Worcestershire Acute Hospitals NHS Trust

Safer Staffing Guidance for The Occupational Therapy Service

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

This guidance is aimed at assisting and establishing safe and clinically effective staffing levels in the Occupational Therapy service. Through safer staffing the service can aim to achieve greater resilience amongst the workforce in times of variable and fluctuating staffing; with therapists having proactive management skills to meet patient demands safely.

The driver for change: Right Occupational Therapy workforce that can deliver patient care at the right time, with the right skills in the right place over the next 3-5 years.

This required change has also been informed by the 4ward signature behaviours 'No delays, everyday' and the Occupational Therapy Practice strategy; where Occupational Therapy services should be clinically effective, occupationally focused and have staff that are professionally resilient to cope with the increasing population demands across the Hereford and Worcestershire health economy.

This guideline is for use by the following staff groups :
Occupation Therapy Services

Lead Clinician(s)

Charlotte Jack	Occupational Therapy Services Manager
Approved by Therapies Clinical Governance Approval Group on:	4th January 2023
Review Date: This is the most current document and should be used until a revised version is in place	4th January 2026

Key amendments to this guideline

Date	Amendment	Approved by:
January 2023	New document approved	Therapies Clinical Governance Approval Group

Introduction

Case for Change

Over the last 4 years the Occupational Therapy Service at Worcestershire Acute Hospitals NHS Trust has undergone significant structural, workforce review and staff changes.

These changes have been driven by new senior management to ensure a robust workforce and sustainable service over the next 3 to 5 years, in line with the Therapy services clinical services strategy and Trust directives.

In 2019 CQC stated as a required area of improvement that:

CQC MC515 – The trust should ensure that there is enough Occupational Therapists at the right time, right place to provide a timely and responsive service

In response to this required CQC improvement there have been significant efforts to recruit into the service, create opportunities for exiting employees, so that hard working and experienced staff are retained based on a stronger and more enticing workforce and professional career development and framework as well as attract 'new talent' to influence clinical delivery.

There has been continual workforce planning through multiple reviews and service structural changes, all have been a necessity to ensure a workforce where the skills and working practices of staff evolve to support the aging population, changes in technology, increases in demand and changing context for care. The emphasis has also been to encourage Occupational Therapy staff to be skilled and experienced in resource management, service redesign, delivery, strategic planning and clinical leadership.

OT vacancy rates have been high and over the last 2 years, the service has seen staff leave because they have chosen to take earlier retirement or leave based on reports of increasing pressures with the acute setting. This has resulted in some minimal staffing levels across some services carrying longstanding vacancies or stretching resources due to recruitment lag time.

Current Situation

With Occupational Therapy fully transitioned to E-rostering; the need to establish safe and clinical effective staffing has been absolutely essential to ensure that we are putting patients first and that staff have the right working conditions to feel effective as clinicians.

There is no single guidance or standard approach to inform OT staffing levels required. Each Allied Health Profession has specific information and guidance available to support staffing levels for a particular type of service i.e. Stroke.
Royal College of Occupational Therapy (2015) states that OT staffing levels should be determined through a range of methods which include demand & capacity, skill mix, acuity, complexity in case load management based on average patient/non-patient contact time. Services should factor in what type of service is required and the staff and skill set to ensure clinical effectiveness and better patient outcomes.

Allied Health Solutions (2017) provides guidance that workforce calculations in acute services for Occupational Therapists should be considered at a range **of 0.06-1.15 WTE** per patient referrals received across a 5-day service. The range of WTE should consider average time spent with a patient (patient and non-patient time), which would be determined by the average follow up sessions a patient would receive from an Occupational Therapy member of staff.

