Classification: Official

Publication approval reference: PAR772

Respiratory syncytial virus 2021 preparedness

Children's safer nurse staffing framework for inpatient care in acute hospitals

August 2021

Contents

1. Introduction

This guidance supports the redeployment planning processes to respond to the anticipated earlier and greater than usual increase in respiratory syncytial virus (RSV) and other respiratory illnesses in children, which will increase pressure on paediatric critical and inpatient care.

Through appropriate workforce planning, aim to maintain nationally recommended nurse-to-patient ratios using mutual clinical aid[1] options including system working. Should such mutual aid arrangements be exhausted, strategies to increase the clinical workforce to meet staffing requirements at times of exceptional demand need to be planned in advance being cognisant of the impact deployment decisions have on other services.

Organisations will vary in their staff skill mix, staff availability and the services they have on site, so we emphasise that this document has been prepared as guidance to support local decision-making.

National, regional and local collaboration will be needed when deciding which of the measures outlined here should be enacted and the timing of their implementation.

We include example phased staffing plans for levels 2 and 3 paediatric critical care in a tertiary care setting and levels 1 and 2 in a secondary care setting.

We are grateful to the following for contributing to this guidance:

- Association of Chief Children's Nurses (ACCN)
- British Association of Critical Care Nurses (BACCN)
- Critical Care National Network Nurse Leads Forum (CC3N)
- Health Education England (HEE)
- Intensive Care Society (ICS)
- Nursing and Midwifery Council (NMC)

[1] Mutual aid is system wide redeployment of staff, equipment, transfer of patients where clinically appropriate and safe to do, services and supplies to mitigate risks to patient safety.

- Paediatric Critical Care Society (PCCS)
- Public Health England (PHE)
- Royal College of Nursing (RCN)
- UNISON.
- Unite the Union.

1.1 Principles

The guidance is based on the following principles:

1.	A flexible, pragmatic and staged approach with an emphasis on team working should be followed.
2.	Through appropriate workforce planning, aim to maintain nationally recommended nurse-to-patient ratios using mutual clinical aid options including system working.
3.	Should such mutual aid arrangements no longer be viable, strategies to increase the clinical workforce to meet staffing requirements at times of exceptional demand need to be planned in advance being cognisant of the impact deployment decisions have on other services.
4.	Nursing staff identified as able to support the requirement for an increased paediatric critical care workforce in response to exceptional demand are categorised into four groups: paediatric critical care trained nurses and category A, B and C staff.
5.	Identification of staff to support the paediatric workforce should consider the actual and potential requirements of other services.
6.	Redeployment of staff into paediatric critical care areas or children's and young people's wards from another service should be on a voluntary basis. Redeployed staff should receive regular check-ins both during and after redeployment regarding their health and wellbeing. These should include discussion of their return to their usual role and the timing of this.
7.	Following conversations with the identified staff, individualised training needs analysis should be completed. Staff must receive appropriate training,

	induction and familiarisation with the new work environment and processes. Health Education England e-Learning for Healthcare (HEE e-LfH) has created an e-learning programme to support the cross-skilling of the NHS workforce available.
8.	Organisations should ensure that staffing plans are reviewed and signed off by the chief nurse, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams. Discussions about staffing at meetings to agree mutual aid and how to address system challenges – at hospital cell/situation report (SitRep) meetings, local system resilience meetings and regional Emergency Preparedness, Resilience and Response (EPRR) calls – should be documented.
9.	The trust board should review its risk appetite in relation to quality and workforce risks associated with potential future spikes in demand for children's services as a result of RSV and other respiratory illnesses and be clear about the tolerances it is willing to accept. The trust board should be assured that appropriate measures are in place to mitigate any identified risks.

Although this guidance focuses on the clinical nursing workforce, the response to increased demand must be agile and multiprofessional, based on holistic person-centred need. Trusts will need to employ the skills of the full multiprofessional team appropriately to ensure the clinical environment is as safe as it can be for patients, staff and their respective families. As maternity services are outside this scope, they are not considered in this document.

1.2 Guidance on self-isolation for essential staff

Government updated its guidance on 19 July 2021.

Accountability for trigger thresholds to release staff from self-isolation is locally determined and risk assessed in a local context. The trust board is accountable for increasing and/or consistently applying infection prevention and control (IPC) mitigation measures. The IPC guidance allows for risk-based decisions to ensure safe systems of work. An established system is in place for lateral flow test access and staff will continue to order their tests online.

2. Roles, responsibilities, and accountabilities

The supportive structures and processes set out in the National Quality Board (NQB) Safe, sustainable and productive staffing (2016) and the regulatory mechanisms in Developing workforce safeguards (2018) provide the framework for safe staffing at all times. However, these need to be applied within the context of the current challenges.

2.1 Trust boards

The trust board is accountable for ensuring that high quality care is consistently delivered. Boards should seek assurance that the systems and processes in place enable the identification and resolution of staffing risks. Robust mechanisms for escalation from point of care delivery to the trust board should be in place. This includes ensuring a supportive culture is embedded in the organisation. Clear and effective processes should allow clinical staff to readily raise concerns about staffing through a variety of routes, including huddles and risk and incident reporting processes. These processes should be available to substantive and temporary staff. Leaders should also ensure there is regular communication with staff-side representatives and Freedom to Speak Up guardians, so they can channel the concerns raised with them.

