention.
 - 12.3.8 Serious incidents – staffing as a contributory factor.
 - 12.3.9 Increased complaints
 - 12.3.10 Missed breaks - staff.
 - 12.3.11 Mental health – Detained patients unable to be offered fresh air at least once a day.
 - 12.3.12 Prioritised assessments/clinics/visits are not carried out or cancelled.
 - 12.3.13 Consistent Deferred visits
 - 12.3.14 Essential visits not covered.
- 12.4 In the event of when operational staffing has been reviewed and despite proactive interventions the risk remains high, the safe staffing escalation framework is required to ensure that risks are identified, escalations and actions are taken to mitigate the risks.

13.0 Safe Staffing Decision Tool and Escalation Framework for Inpatients

Draft safe staffing decision tool and escalation framework for In-patients



- 13.1 In the event whereby Directorate Staffing & Safety review identifies high risk (Red) staffing depleted or unmitigated high risk (Black) then support, and action is escalated to the trust wide Matron for safe staffing and/or assistant director for nursing and quality The Staffing and Safety huddle is convened and staffing, and safety assurance templates completed (Appendix 7). Please see Staffnet for The Trust wide bed closure SOP.
- 13.2 The management of safe staffing is dynamic with unplanned workforce challenges. It is essential therefore that each directorate adopts the overarching principles and guidance identified in this policy, including the daily operational staffing review and safe staffing escalation framework to recognise changes in demand and react dynamically to mitigate the risk. It is acknowledged the overarching principles and guidance will be adapted and locally standardised to operate in practice e.g. CHS in-patient Safe Staffing SOP also found on Staffnet.

14.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Frequency of monitoring
Section 7.0	Annual establishment resetting with 6 monthly updates. Safe staffing reviews	Quality & Safety Committee and Trust Board Work Plan	Assistant Director of Nursing & Quality	Bi-annual

15.0 References and Bibliography

- Birmingham and Solihull Mental Health NHS Foundation trust, Safer staffing policy (August 2021)
- Developing workforce safeguards supporting providers to deliver high quality care through safe and effective staffing, NHS Improvement (October 2018)
- LPT Optimising Electronic Rostering at LPT (Dec 2020)
- LPT Trust wide Decision-Making process for Bed closures (Nov 2021)
- LPT Preceptorship Policy (Dec 2023)
- LPT Probation Policy (Jan 2024)
- LPT Trust Wide Bed closure Standard Operational Procedure
- LPT CHS Safe Staffing SOP
- Nottinghamshire Healthcare NHS Foundation trust, In-Patient Safe Staffing – Essential Guidance to Defining and Managing Nurse Staffing Resources (August 2021)
- National Quality Board (2013) how to ensure the right people, with the right skills, are in the right place at the right time – A guid to Nursing, midwifery and care staffing capacity and capability.

- North Devon Healthcare NHS trust Nursing Safer Staffing Policy (May 2019)
- Nursing Workforce standards supporting a safe and effective nursing workforce (May 2021) Royal College of Nursing
- Professional judgement framework: a guide to applying professional judgement in nurse staffing reviews Saville, Christina, Griffiths, Peter, Casey, Ann, Chable, Rosemary, Chapman, Hilary, Radford, Mark and Watts, Natasha, Professional judgement framework: a guide to applying professional judgement in nurse staffing (2023)
- Staffing Assurance Framework For winter 2021 Preparedness (Nov 21)
- Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time, Safe sustainable and productive staffing, National Quality Board (July 2016)
- Workforce Standards For the District Nursing Service (Nov 2019) Queens Nursing Institute
- University Hospitals of Leicester (UHL) Safe Staffing for Nursing and Midwifery Trust Policy and Procedure (Jan 2023).