Based on WAHT in-patient service level reporting from 2018-2021, the following assumptions in relation to **workload volume changes** can be made:

Summarised Data from IP Service Level Reporting for Occupational Therapy (2018-2021)

Financial Year	2018-19	2019-20	2020-21
New Patient Activity	11, 765	13, 580	14, 111
Follow up Activity	18, 609	31, 148	37, 449
TOTAL	30, 374	44, 728	51, 560

- Growing demand for Occupational Therapy
- Level of intensity provided in assessment and interventions has increased requiring more patient follow up sessions
- With increased patient contact it is likely that non patient activities, i.e. clinical documentation, completion of electronic referrals, MDT liaison has increased.
- Caseloads in terms of complexity (based on follow up activity) are likely to be simple long where reasoning is procedural; decisions can be made using basic or standard protocols; situation is familiar to the therapist from previous experience but requires more time but is not difficult.
- Caseloads are increasing in complexity where problems are not readily identified or resolved, interventions are long and difficult due to cultural or personal issues, and interventions involve multiple participants in numerous steps. Reasoning is not procedural; situation demands a highly individualised approach; clinical reasoning needs to be creative, imaginative and initiative; planning, intervention and documentation is time consuming, previous experience assists with effective monitoring of cases.

It is also anticipated that the Occupational Therapy service (based on increased activity) will see changes in skills and the nature of the workload, which are summarised:

Changes in Skills and Nature of workload

- Undertaking more highly specialist assessment of patients, including those with diverse or complex presentations/multi-pathologies; using expert clinical reasoning skills and manual assessment techniques to provide an accurate foundation for the management of their condition.
- Having to develop more and new clinical protocols and ensure such protocols are implemented and regularly audited.

- Having to prepare and deliver more individual occupational therapy interventions based on an expert knowledge of evidence based practice and treatment options, using expert clinical assessment, reasoning skills and treatment skills.
- Possibly moving towards carrying out more diagnostic procedures (cognition, capacity) and interpret the results/provide advice in specialised areas.
- An increase in advanced verbal and non-verbal communication tools to communicate effectively with patients in order to progress treatment intervention.
- Understand 'Occupation' related to larger system of environment/community not just in a clinical setting which evidently controls its environment.
- Consider and pre-empt factors that can affect health and occupation which are not visible in a clinical setting
- Manage foreseeable and unforeseeable risk in a community environment based on unpredictability of a patients' interaction in their own home and community
- Know the community in order to develop meaningful interventions that are based on the individual's occupational preferences

Patient safety, ensuring sufficient time for consistently good quality effective care and care provided with compassion and respect for patients' dignity, must be at the heart of all healthcare and be central to the allied health professional's work. (Jones & Jenkins 2014).

The problem

"**The problem is, and always has been, the lack of nationally accepted norms or guidelines from which to estimate the number of Occupational Therapy staff required"**

Although there has been a significant increase in Occupational Therapy staff in Worcestershire Acute Hospital trusts over the last 20 years; staffing levels have often been determined by managers, team leads and clinicians drawing on experience, and using that experience to forecast demand based on previous referral habits of wards with a similar specialist nature.

Service line reporting for in-patient data has seldom been used and there has been no common methodology for calculating WTE for new wards or justifying increased demand for OT WTE in business cases. The only services that have been calculated using national norms are Stroke and Critical Care.

The objectives for Safer Staffing for WAHT Occupational Therapy service:

1. Identify the most appropriate methodology/tool for the service to assist in establishing whether the current WTE within the services is optimal or has a significant deficit.
2. To use the agreed methodology/tool in establishing safe and therapeutic staffing levels, per day, suitable to all services within the structure.
3. To be able to move away from 'woolly assumptions' regarding productivity and WTE and define and describe numerically the potential workload arising from cases across the specialities using historic and current service line reporting inpatient data.
4. Describe the expected demand of new patients and follow up activity per day, per week, per month and understand the effect of various staffing levels in practical terms such as caseloads according to banding and input per case.
5. To develop a RAG rating tool that assists staff understanding their minimal and optimal staffing in their services and what the proportionate response of that service will be.
6. To use a methodology/tool that can calculate future workforce that can therefore be used in business cases.
7. To use the agreed tool/methodology for supporting future 7 day working directives and to assist in job planning scheduled for 2022-23
8. To use the second phase of E-rostering to reflect what the optimal and minimal staffing within the individual services should be.