Boards should ensure that their local system (via the local resilience forum) and NHS England and NHS Improvement regional leadership teams are kept abreast of any major changes or challenges through the EPRR management systems. This will enable system and regional support to mitigate staffing risks where necessary.

2.2 NHS England and NHS Improvement regional leadership teams

NHS England and NHS Improvement regional leadership teams are collectively responsible for supporting and enabling provider leadership teams to respond to local escalation of demand and concerns. They will support the deployment of mutual aid within the regional systems and keep the NHS England and NHS Improvement executive informed of the unfolding demand for services and staffing challenges.

2.3 NHS England and NHS Improvement executive team

The team are collectively responsible for supporting and enabling inter-regional responses to escalation of demand and staffing concerns, and keeping the Department of Health and Social Care (DHSC) updated to support and review the national response.

3. Principles of clinical nursing workforce redeployment

There are three defined levels of paediatric critical care, with levels 1 and 2 mapping to high dependency care and level 3 to intensive care. The Paediatric Critical Care (PCC) Healthcare Resource Group (HRG) classifies the three levels of paediatric critical care:

- level 1 critical care: basic critical care provided in all district general hospitals which provide children and young people's in-patient facilities
- level 2 critical care: intermediate critical care provided in tertiary hospitals and a limited number of District General Hospitals
- level 3 critical care: advanced critical care provided in tertiary and specialist hospitals

Children and young people requiring level 1 critical care may be admitted to and cared for in designated beds within children's and young people's inpatient wards. The PCCS Quality Standards for the Care of Critically Ill Children states that with Paediatric Critical Care Network agreement, CPAP for bronchiolitis may be initiated or continued in a number of Level 1 Paediatric Critical Care Units. Patients needing an enhanced level of observation, monitoring or intervention will need to be admitted to a paediatric critical care unit (PCCU) that provides this level of care.

3.1 Categories of staff who can potentially be redeployed

PCCU trained nurses	Paediatric critical care trained nurses – nurses with appropriate competencies in levels 1, 2 and 3 paediatric critical care/successful completion of foundation programme
Category A staff	Registered children's nurses with appropriate competencies in levels 1 and 2 paediatric critical care
Category B staff	Registered children's nurses and nursing associates with recent/previous paediatric critical care experience or some transferable skills Registered adult critical care trained nurses Registered adult trained nurses with recent/previous critical care experience or some transferable skills
Category C staff	Registered children's nurses with no critical care skills Adult registered nurses with no critical care skills Nursing associates with no previous paediatric experience Allied health professionals (AHPs) and nursing support staff

Where possible, PCCUs should maintain the national recommended nurse-to-patient ratios through redeployment, appropriate escalation and use of mutual clinical aid options, including system working. Once these strategies are exhausted, it may be appropriate to move to a team-based approach using non-critical care trained paediatric staff or non-paediatric staff to deliver nursing care under the supervision of paediatric critical care trained nurses or Category A nurses in PCCU areas.

To support redeployment of registered children's nurses into PCCU areas, non-paediatric staff may be required to be redeployed to children's and young people's wards to deliver nursing care as part of a team-based approach under the supervision of registered children's nurses.

Moving to work in an area that is not their normal practice area may mean that those redeployed will need to be supported to ensure safe practice, safe patient care, staff wellbeing, appropriate supervision and appropriate delegation of care. A quality impact assessment to determine any risks and identify mitigations should be completed prior to staff redeployment – see Appendix 2.

3.2 Staffing provision

Throughout the changing situation, staffing arrangements should:

1.	Be based on a multiprofessional team approach to caring for patients.
2.	Ensure each clinical area is supervised by a senior clinical leader, recognising their vital role in staffing arrangements and support.
3.	Be based on an assessment of the patients' needs, with consideration for and account of acuity[2] and dependency[3] as well as environmental aspects.
4.	Always ensure clinical leaders' **professional judgement** is part of all staffing decisions.
5.	Consider the skills required to meet the patients' needs and deploy the most appropriate staff/organise the team around them accordingly.
6.	Ensure that clinical staff know how to escalate any concerns regarding staffing and are given appropriate support.
7.	Ensure IPC teams are appropriately resourced and enabled to work efficiently and effectively.
8.	Continually enable redeployed staff to increase their confidence and skills in paediatric ward/department-based nursing.
9.	Ensure that all staffing plans are reviewed and signed off by the chief nurse. Staffing decisions including redeployment and daily deployment of staff are led by the senior clinical leadership teams and are documented according to local reporting policy.

[2] Acuity is the level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care and hygiene, mobilisation (NICE, 2014).
[3] The level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care and hygiene, mobilisation (NICE, 2014).

10.	Ensure that all staffing plans are reviewed on a weekly basis or more frequently if required/indicated.

4. Phased staffing plans for expansion of critical care capacity

Individual units are responsible for determining an appropriate mix of staffing that aligns to their service, eg staffing skill set, geographical layout.

