**Maintaining Safer Staffing to priority services:**

**Revised Deployment Approach**

This paper aims to set out the agreed approach to deployment & redeployment of staff in order to maintain minimum safe staffing levels within the agreed priority services of the Trust, as a result of significant and sustained reduced staff availability as a result of the on-going Covid pandemic or other pressures.

In the initial stages of the Covid pandemic, an approved process for proactive Redeployment of staff was developed and implemented (Clinical & Operational Staffing Redeployment, April 2020 – attached as Appendix 1).

Both during and following implementation, the redeployment process has been reviewed through a number of processes (such as ongoing redeployment forums, some facilitated discussions with ward / team managers, and through the wider Trust evaluation and staff feedback processes). The feedback and learning has been considered and incorporated into this revision, which has also been developed through discussions with operational, clinical and professional leads.

This revision also sets out a revised approach to the prioritisation of services, based on significant discussion across Care Services and beyond, including through the Operational Delivery Group.

For a small number of ad-hoc / single instance requirements for additional staff in order to maintain safe staffing levels, the standard approaches of seeking additional staff, negotiating changes with local staff (such as cancelling training or ad-hoc leave) and moving staff on a shift by shift basis based upon need will be applied (as set out in the Staffing Escalation Protocol, which can be found at Appendix 3 of the Clinical & Operational Staffing Redeployment process).

However, when the need for additional staff to maintain minimum staffing is more sustained (or when actual or predicted levels of absence exist across a large number of services), an alternative approach is required.

Deployment & Redeployment is overseen by a dedicated group, which includes operational, clinical / professional and work force representatives. The Terms of Reference are attached as Appendix 2.

1. **Identification of need**

In order to identify a sustained need, a number of potential factors will be considered:

* Use of a workforce information dashboard
* Daily staffing reporting from all priority services through the operational route
* Escalation from Heads of Operations
1. **Workforce information dashboard**

Utilising existing workforce information systems and data capture processes, a collection of KPI’s will be compiled into a dashboard with an embedded RAG rating system to identify potential sustained staffing shortages. The dashboard will act as an early warning system enabling us to make informed, evidence based decisions about potential / actual need for additional staff to maintain safe staffing.

The dashboard will be produced and distributed at 2 separate intervals (weekly and 4 weekly forecasting) to effectively capture and manage both short-term spikes and trend trajectories at ward level across the organisation.

The planned schedule is as follows:

***Weekly Report:*** Capturing a 7 day forecast for the coming week which will aggregate data to capture areas consistently struggling and trends in staffing availability.

***4 Week Reporting:*** Aligned to the Ward rosters, this report is an extension of the 7 day forecast report but allows for a greater projection to determine whether planned absence/leavers/starters will contribute to the ability to staff the ward safely.

The Scorecard will include

* ***Covid Related Absence* -** All Covid related absence is recorded under the “Other Absence” code in the Healthroster system in real time by ward managers and has been utilised throughout the Covid period to provide the National SitRep data to NHS Digital
* ***Total Unavailability*-** a combination of all types of unavailability affecting the units’ ability to Safely Staff this includes Sickness, Annual Leave, Maternity, Study & Other absence ( Jury Duty, Compassionate leave etc). Wards are profiled to accommodate an unavailability of 24%.
* ***Unfilled Roster -*** The number of hours that remain unfilled after all shifts have been rostered, sent to Bank/Agency for cover this would incorporate vacancies and shifts not covered due to the above unavailability reasons.
* ***Redeployed People Hours* -** where action has already been taken to support the unit and staff from outside the service have been utilised
* ***Vacancy rate –*** indicator of the level of vacancy in the service, which will impact on consistency of staffing and capacity of the ward to manage an increased unavailability

*Example Dashboard:*

|  |
| --- |
| **Redeployment Dashboard Test** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Unit** | **Covid Absence %** | **Total Unavailability %** | **Unfilled Roster %** | **Redeployed People Hrs** | **Current Vacancies**  |
| Newsam Ward 5 | 10.1 % | 25.4 % | 3.8 % | 201.00 | 6% |
| Becklin Ward 1 | 6.9 % | 12.4 % | 8.8 % | 0.00 | 4% |
| Becklin Ward 3  | 14.8 % | 38.9 % | 12.1 % | 0.00 | 11% |

In addition to the above, real time information can be drawn from the system as required on a daily basis to better understand and predict safer staffing issues as they arise and are escalated from the daily reports and through clinical / operational routes below.