16.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

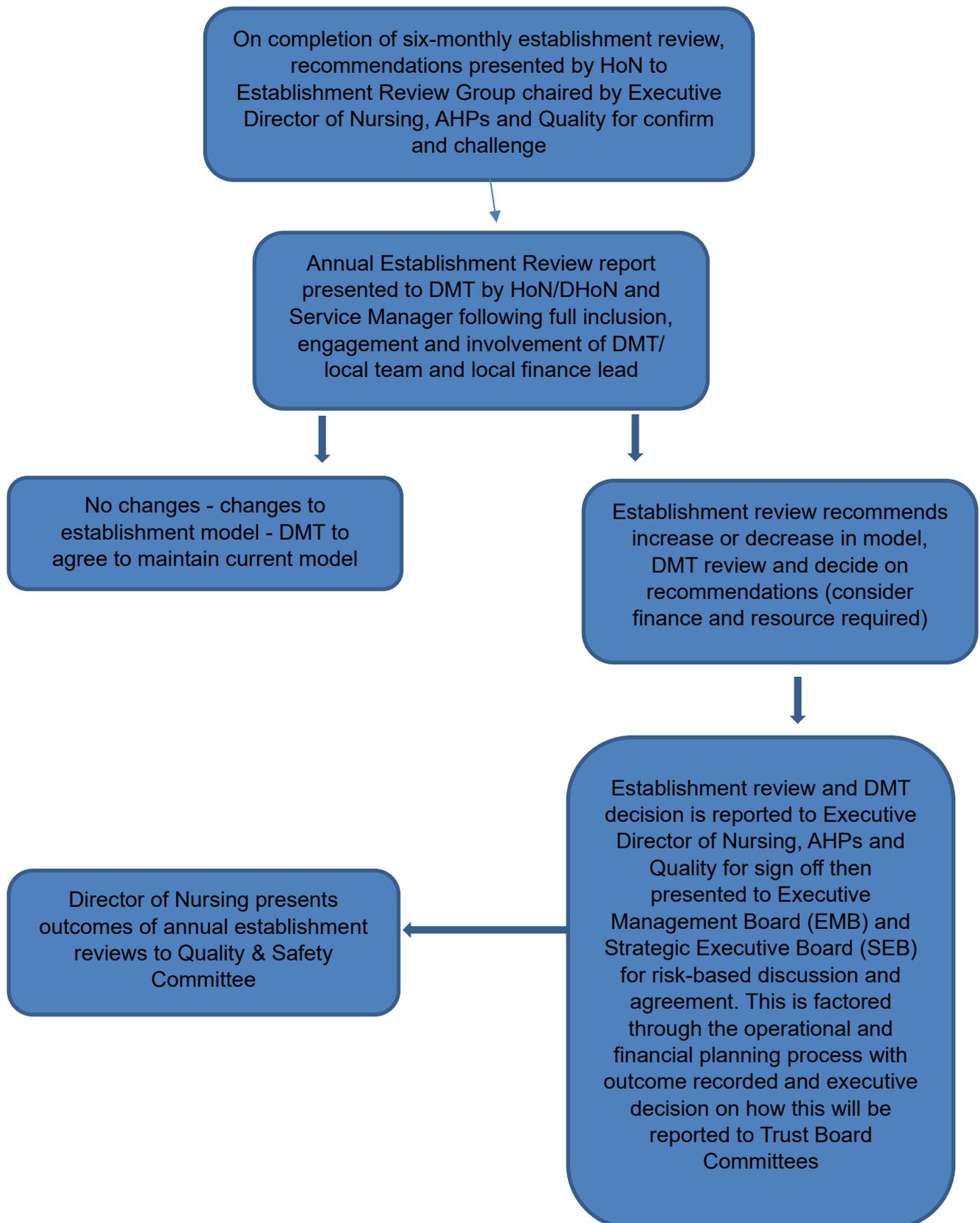
Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Flowchart

Establishment Review Governance and Sign Off Process



Appendix 2 Training Needs Analysis

Training topic:	e-Rostering, Annual Establishment Reviews and Evidence based workforce planning tool relevant to area of practice - SNCT (CHS In-Patients) MHOST (DMH + FYPC.LDA) LDOST (LDA) CNSST (CHS Community)
Type of training:	Role specific
Directorate to which the training is applicable:	Adult Mental Health Community Health Services Families Young People Children / Learning Disability/ Autism Services
Staff groups who require the training:	Ward managers, charge nurses, team leaders, matrons
Regularity of Update requirement:	One time only
Who is responsible for delivery of this training?	e-Rostering training is via workforce team and the Annual Establishment Review training will be rolled out to all ward managers as part of the Annual establishment review (by acting Assistant Director for Nursing and Quality and workforce and safe staffing matron) NHSE provide train the trainer approach to Evidence Based Tools such as SNCT,CNSST.
Have resources been identified?	Within the JD of the roles identified
Has a training plan been agreed?	E-rostering is provided on a bespoke basis Yes as part of the Annual establishment reviews (one time only)
Where will completion of this training be recorded?	Other – as per Annual establishment review
How is this training going to be monitored?	As part of the Annual Establishment Review process and in line with the essential to role requirements of ward sister/charge nurse/clinical team leader