4.1 A phased approach

Local, system and regional escalation plans should demonstrate how staffing levels will be adjusted to respond to fluctuations in the number, acuity and dependency of patients and staff availability across their services. Providers' plans for expanding the paediatric critical care nursing workforce as demand increases should take a flexible, pragmatic and phased approach that emphasises teamworking. The Paediatric Critical Care Society (PCCS) Quality standards for the care of critically ill children (2015) align as follows to the operations pressure escalation levels (OPELs):

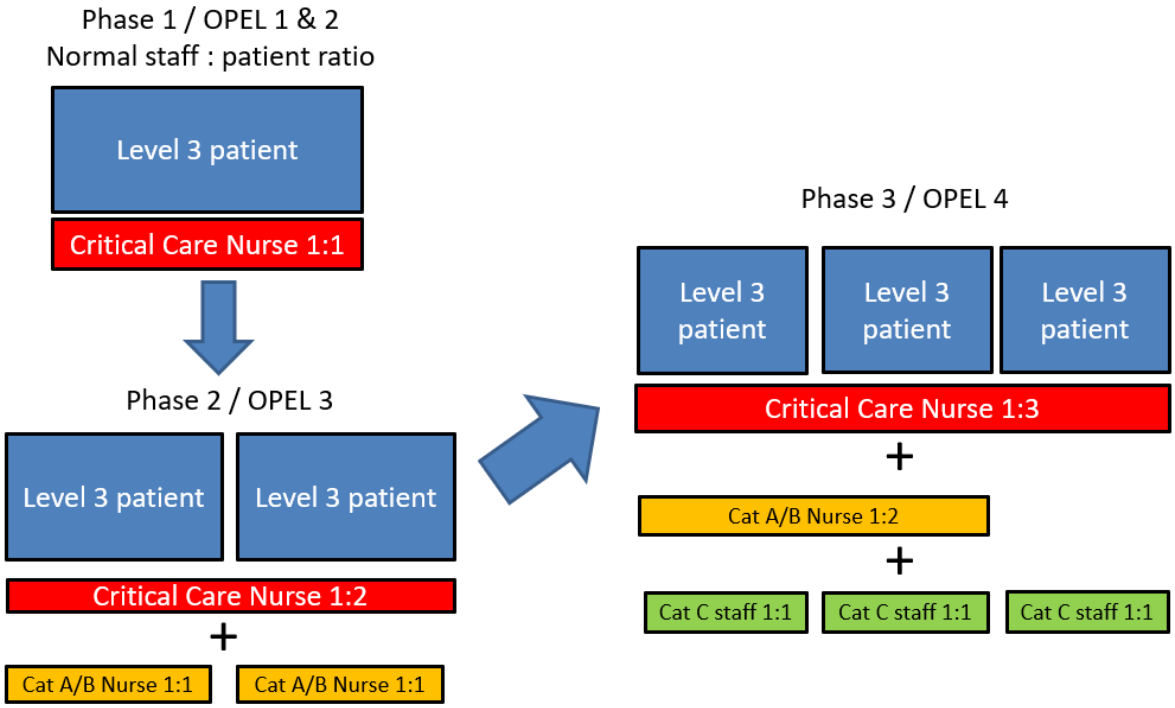
OPEL level	PCCS nursing ratio guidance
OPEL 1 and 2	Usual PCCS nursing ratio standard applies
OPEL 3	Usual PCCS nursing ratio standard applies, but nurses skilled in other areas of critical care, or nurses with historical critical care skills, can be utilised as appropriate
OPEL 4	A flexible and pragmatic approach will need to be taken, using such staff as are available under the supervision of PCCU nurses