Chosen Methodology/Tool

- **The Jones & Jenkins Approach (2014)**
- This method was chosen because much of the data and information the service already has (in and out-patient data, details regarding patient cohort, new patient versus follow up ratios). This helps therefore provide a rigorous evidence-based approach to staffing determination.
- It is anticipated that this method will enable this and will benefit patients we serve, resulting hopefully in safe, effective and efficient service provision.
- This methodology also allows managers, leaders and clinicians to draw on experience.

Our main aim is to show how effective and safe staffing levels can be calculated using the data and information already available to our service.

Method

Step 1	What specialty is the service to be provided for?
Step 2	What is the dependency of the level of patients to whom this service is provided to – ***Volume of follow up activity***
Step 3	What is the annual workload ***demand***? This is the in/out patient activity
Step 4	What are the quality parameters? **Responsive**, **Early intervention** (patients are clinically optimised), **waiting lists** of less than 6 weeks, evidence of **Occupationally Focused** practice
Step 5	Assess which OT service requires this

Step 6	Assess the levels of expertise and experience needed from each OT service. This has been considered in the original paper where ***changes in skill***, ***changes in workload nature*** (more simple long and complex patients) and ***workload volume*** (comparison of activity to previous financial years) have been factored into this.
Step 7	What is the annual activity and workload capacity? ***(Demand)***
Step 8	What is the individual WTE caseload capabilities ***(average WTE per new patient)?***
Step 9	Total the ***required individual WTE*** to meet the annual activity
Step 10	Ensure that the overall WTE meets anticipated workload and consider staffing costs

In-Patient Workforce Calculations and Caseload Assumptions based on WAHT service line Reporting (18-19/19-20 and 20-21)

5 DAY SERVICE

Total OT establishment = **66.99 WTE**
Total in-patient establishment ~ **60.76WTE**
Minus 1.2 WTE additional funding for 7-day stroke service = (based on 2 qualified/1 non Q sat/sun)
In-patient establishment ~ **58.13 WTE – minus 1.43 WTE Band 6 Student/8A Practice & Ed Role**

NEW PATIENTS

Based on IP Service Level Reporting for OT (18-19/19-20 and 20-21)
Average OT NEW PATIENTS assessed across WRH and AGH ~ **1,100 per month**

FOLLOW UP SESSIONS

Average OT follow up activity across WRH and AGH = **~ 2.16** follow up sessions per patient

PATIENT & NON PATIENT CONTACT TIME

- Initial OT new patient assessment = on average 60 minutes (investigation/triage/assessment)
- Follow up Patent Face to Face Sessions (30 minutes) x 2 on average = 60 minutes
- OT Administration (community visits, documentation, referrals, telephone calls etc.) = 60 minutes
- Average total time = 3 hours (0.03 WTE x 3 hours)/average 5 days = 0.09 WTE x referrals per WEEK

Forecasted clinic templates for Occupational Therapy Out-Patient 22/23

Out-Patient Service	Targeted NP per month	Target PIFU per month	Patient slots per month	Patient slots per week	Targeted new patients per week
Elective Orthopaedics	75	0	216	50	18
Rheumatology	59	6	152	38	14
Hand Therapy	74	19	150	40	18
Neuro Out-Patients	30	5	76	18	7
TARGETED PERFORMANCE 22/23	250	30			

OUT- PATIENT & NON PATIENT CONTACT TIME

- Initial telephone/video NP = on average 60 minutes (investigation/triage/assessment)
- Follow up Patent Face to Face/video Sessions (30 minutes) x 2 on average = 60 minutes (based on reduction)
- OT Administration (documentation, referrals, telephone calls etc.) = 60 minutes Average total time = 3 hours (0.03 WTE x 3 hours)/average 5 days = 0.09 WTE x targeted NP per week

EXCLUSIONS

- At this current phase sickness, annual leave, study and other leave has not been factored into the methodology as the focus should be achieving a baseline of WTE per service
- E-rostering will then allow for intelligence reports on annual leave, study leave and sickness and will be used and averaged out across the teams, to allow a review of the calculated staffing levels.
- The calculated average WTE per month of sickness, annual leave or study leave can be applied to the main calculation for Occupational Therapy Staffing
- If the establishment's WTE staffing is at a surplus (based on the methodology) then this could allow some flexibility when considering other types of leave in the overall WTE calculation against each service.