Appendix 3 The NHS Constitution

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

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

Appendix 4 Due Regard Screening Template

Section 1			
Name of activity/proposal		Safe Staffing Policy	
Date Screening commenced		15.03.24	
Directorate / Service carrying out the assessment		Nursing Corporate team	
Name and role of person undertaking this Due Regard (Equality Analysis)		Elaine Curtin Workforce & Safe Staffing Matron	
Give an overview of the aims, objectives and purpose of the proposal:			
<p>AIMS: The aim of the policy is to outline a clear escalation process from frontline staff to board describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift/community team. To ensure that by providing a structure and process for carrying out establishment reviews that planned staffing for registered and non-registered nursing match the acuity and dependency needs of patients. The skill mix and capability of the workforce is of an appropriate level to provide high quality safe and compassionate care. Service users and staff will benefit from this policy.</p>			
<p>OBJECTIVES: Ensure there is a clear escalation process in place and staff are able to escalate their safe staffing concerns from ward to board. All nursing staff clearly understand the policy and procedures within it to enable the safety of patients and the health and wellbeing of the workforce.</p>			
Section 2			
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details		
Age	The policy supports safe staffing levels for all service user's and staff and there is no evidence it will disproportionately have an impact.		
Disability	As above		
Gender reassignment	As above		
Marriage & Civil Partnership	As above		
Pregnancy & Maternity	As above		
Race	As above		
Religion and Belief	As above		
Sex	As above		
Sexual Orientation	As above		
Other equality groups?	As above		
Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4. <input checked="" type="checkbox"/>	
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor	Elaine Curtin	Date	15 March 2024
<i>Sign off that this proposal is low risk and does not require a full Equality Analysis</i>			
Head of Service Signed	Jane Martin	Date	15 March 2024

Appendix 5 Data Privacy Impact Assessment Screening

<p>Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.</p> <p>The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.</p>		
Name of Document:	Safe Staffing Policy	
Completed by:	Elaine Curtin	
Job title	Workforce and Safe Staffing Matron	Date: 15 March 2024
Screening Questions	Yes / No	Explanatory Note
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
<p>If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</p>		
Data Privacy approval name:	 Hannah Plowright	
Date of approval	17/04/2024	

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

Appendix 6

Operational Pressure Escalation Levels (OPEL) Rating Risk scoring for Directorates

Action Levels			
Community Health Services			
Triggers			
Level 1 Normal Working	Level 2 – Moderate Pressure	Level 3 – Severe Pressure	Level 4 – Extreme Pressure
Community Hospital Beds	Community Hospital Beds	Community Hospital Beds	Community Hospital Beds
<p>Bed capacity is 15 beds or more with discharges planned. No operational issues. Staffing meets demand. Availability outweighs demand. Good spread of gender and geography availability</p>	<p>Bed capacity is less than 15 beds available. Discharges are planned for same day Availability outweighs demand and discharges planned within 24 hours. Service area experiencing staffing Issues.</p>	<p>Bed capacity is less than 7 beds available. Availability less then demand with discharges planned in the next 24 hours Service line experiencing staffing issues.</p>	<p>No beds available No discharges planned in the next 24 hours CHS experiencing staffing issues across all service lines.</p>
Community Services	Community Services	Community Services	Community Services
<p>Able to accept referrals and provide on-going care to Home first and community health services patients.</p> <p>No operational issues. Staffing issues not impacting on services Staff able to fully engage in community board rounds and proactively review ongoing caseloads, identify patients for discharge and self-care.</p> <p>Staffing hours available match on going service need</p> <p>Rapid responder allocated per team.</p> <p>Hub leadership teams working within</p>	<p>Unable to guarantee non-urgent (planned) or unscheduled service response times in one locality/ home first. Staff unable to participate in board rounds to proactively identify patients for discharge or ongoing referral in one locality. Staffing issues which result in cancellation of routine activities and mobilisation of staff on non-clinical duties in one locality. Service demand in a single locality outweighs the staff available. Unable to guarantee attendance of MDT/ PCN meeting in one locality. Reduced rapid responder capacity within one locality. Unable to protect nonclinical leadership within one locality. Staffing issues managed within service</p>	<p>Unable to guarantee non-urgent planned or unscheduled service response times in more than one locality.</p> <p>Significant staffing issues which result in cancellation of routine activities in more than one locality</p> <p>Staff unable to participate board rounds to proactively identify patients for discharge or ongoing referral in more than one locality. Service demand in more than one locality outweighs the staff available. No rapid responder element in more than one locality Non-clinical leadership mobilized to work clinically in</p>	<p>Unable to guarantee urgent and non-urgent unscheduled and planned service response times across the service line. Cancelling routine clinic appointments to release staff. CHS experiencing staffing issues across all service lines.</p>