4.2 Paediatric critical care units (PCCUs): levels 2 and 3 PCCU in a tertiary setting

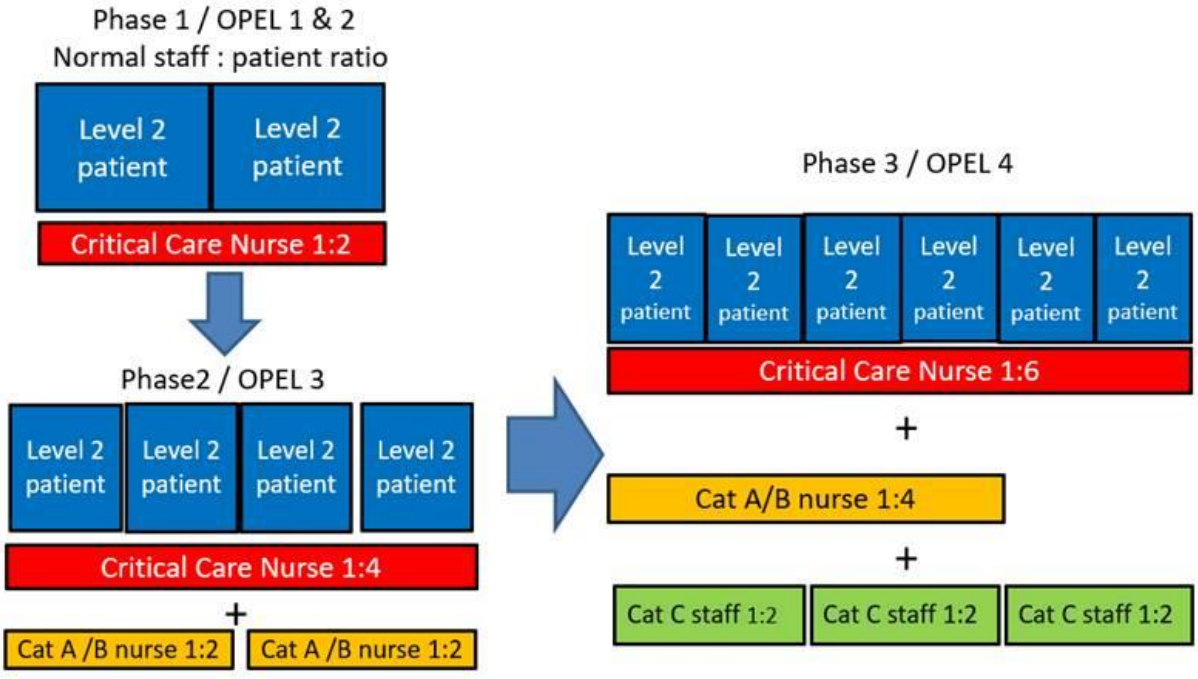
The example phased nursing workforce plan below outlines the three phases of response to rising demand. Ratios are provided to guide workforce requirement planning, but a flexible team-based approach will be required.

	Staff-to-patient ratio Level 3 PCCU patient	Staff-to-patient ratio Level 2 PCCU patient
Phase 1 (OPEL 1 and 2) – Initial local increase in demand; maintain current paediatric critical care trained nurse-to-patient ratios using mutual clinical aid across the system.		
PCCU trained nurse	1:1	1:2
Phase 2 (OPEL 3) – increasing demand across the system		
PCCU trained nurse	1:2	1:4
Category A and B staff	1:1	1:2
Phase 3 (OPEL 4) – exceptional increase in demand across the system		
PCCU trained nurse	1:3	1:6
Category A and B staff	1:2	1:4
Category C staff	1:1	1:2

Example: Staffing for level 3 PCCU patients in a tertiary care setting



Example: Staffing for Level 2 PCCU patients in a tertiary care setting



Units may not move sequentially through the three phases of response.

The following minimum nurse staffing levels should be achieved:

- at least one nurse with up-to-date advanced paediatric resuscitation and life support competencies on each shift
- at least two registered children's nurses on duty at all times
- at least one nurse per shift with appropriate level competencies in paediatric critical care
- at least one nurse per shift with competencies in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation
- at least one supernumerary co-ordinating nurse on each shift
- access to an educator for the training, education and continuing professional development of staff.

In addition, other support staff should be available to assist with delivering and supporting the delivery of patient care.

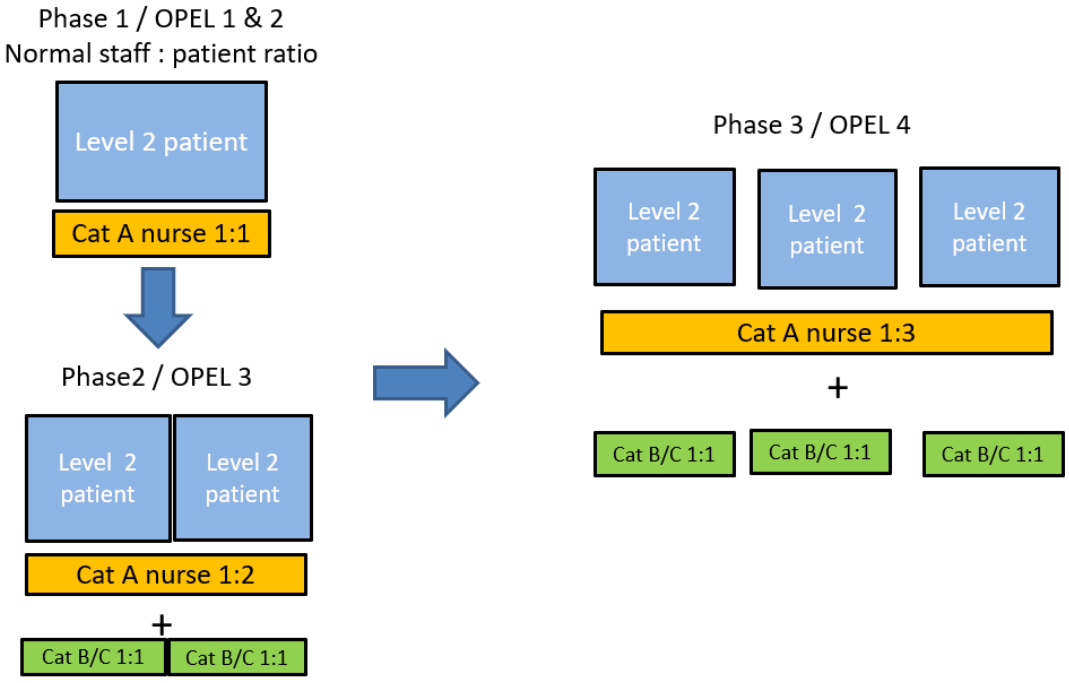
4.3 Levels 1 and 2 PCCU in a secondary care setting

The example phased nursing workforce plan below outlines the three phases of response to rising demand. Ratios are provided to guide workforce requirement planning, but a flexible team-based approach will be required.