SAFER STAFFING WTE CALCULATIONS FOR OCCUPATIONAL THERAPY IN-PATIENT SERVICES

In-Patient Safe Staffing Requirements based on Jones/Jenkins (2014) methodology:

- Each in-patient OT Service must be considered
- IP service line reporting for the last financial year
- Interpretation of service line reporting – New Patient volume and Follow up activity
- Utilising reports i.e. Korner that breaks down new patient units of time, follow up units of time and clinical administration units of time

- Calculating the average WTE per new patient and average WTE per follow up activity (facing and non-patient facing)
- Current Establishment of Funded WTE
- **Vacancy Factors**
- Establish optimal staffing and minimal staffing based on current establishment and safer staffing calculation. Non-qualified and qualified ratio's must be considered and skill mix within each of the areas based on their service requirements and demands
- Optimal and minimal staffing may need to be adjusted according to vacancy levels but the safer staffing calculation closely considered

Calculation =

New Patients (per week) x Average WTE hours per patient = REQUIED STAFFING

Based on 19/20 Monthly IP service Level reporting and 21/22 clinical/non clinical timed units

Medicine (across sites)

SITE	NP per year	NP per month	NP per week	Jones & Jenkins Methodology 0.09 WTE x NP referrals per week (REQUIRED STAFFING)	Current Establishment (FUNDED TO WORK) (Q & NQ)	Optimal Staffing per day	Minimal (safe) staffing per day
WRH	4253	350	80	7.20 WTE	8.71 WTE	6 (Q) 1 (NQ) = 7	5 (Q) 1 (NQ) = 6
AGH	4319	360	83	7.50 WTE	8.6 WTE	6 (Q) 1 (NQ) = 7	5 (Q) 1 (NQ) = 6

Trauma (WRH) Based on Trauma reconfiguration and previous Trauma activity at AGH

SITE	NP per year	NP per month	NP per week	Jones & Jenkins Methodology 0.09 WTE x NP referrals per week (REQUIRED STAFFING)	Current Establishment (FUNDED TO WORK) (Q & NQ)	Optimal Staffing per day	Minimal (safe) staffing per day
WRH	3842	320	75	7.0 WTE	8.8 WTE	6 (Q) 1 (NQ_ = 7	5 (Q) 1 (NQ) = 6

GEMS – no specific Geriatric AGH IP monthly reporting for 19/20 so 20/21 IP data used (inclusive of Urgent Med)

SITE	NP per year	NP per month	NP per week	Jones & Jenkins Methodology 0.09 WTE x NP referrals per week (REQUIRED STAFFING)	Current Establishment (FUNDED TO WORK) (Q & NQ)	Optimal Staffing per day	Minimal (safe) staffing per day
WRH	2124	177	40	4.0 WTE	7.6 WTE	5 (Q) 1 (NQ) = 6	4 (Q) 1 (NQ) = 5

Surgery (Based on recorded activity across sites from 19/20 IP reporting under Surgery)

SITE	NP per year	NP per month	NP per week	Jones & Jenkins Methodology 0.09 WTE x NP referrals per week (REQUIRED STAFFING)	Current Establishment (FUNDED TO WORK) (Q & NQ)	Optimal Staffing per day	Minimal (safe) staffing per day
WRH	1067	89	21	2.0 WTE	3.55 WTE	3(Q) 1(NQ) = 4	2 (2 Q) = 2

Complex Care (RCP OT staffing levels considered & new approx. referral rates per month 21/22 WTE per patient based on RCP Stroke guidelines (due to the complexity, presentations and intensity these patients can receive)

SITE	NP per year	NP per month	NP per week	Jones & Jenkins Methodology 0.136 WTE x NP referrals per week (Based on Stroke RCP REQUIRED STAFFING)	Current Establishment (FUNDED TO WORK) (Q & NQ)	Optimal Staffing per day	Minimal (safe) staffing per day
County	780	65	15	2.04 WTE	4.0 WTE	2(Q) 1(NQ) =3	2 (Q) =2

Stroke Services (RCP stroke OT staffing levels considered and IP Monthly reporting from 19/20)