1. **Daily staffing reports**

As a result of increased absence, all priority services report their staffing position each morning for the next 24 hours (and on Friday for the weekend period). This supports the local operational & clinical managers, on-call managers and duty Head of Operations to predict and address staffing shortages, and to prioritise staff deployment as required.

Clearly this is a snapshot in time; experience has shown that the reported position at 9am is frequently very different to the position at midday (often due to shifts being filled during the course of the morning).

When the daily report indicators that there are significant forthcoming shortages across a number of the services, the duty Head of Operations will consider convening further reviews of the changing staffing position as required throughout the day, and will seek to ensure that mitigating actions are taken to maintain (minimum) safe staffing numbers across all priority services. As indicated above, information can be drawn from the HR / workforce information systems to support this if required.

1. **Escalation from Head of Operations**

There are some additional clinical & operational factors that will have an impact on both staffing requirements and safety within services – these include, for example, high levels of acuity, enhanced observations, incidents of significance and bed occupancy. Where these factors exist and this results in a requirement to increase staffing for a sustained period, this will be escalated by the Head of Operations (or in their absence via the ward matron or designated deputy).

The staffing position for each service is also routinely reviewed at the Clinical & Operational meeting, which currently meets 3x per week, but can increase to a daily meeting if required.

1. **Revised prioritisation of services**

In line with the previous process, we have maintained an approach of prioritising services using the following criteria:

|  |  |
| --- | --- |
| **Priority 1 services** | These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained. This includes 24/7 inpatient services, supported living houses and urgent access / crisis services. |
| **Priority 2 services** | There services need to be maintained, but may safely be delivered at a reduced capacity or alternate skill mix. . This will be informed by an assessment of service user need, risk and vulnerability using our agreed clinical RAG rating process. Services may therefore be reduced or consolidated, and some staff redeployed into priority 1 services |
| **Priority 3 services** | These services could be reduced to a minimum level of delivery or could be stepped down entirely. The majority of staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill mix to release other staff to priority 1 services) |

The key change is that, whereas a number of service were previously stepped back to minimum staffing providing only emergency or signposting cover, the vast majority of services have moved into the ‘priority 2’ grouping. This reflect a specific wish to maintain a level of direct service provision across all services, reflecting both national & local drivers to carry on providing as many services as possible, and recognising the impact of some services (in terms of escalation of clinical presentation and significant increased waiting lists) of the previous redeployment approach. The revised service priority groups are therefore shown at Appendix 3.

This has been debated at some length, with a number of different views considered.

The impact of this approach is that, rather than identify services to step down immediately, services within the priority 2 group will have identified a number of staff that are available to be redeployed, and this will be agreed with the staff in advance. The service will be able to proactively plan – and clearly articulate – the potential impacts of those staff being redeployed, and will be able to plan to mitigate & manage these accordingly. This approach was strongly advocated and favoured by both the clinical and operational leaders.

It is however essential to recognise that, as part of this approach, if safer staffing cannot be maintained through the redeployment of the identified staff, then it will be necessary to consider releasing additional staff from these services (and therefore further reducing their capacity & operational delivery) or stepping down some services entirely in order to release additional capacity. This approach is described below.

1. **Identifying staff for redeployment**

In the first instance, for low level and short term additional staffing requirements to maintain agreed minimum staffing levels, the usual local actions will be taken to seek to meet these (as set out in the Staffing Escalation policy) . These include (but are not limited to)

* Review of current staffing requirements on the ward (including enhanced observations and any escorted patient leave)
* Seeking additional bank staff or overtime
* Cancelling training & rostered management days
* Cancelling ‘ad hoc’ annual leave in negotiation with the member of staff
* Moving of staff from other clinical areas whilst maintaining agreed minimum safe staffing numbers

However, once a priority 1 service has been identified as having a sustained requirement for additional staffing, the ‘redeployment group’ will utilise available information to determine the number of staff required and an appropriate skill mix, supported by additional members from the clinical & operational leadership teams as required.

Appropriate staff will then be identified using a hierarchy as below, working from the top until the identified need is met

1. *Volunteers* - cohort of staff who have self identified as willing to be redeployed and have completed the redeployment proforma identifying skills & areas of preference. This includes volunteers from non-clinical / corporate services (based on positive experience previously)

1. *Cohort of ‘early redeployees’* - identified specific groups of staff who would be redeployed in initial wave (generally clinical staff not undertaking direct clinical roles; this may include partial redeployment, as previously)
2. *Identified proposed redeployees from Amber priority services* (services that will be reducing staff & operating differently but maintained)
3. *Additional redeployment from Amber priority services (*with assessment of associated risks / impacts and how these could be managed; this may result in a service being stepped down to minimum cover)
4. *Stepping down of non- priority 1 services* - services that will be stepped down or reduced to minimum cover to release further staff. This would require IRT approval.