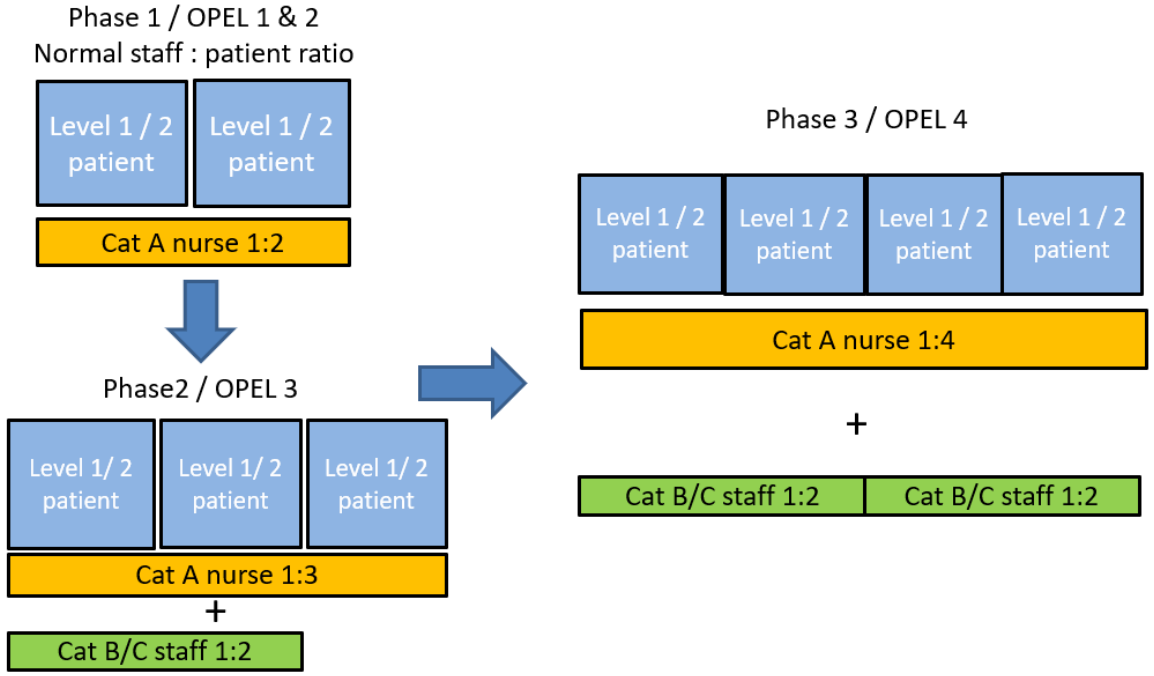
	Staff-to-patient ratio Level 2 PCCU patient in a side room	**Staff-to-patient ratio Level 1 PCCU patient and level 2 PCCU patient in a bay**
Phase 1 (OPEL 1 and 2) – Initial local increase in demand; maintain current Category A nurse-to-patient ratios using mutual clinical aid across the system.		
Category A	1:1	1:2
Phase 2 (OPEL 3) - increasing demand across the system		
Category A	1:2	1:3
Category B and C staff	1:1	1:2

Phase 3 (OPEL 4) - exceptional increase in demand across the system		
Category A	1:3	1:4
Category B and C staff	1:1	1:2

Example: Staffing for level 2 PCCU patients in a side room in a secondary care setting



Example: Staffing for levels 1 and 2 PCCU patients in a secondary care setting



Units may not move sequentially through the three phases of response.

The following minimum nurse staffing levels should be achieved:

- at least one staff member with up-to-date advanced paediatric resuscitation and life support competencies on each shift
- at least two registered children's nurses on duty at all times
- at least one nurse per shift with appropriate level competencies in paediatric critical care
- at least one nurse per shift with competencies in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation in level 2 PCCUs
- a co-ordinating nurse on each shift who is supernumerary where possible
- access to an educator for the training, education and continuing professional development of staff.

In addition, other support staff should be available to assist with delivering and supporting the delivery of patient care.

A system-wide approach should be taken regarding staffing planning with consideration of prompt identification and early transfer of patients requiring critical care to a tertiary centre as demand increases.

5. Key considerations for redeployment of the clinical nursing workforce

Trusts and regions should estimate the number of surge beds they will provide and then in advance identify how many suitable staff they will need to deploy.

Local paediatric critical care networks will offer mutual aid. Staff or patients (where clinically appropriate) may be relocated between critical care sites to balance supply and demand. The digital staff passport helps staff move temporarily to another organisation to provide mutual aid.