Assumptions: 0.67 WTE per 5 beds

Bed base considered 20 beds, however also approximation of Stroke outliers considered + 10 beds
5-day provision considered 0.136 WTE x 30 (20 beds and approx. 10 outliers) = 4.08 WTE

Saturday and Sunday (ideally 2 Q + 1 NQ) PER DAY = 0.2 WTE X 6 early shifts 1.2 WTE (Total 5.28 WTE)

SITE	NP per year	NP per month	NP per week	0.136 WTE x NP referrals per week (Based on Stroke RCP REQUIRED STAFFING)	Current Establishment (FUNDED TO WORK) (Q & NQ)	Optimal Staffing per day	Minimal (safe) staffing per day
Countywide	1607	134	31	5.28 WTE	7.0 Q 1.8 NQ	5 (Q) 1 (NQ) =6	4 (Q) 1(NQ) =5

SAFER STAFFING WTE CALCULATIONS FOR OCCUPATIONAL THERAPY OUT-PATIENT SERVICES

Out-Patient Safe Staffing Requirements based on Jones/Jenkins (2014) methodology:

- Each out-patient OT Service must be considered
- OP annual planning service line reporting for the last financial year
- Interpretation of service line reporting – New Patient volume and Follow up activity
- Utilising reports i.e. Korner that breaks down new patient units of time, follow up units of time and clinical administration units of time
- Calculating the average WTE per new patient and average WTE per follow up activity (facing and non-patient facing)
- Current Establishment of Funded WTE
- **Vacancy Factors**
- Establish optimal staffing and minimal staffing based on current establishment and safer staffing calculation. Non-qualified and qualified ratio's must be considered and skill mix within each of the areas based on their service requirements and demands
- Optimal and minimal staffing may need to be adjusted according to vacancy levels but the safer staffing calculation closely considered

Required Out-Patient staffing based on annual planning 22-23 performance (104%)

Jones & Jenkins (2014) has been used to calculate the safe staffing requirement to respond to weekly NP targets to assist in determining clinic templates and protected NP slots

Service	Current WTE	0.09 WTE assumption x every new patient assessment target required per week	Deficit/Surplus	Guidelines considerations for staffing
Elective Orthopaedics **Inclusive of IP Elective ward**	3.40	**1.62 to see 18 new OP patients per week** **1.58 to see 35 new in-patients at 0.045 WTE (as these patients may have been seen as an OP)**	(+ 0.20 WTE)	
Rheumatology	3.04	**1.26 to see 14 new patients per week**	(+1.78 WTE)	EULAR guidelines state 1.0 WTE OT B6/7 per consultant
Hand Therapy	3.42	**1.62 to see 18 new patients per week**	(+1.80 WTE)	Allied Health (2017) 1.0 WTE B7 per consultant/0.5 WTE B6 per consultant
Neuro-outpatients	1.65	**0.63 to see 7 new patients per week**	(+1.02 WTE)	

Out-patient Safe Staffing Requirements based on Jones/Jenkins (2014) methodology:

Service	Contracted WTE (Budget)	Jones & Jenkins Methodology Calculated WTE to respond to NP Weekly activity	Optimal Staffing Required per day	Minimal staffing (safe staffing) per day
Elective	3.40	3.20	3Q and 2 NQ	2 Q and 1 NQ
Rheumatology	3.04	1.26	3Q	2 Q
Hand Therapy	3.42	1.62	3Q and 1 NQ	2 Q and 1 NQ
Neuro Patients	1.65	0.63	2Q	1 Q