A pre-determined duration for all redeployments will be agreed to ensure we can meet the needs of the sustained requirement for additional resource as well as manage the expectations of the ‘home’ service, redeployed service and individual staff members.

1. **Deployment of staff to identified cohorting areas**

Recognising the particular challenges of staffing identified cohorting / Covid-positive areas (based upon the earlier experiences), the following approach will be taken in addition in these areas:

* Acute adult and Older Peoples services will have identified a cohort of staff who express a willingness to work in these areas, and this will also be asked of Bank staff. This will be known to the redeployment group and these staff will be prioritised for deployment into these areas.
* For all staff, their well being assessment and individual circumstances will influence the decision in relation to working within the cohorting area.
* Once deployed into the Cohorting area, staff will remain there for the period that the unit remains open. Other than in emergency circumstances staff will only work each day in the cohorting area, and will not move between wards.
1. **Learning from previous redeployment feedback**

Significant efforts have been made to ascertain and then collate feedback regarding the initial redeployment process, with responses obtained from:

* Manager forums
* Your Voice Counts
* Redeployment staff forums
* Evaluation by the Clinical Effectiveness team.

As a result, a number of process changes have been developed in order to:

* Improve **communication** between the redeployment team, managers, clinical and professional leads
* Raise **awareness**, via multiple methods, for all staff regarding rationale for redeployment and the process for implementation
* Improve **consistency of implementation** of the deployment and redeployment processes across teams and service areas
* Provide clearer **information** for redeployed staff regarding their new teams / roles and for managers regarding their skills, competencies and potential concerns
* **Plan** for redeployment actions in advance wherever possible with individual services to mitigate impact and provide opportunities for staff engagement
* Improve **effectiveness** of redeployment by seeking to redeploy staff who volunteer and/or have developed relevant skills, training and experience having been redeployed previously to the priority 1 service areas
* Improved focus on **supporting staff well being** through incorporating staff wellbeing assessments into the redeployment process and being clear as to the expected duration of their redeployment commitment
* Wherever possible, provide **clear anticipated time scales** for the duration of the redeployment period on an individual basis.

These priority changes have been incorporated into this revised process, and will continue to be reviewed and evaluated both through the Redeployment Group and through other Trust structures.

**Appendix 1 – Original Clinical & Operational Staffing Redeployment process.**



**Appendix 2 – Redeployment Group Terms of Reference**



**Appendix 3 : Clinical & Operational Redeployment – Service Categorisation**

|  |
| --- |
| **PRIORITY SERVICES** |
| CRISSOlder Peoples IHTTLD Intensive Support TeamMH Primary CareALPS & LTHT Liaison InreachSection 136 suite Veterans High Intensity Service  | All crisis / urgent access services |
| Acute Wards & PICUCAUMount wardsAsket WardsMill LodgeMother & Baby UnitYCED (Ward 6)Complex Rehab (Ward 5)Forensic WardsParkside Lodge / 3 Woodlands SquareSupported Living | Inpatient services and Supported Living Houses – maintain 24/7Some reduction in full MDT availability in some teams, which will be managed by cross cover or redeployment (depending on requirements)Minimum staffing requirements being reviewed & confirmed in partnership with nursing directorate |
| NICPM | Maintain as a priority ward unless LTHT require ward space.  |
| **Maintain but can reduce / redeploy some staff** |
| CMHTsCLDTsAssertive OutreachCommunity R&RCONNECT community teamCommunity Forensic TeamCommunity PerinatalDeaf CAMHSPhysical Health TeamCare Homes TeamRecovery College (telephone & online support)Forward Leeds (Addictions)PD Network LADS & ADHD Gender service Gambling service Chronic Fatigue & Liaison Outpatients Psychosexual medicine Offender PD services Veterans service | These services can all operate currently on a reduced number of staff, but have a requirement to maintain some access and an active caseload, including direct contact (inc some face to face contact) with some service users.All service users have been RAG rated and this informs the required capacity and skill mix for the teamSome staff are therefore available for redeployment from these teams. |
|  **Could step down**  |
|  LD Involvement Team PD Pathway Development Service 2 Woodland Square  | These services can be closed to new referrals and stepped down, with only emergency contact cover in place |