However, we envisage that non-critical care trained paediatric and adult staff will be required to deliver nursing care under the supervision of PCCU trained nurses in tertiary PCCUs or category A staff in secondary care.

5.1 Identifying staff for redeployment

Nursing staff

Trusts should identify the surge workforce as early as possible. This may consist of registered children's nurses, specialist nurses, nursing associates, adult critical care nurses and adult nurses. Early identification provides adequate time and access to resources for training and preparation, with the aim of achieving the best possible patient outcomes and support to staff.

Working patterns may need to be redesigned to support increased staff presence at night and out of hours. This should where possible be discussed and planned in advance with staff-side representatives and trade unions.

Before their redeployment into paediatric critical care areas or children's and young people's wards, staff should be given, and time allowed for, both formal training and

the opportunity for supernumerary work shadowing either PCCU trained nurses or registered children's nurses with the appropriate level competencies, depending on proposed redeployment area.

Nursery nurses

Nursery nurses make sure that children are safe, stimulated and supported during clinical procedures. They also promote public health, provide key parental and carer support and act as a liaison between clinicians and families. Nursery nurses can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Healthcare support workers

Healthcare assistants and clinical support workers may be redeployed to assist clinical staff in a range of settings and in a variety of ways, including transporting patients, assisting with clinical recording, and arranging and following up diagnostics. Healthcare support workers can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Neonatal nurses

Their redeployment should be considered with caution. While neonatal nurses have many transferable skills to support PCCU areas, over-reliance on neonatal critical care staff may negatively impact on the ongoing requirements for this essential service.

Operating department practitioners (ODPs)/recovery staff

While ODPs and recovery staff have many transferable skills to support PCCU areas, over-reliance on anaesthetics/theatre staff for surge capacity should be avoided while elective surgical activity continues.

Public health nurse workforce

Health visitors and school nurses (and their teams) may have specific skills and expertise within PCCU, high dependency and paediatric care. However, their role

should focus on supporting children and families from a public health and prevention perspective to ensure delivery of the Healthy Child Programme (HCP). Health visitors are autonomous practitioners who lead and deliver crucial and technical services. Their role supports awareness raising with parents and early identification of vulnerable groups. Redeployment of public health nurses will require negotiation between local authority directors of public health, HCP commissioners and chief nurses within provider trusts.

Student nurses

Student nurses from all branches of nursing should continue with their planned clinical practice placements across all years. This will ensure they can continue their educational programme while also contributing to clinical services during the anticipated surge in paediatric demand as a result of RSV and other respiratory illnesses. Local arrangements with students on paediatric placement should be reviewed with the higher education institution (HEI). Increasing student placements in PCCU settings may be considered where there is a sufficiently safe and supportive environment for learning. Collaborative working with HEIs should continue to ensure there is appropriate health and wellbeing support for the students as well as learning opportunities. Any interventions offered to substantive and temporary staff should also be made available to students, including debriefing or interventions to support mental health issues as in the initial COVID-19 response.

Allied health professionals

The 14 distinct allied health professions have a huge range of transferable skills. AHPs work as autonomous practitioners and may be redeployed to lead and deliver crucial therapy, clinical and technical services. AHPs subdivide into two areas of expertise: therapy/rehabilitation and science/technical. The former can lead and deliver the crucial cross-system rehabilitation services that drive hospital flow, minimise admission and optimise early discharge and recovery at home. The science/technical AHPs can maximise imaging capacity and build critical care and ambulance service capacity. AHPs may also play a significant role in maintaining existing services across a range of systems where access to wider team members is reduced. These roles can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to

redeployment they should receive appropriate training and induction alongside ongoing supervision.

Pharmacists and pharmacy technicians

Hospital pharmacists play significant clinical roles in most specialty teams, including paediatrics. Pharmacy technicians manage areas of medicines supply, usually under the supervision of a pharmacist, and are also involved in the production of medicines in hospitals. These roles could be considered for redeployment to support the optimisation of the provision, preparation and administration of medicines. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Play specialists/activity co-ordinators

Play specialists provide therapeutic play interventions for sick infants, children and young people, service users, carers and families. They develop and implement complex communication plans with children and families and provide key parent and carer support, acting as a liaison between clinicians and families. These roles can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Volunteers

Volunteers can give extra support to patients, their families and carers, and staff and the public. The roles they undertake will be determined jointly by the volunteers and the local NHS organisation in accordance with local arrangements.

5.2 Professional regulation

The NMC recognise that these unprecedented times will present challenges to nurses working in different circumstances. These include:

- Those nurses who may not have worked in paediatric settings previously and are unfamiliar with caring for children and young people
- Those asked to provide critical care in paediatric settings
- Experienced nurses who are accountable for delegation of care to colleagues

Nurses will need to exercise their professional judgement and act in the best interests of their patients when delegating duties to colleagues, and be able to provide a rationale for their decisions.

The NMC encourage nurses who carry out delegated care and duties to work in partnership with nursing colleagues and the wider multidisciplinary team, to ensure that risk assessment and decision making is shared and informed by relevant professional guidance, and the values and principles set out locally.