Implementation of Safer Staffing

1. All staff through Allocate will have access to the E-Rosters of the team and service which they work.
2. All staff will have access to their agreed optimal and safer staffing levels for the services which they work. This will be made available through hard copies in the team offices and through the recommended use of a safer staffing board in their offices.
3. All optimal and safer staffing levels should have been discussed with the clinical leads, with appropriate time provided for consultation and amendments and sign off of the agreed staffing levels
4. All clinical and team leads will have access to their specific E-rosters providing an electronic overview of their optimal and safe staffing per day, weekly and monthly. This will support proactive annual leave management and authorisation and ensure that the agreed staffing levels are maintained and protected for services to deliver effective patient care
5. For E-Rostering purposes and the release of rosters up to 2 months in advance; all staff will be supported to plan their annual leave in advance against the staffing requirements. It is expected that staff will book at least 80% of their annual leave at the beginning of a financial year. This is to ensure that all staff can take their leave as they wish to and to protect safer staffing levels.
6. Each service will have an approved Safer Staffing Escalation Action Card which will illustrate a RAG system stipulating the service delivery according to and define what is meant as Critical, Safe and Optimal staffing
7. Each Safer Staffing Escalation Action Card must be adequately displayed in the office bases of teams supporting and reminding them of the required behaviours and service delivery according to the staffing levels
8. Each service must also display what their safer staffing level is each day, through a laminated colour A4 sheet so that staff have full awareness of the staffing requirements that day and the expected service delivery
9. The Senior Therapist in Charge (STIC), Clinical and Team lead must know the safer staffing level daily and be accountable for providing assurances when asked by Senior Management
10. It is a requirement that safer staffing will be discussed at weekly senior leads group meeting to provide the required assurances
11. Each service has the responsibility of communicating their safer staffing levels to internal partners to forewarn colleagues of potential pressures and a slower response to new patient and follow up activity

12. **Definitions of these staffing levels and their service requirements are as follows:**

RAG	Descriptor
RED	**Critical Staffing** – Unable to achieve meeting the targeted/forecasted NP daily and the required follow up activity in a timely fashion. Prioritisation and Triage must be implemented and only URGENT patients seen based on foreseeable risk and harm and or because there is the is confidence that the OT activity will result in an immediate outcome for the patient and discharge. Planned PETAL sessions, meetings, study and supervisions cancelled
AMBER	**Safe Staffing –** Meeting the targeted/forecasted NP and follow activity is strained and slower. Triage and Prioritisation must be implemented and the response to priority 1 and urgent patients maintained (priority definitions may differ according to each service). Allocation may be slower and result

	in some patients receiving OT assessment or intervention later than expected. Routine activity may be compromised Planned PETAL sessions, meetings, study and supervisions will be reviewed and a decision as to whether they are cancelled
GREEN	**Optimal Staffing** - Normal service. Services are able to meet their targeted/forecasted NP and follow up activity within the expected timescales. Priority 2 or routine patients will be maintained in order to ensure that occupationally focussed assessments and interventions can occur for better outcomes. Urgent/Priority 1 and Priority patients can be supported and staff supported with Planned PETAL sessions, meetings, study and supervisions.

13. Where safer staffing may be compromised by events such as unplanned absence and vacancies, there will be a requirement for the appropriate clinical leads to action the following to ensure that staffing levels stop going into critical (Red) or alternatively is brought from a Safe staffing (amber) to an optimal staffing (Green).
14. This will be done through:

    - **Reviewing staffing across other teams they may be accountable for; therefore, expecting cross site working**
    - **NHSP use which will be supported though OT Manager approval and will be subject to whether those services have regular qualified and unqualified NHSP resource to utilise**
    - **The 8A Clinical Leads including Clinical Practice & Education Lead will be expected to reduce their management responsibilities and provide clinical cover therefore topping staffing levels up out of critical and towards optimal levels**

15. In the event that services are likely to experience consistent 'Critical Staffing' due to multiple vacancies as well as additional sickness from existing members of staff in those teams; there will be expectation that this is discussed with the OT manager and considerations made as to whether the Trust's Risk Register needs to be used with continuous monitoring.
16. In phase II of E-Rostering it is expected that all Clinical and Team leads should be able to view their E-rosters with the associated RAG rating according to staffing
17. Phase II of E-rostering, approved optimal and safer staffing levels will be set to avoid staffing going into Amber and Red levels more proactively.