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

Families Young People Children, Learning Disabilities & Autism Service

Triggers

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

Appendix 7

Annual Establishment Review Template

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

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

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

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

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

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

Service developments or changes

Outline any service developments/changes and impact to staffing

Outcomes

Review of last 6 months Nurse Sensitive Indicators (monthly safe staffing) Quality, Patient Safety & Experience

Does the data suggest a need to increase staffing? Or reduce

Temporary staff use

Agency usage above 6%

Shifts whereby 50% are substantive

Fill rates and temporary worker utilisation

Skill mix and new roles

Nursing Associates

Medication Administration Technicians AHP – Therapy liaison roles

QIA for any new role and see Staffnet for Skill Mix Proposal Pack

Proposed staffing

Planned staffing per shift Financial cost

Impact assessment

Appendix 8

Staffing and Safety Assurance Templates

CHS Community ONLY

	Directorate:	Date:	Representative:
Dropdown option (Cells: B9, C9, D9, B21, B22, B23)			
	<i>Drop down box: B9</i>	<i>Drop down box: C9</i>	<i>Drop down box: D9</i>
Information required:			
Safe staffing areas to note under planned levels - shift and staff required			<i>Free text box</i>
Levels of staffing risk			<i>Free text box</i>
Quality and safety concerns			<i>Free text box</i>
<u>For Community ONLY</u> Red flags would include essential visits not covered. Workload reprioritised. Clinics / Visits cancelled.			<i>Free text box</i>
Clinical mobilisation			<i>Free text box</i>

Analysis of incidents / emerging themes and impact on patient safety		<i>Free text box</i>
Actions taken to date and what further action is required		<i>Free text box</i>
Community areas to highlight		<i>Free text box</i>
Grading of current risk		<i>Drop down box: B21 Please refer to Guidance tab for explanations</i>
Opel Level		<i>Drop down box: B22 Please refer to Guidance tab for explanations</i>
Action Level		<i>Drop down box: B23 Please refer to Guidance tab for explanations</i>
Staff feedback regarding their Health and Wellbeing		<i>Free text box</i>

DMH/FYPC.LDA/CHS Inpatients

	Directorate:	Date:	Representative:
Dropdown option (Cells: B9, C9, D9, B21, B22, B23)			
	<i>Drop down box: B9</i>	<i>Drop down box: C9</i>	<i>Drop down box: D9</i>

Information required:			
Safe staffing areas to note under planned levels - shift and staff required			<i>Free text box</i>
Levels of staffing risk			<i>Free text box</i>
Quality and safety concerns			<i>Free text box</i>
<u>For Community ONLY</u> Red flags would include essential visits not covered. Workload reprioritised. Clinics / Visits cancelled.			<i>Free text box</i>
Clinical mobilisation			<i>Free text box</i>
Analysis of incidents / emerging themes and impact on patient safety			<i>Free text box</i>

Actions taken to date and what further action is required		<i>Free text box</i>
Community areas to highlight		<i>Free text box</i>
Grading of current risk		<i>Drop down box: B21 Please refer to Guidance tab for explanations</i>
Opel Level		<i>Drop down box: B22 Please refer to Guidance tab for explanations</i>
Action Level		<i>Drop down box: B23 Please refer to Guidance tab for explanations</i>
Staff feedback regarding their Health and Wellbeing		<i>Free text box</i>