The NMC recognise that the individuals on their registers may feel anxious about how context is taken into account when concerns are raised about their decisions and actions in these very challenging circumstances. Where a concern is raised about a registered nurse, the NMC will always consider the specific facts of the case, taking into account the factors relevant to the environment in which the nurse was working. The NMC would also take account of any relevant information about resource, guidelines or protocols in place at the time.

5.3 Preparing staff for redeployment

Planned redeployment of staff into paediatric critical care and children and young people's wards from another service should be on a voluntary basis. They should be appropriately trained in processes and inducted and familiarised with the new work environment. Appropriate preparation and voluntary redeployment can promote growth and resilience.

Staff redeployed into paediatric critical care and children and young people's wards will require close supervision for both patient safety and personal safety/welfare reasons. They should receive regular check-ins during and after redeployment regarding their health and wellbeing, with plans for their return to their usual role discussed. Ideally, supervisors should be trained in active listening.

Training resource

Health Education England e-Learning for Healthcare (HEE e-LfH) has created an e-learning programme to support the cross-skilling of the NHS workforce to manage:

- existing demand in children's services

- future spikes in paediatric demand as a result of RSV and other respiratory illnesses
- longer term, increases in paediatric acuity and demand within children's services.

This programme is free to access and appropriate for the various settings where a child can present with respiratory illness, including home, primary and community care, and across the acute hospital environment. New content is regularly added.

Before being redeployed staff should undertake a skills and competency assessment to identify learning requirements. Clinical competence is context-specific and is not the same as confidence, or necessarily related to seniority. The HEE e-LfH programme includes a downloadable interprofessional skills matrix appropriate to all professions. This maps key educational content to skills, by domain (eg recognition, management and escalation: care of the sick child) and level of paediatric care required in primary, secondary or tertiary care. The content aligns with The Royal College of Paediatrics and Child Health (RCPCH) and the RCN/NMC professional competencies, to support revalidation with the NMC as well as annual presentation for revalidation and appraisal.

Paediatric life support

All clinical staff working in children's and young people's areas should have completed paediatric basic life support training. In addition, areas providing levels 1, 2 and 3 paediatric critical care should have at least one staff member with up-to-date advanced paediatric resuscitation and life support competencies on each shift.

Local induction

All substantive and temporary staff redeployed to a new clinical area should receive a focused local induction. This should concentrate on the delivery of safe patient care, communication with children and families/carers, paediatric life support, paediatric safeguarding and how to raise concerns regarding scope of practice. Organisations need to maintain robust training and orientation records for all staff members including bank and agency staff.

Although not exhaustive, local induction should include the following:

- welcome to the team: a place and person to contact on arrival

- orientation in the environment and equipment including personal protective equipment (PPE)
- local guidelines/standard operating procedures (SOPs) and training materials
- information technology access and orientation
- pass cards and access
- key team members for escalation and support
- breakrooms/rota/shift times/handover
- ward/unit routine and culture/values.

Supervision

Staff should receive clinical supervision to enhance safety, mitigate workplace stress and provide support. It can help staff manage the personal and professional demands of their work. When redeployed staff return to their normal roles, they should be given the opportunity to reflect on their work, be thanked properly and have their mental wellbeing actively monitored by their receiving supervisors.

Staff identification

Staff should be issued with and wear – outside of any PPE – identification badges that clearly state their name, professional background and the role they are now performing, to inform new members of staff and support safe team working. Redeployed staff will often be moving into unfamiliar teams and settings with the risk that colleagues make assumptions about their levels of experience and expertise

5.4 Health and wellbeing

Local support, including from professional nurse advocates who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available, in addition to access to regional health and wellbeing hubs. All resources and tools to support the needs of staff should be regularly reviewed and refreshed. A range of staff wellbeing guides, apps and resources are available at www.england.nhs.uk/people.

Rostering

Working patterns may need to be redesigned for some staffing groups; for example, to increase their presence at night and out of hours and/or to run seven-day

services. The impact of such changes on staff morale should be considered and plans to support staff should be prioritised. Rostering should ensure staff do not exceed recommended working hours and that they have sufficient time to rest and recover between runs of shifts. The principles of good rostering apply.

Staff skills recorded within the e-rostering system must be kept up to date and consistent terminology used to do this across the organisation. This will help with the identification of staff who have the relevant skills for redeployment and aid system-wide planning processes.

Organisations should have a clear process for confirming shifts with staff. This is particularly important for staff moving to new areas or changing their usual work patterns.

Staff need to be coded appropriately so that rosters can be drawn up that give an acceptable ratio of PCCU trained, category A, category B and category C staff. This categorisation also enables redeployment decisions that balance clinical leadership and supervision across the service. Organisations should consider creating separate rosters for redeployed staff to increase their visibility and aid staffing decisions.

Organisations need robust measures to ensure all staff are identified and contactable, and their attendance/absence is tracked appropriately and recorded in the Electronic Staff Record. This will require significant administrative support within each department.