Monitoring and Amendments to agreed Safer Staffing Levels and Escalation Action Cards

1. Each service will have its establishment reviewed on a bi-annual basis to determine what changes may have occurred or what additional resource changes are required.
2. In addition to this, each service would have been locally capturing their in-patient referral rates; this data will be pulled annually to see if there are any changes in referral demand.
3. Some services may have in place follow up activity recording mechanisms; this data will be utilised to determine whether the follow up rate has exceeded 2.15 follow ups per patient. There may also need to be an exercise that allows follow up activity to be recorded for a selected duration with analysis and interpretation as to whether this has changed, resulting in safer staffing being recalculated.
4. Any amendments required to safer staffing calculations (including action cards) outside the bi-annual review would need to adhere to the following processes:

- **Case for Change briefing paper developed by the Strategic Clinical Lead and Clinical Specialists**
- **Submission to OT Manager**
- **Discussion at Senior Leadership Group for approval or rejection**
- **Team Leads discussion**
- **Key document amended to reflect accurate safer staffing or amended escalation tool**

5. Some services may see some interim changes to their skill mix, for example interim Band 4's whilst Band 5's are being recruited. This would mean that safer staffing would need to be calculated and therefore the process outlined in point 4, would need to be adhered to (pending the duration of time that the skill mix change is anticipated)

APPENDICES

RAG SAFER STAFFING ESCALATION ACTION CARDS

APPROVED Rheumatology Outpa
APPROVED COMPLEX CARE RAG
APPROVED Gems escalation tool.docx
APPROVED STROKE SERVICES ESCALATIO
APPROVED SURGERY SAFER STA
APPROVED TRAUMA IOT SAFER STAFFING

APPROVED Neuro Outpatient SAFER STA
Approved Red Action Card - WRH v2.docx
Approved Amber Action Card - WRH v2
Approved Green Action Card - WRH v2
Approved Red Action Card - AGH v2.docx
Approved Medicine Amber Action Card - A

Approved Green Action Card - AGH v2.
Elective OT Escalation Card and Operational
OCCUPATIONAL THERAPY HAND THE

REFERENCES

Davis J, Lovegrove M (2017) Allied Health Professions, The Workforce and the Services they provide. A comprehensive Guide, Health Education England.

EULAR Recommendations: Recommendations for management (updated 2022), www.eular.org

Jones R, Jenkins F (2014) Safe and Effective Staffing Levels for Allied Health Professions. A practical guide

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out? Notes audit to include moving and handling documentation

Who will monitor compliance with the guideline? Senior occupational therapists

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
ALL	Monthly Assurance Reports provided by both in-patient and out-patient teams indicating safer staffing levels 1 month retrospectively	Submission of a monthly service report	Monthly	Clinical Leads and Clinical Specialists	OT Manager	Monthly
ALL	Daily Review of Safer staffing levels updating the safer staffing team boards	Senior Therapist in Charge Safer Staffing Boards	Daily	Clinical Leads and Clinical Specialists	Clinical Leads and Clinical Specialists	Daily
ALL	Review of current and upcoming weekly safer staffing across all teams via E-rostering in Senior Leadership Group meeting on a weekly basis	Senior Leadership Group Meeting weekly	Weekly	Senior Leadership Group	OT Manager	Weekly
ALL	Annual Service quality and performance reviews	Quality auditing	Annual	Clinical Leads and Team Leads	OT Manager	Annual

References

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Rachel Latham – Clinical Practice and Education Lead OT
Natalie Morris – Clinical Strategic Lead OT for Specialty Medicine
Beverley Phillips – Clinical Strategic Lead OT for Trauma & Orthopaedics
Eleanor Wild – Clinical Site Lead OT for Alexandra Hospital

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
Therapy Management Team clinical Governance group
Occupational Therapy Senior Leadership Group
Clinical specialist occupational therapists at occupational therapy team leads Clinical Governance

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	no	
	• Ethnic origins (including gypsies and travellers)	no	
	• Nationality	no	
	• Gender	no	
	• Culture	no	
	• Religion or belief	no	
	• Sexual orientation including lesbian, gay and bisexual people	no	
	• Age	no	
2.	**Is there any evidence that some groups are affected differently?**	no	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	no	
4.	**Is the impact of the policy/guidance likely to be negative?**	no	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue?	no
3.	Does the implementation of this document require additional manpower?	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff?	no
	Other comments:	N/A

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.