5.5 Other inpatient services

Critical care outreach services

Paediatric critical care outreach services, where available, should support rapid escalation of care according to carefully considered admission and discharge criteria. Adult critical care outreach services where available may be required to support the stabilisation of paediatric patients awaiting transfer to tertiary PCCUs.

Paediatric and adult critical care outreach services where available may be required to lead/support expert transfer of critically ill patients within the hospital.

As paediatric critical care demand increases, outreach services may need to be strengthened.

Paediatric critical care (PCC) transport services

PCC transport services provide critical care decision support to referring hospitals, triage patients who need transport, find appropriate beds and safely transport patients to critical care units. They are consultant-led, with at least one duty consultant on each shift who supervises transport teams and referrals, co-ordinates transport and provides decision support. Transport teams consist of at least two appropriately trained and experienced staff (consultant, middle-grade doctor or advanced nurse practitioner + critical care nurse) and an ambulance technician/driver. Some lower-risk transports (such as repatriations from critical care units, which only some transport teams perform) can be delivered by a trained nurse and ambulance technician/driver only.

Due to the nature of the transport environment, a transport team cannot usually care for more than one patient at a time. During periods of surge in demand, extra transport teams will need to be established. Delays in responding to request for transport may occur and contingency for maintaining safe care while awaiting transfer needs to be built into local plans.

Emergency departments (EDs)

ED plan triggers should be based on community and hospital levels of disease/demand, paediatric critical care capacity, staff availability and acute bed occupancy. RCN and the Royal College of Emergency Medicine (RCEM) have jointly outlined nursing workforce standards for type 1 emergency departments. The RCPCH recommends that EDs treating children must at all times be staffed with two registered children's nurses with recognised post-registration training in emergency nursing. EDs may require staff to be redeployed from children's services as well as other acute services.

Children's and young people's inpatient wards

All children's and young people's inpatient units should have seasonal workforce plans whose triggers are based on community and hospital levels of disease/demand, acute bed occupancy, PCCU capacity and staff availability. The age, acuity and dependency of the children and young people being cared for should be factored in when considering safe staffing.

Levels 1 and 2 PCCU patients may be admitted to and cared for on children's and young people's inpatient wards. Advanced staffing planning for these patients should follow this guidance: Level 1 and level 2 PCCU in a secondary care setting.

Further ward staffing for non-PCCU patients should be kept at a level that maintains patient safety and optimises patient flow. These staffing levels should be regularly reviewed in relation to activity and patient acuity and dependency, with input from senior clinical decision-makers and support from a comprehensive wider professional team. Staffing should be flexed in line with demand, allowing for levelling and redeployment of staff as required.

The RCN's Defining staffing levels for Children and young people's services: RCN Standards for clinical professionals and service managers states there should always be a minimum of two registered children's nurses per shift (day and night).

Adult critical care units

Children and young people may need to be admitted to an adult critical care unit to be stabilised before they are transferred to a dedicated PCCU facility. They should where possible be nursed in a side room by an adult critical care nurse with the support of a registered children's nurse. However, if cubicle capacity is limited, a risk assessment is required to prioritise cubicle use.

Adult inpatient wards

Some adult inpatient wards may be converted into children's and young people's wards to support increased capacity. Adult nurses from those wards may be redeployed to care for children and young people. Registered adult nurses will have many transferable nursing skills and knowledge but caring for children and young people is different from caring for an adult. Trusts should ensure that staff have the necessary skills and knowledge to undertake the duties required. Staff competencies and limitations should be carefully examined before redeployment and delegation of tasks. Adequate provision to support these areas should be the direct responsibility of paediatric teams and a minimum of two registered children's nurses should be available on every shift in these areas.

Children and young people admitted to an adult ward have the right to a parent or carer staying with them, so somewhere for the parent to sleep (inpatients) and to make refreshments is required.

Children and young people should not be nursed alongside acutely ill adult patients as they are more vulnerable emotionally than adults; ideally the child/young person should be admitted to a side room. However, if cubicle capacity is limited, a risk assessment is required to prioritise cubicle use.

All children and young people who are admitted to adult areas should be managed by the paediatric team and discussed at the daily staffing meetings to review the need for ongoing inpatient care. They should be repatriated to children's area as soon as feasibly possible.

Safeguarding children and young people

To protect children and young people from harm and improve their wellbeing, all healthcare staff must have the competencies to recognise child maltreatment and opportunities to improve childhood wellbeing, and to take effective action as appropriate to their role. All clinical staff caring for children require a minimum of level 2 safeguarding children training, as per the intercollegiate document on child safeguarding. In addition, they should always have access to colleagues trained in level 3 safeguarding.

The provider safeguarding team must be made aware of anyone under the age of 18 who is admitted to a non-paediatric area. At a local level there must be clear processes in relation to seeking support, advice and escalating concerns to the safeguarding children team.

6. Governance around staffing decision-making and redeployment

Good governance is vital in ensuring that safe, high-quality care is delivered. In its simplest terms, governance is a framework of systems and processes, eg risk management, incident reporting, safeguarding, that gives boards and local leaders confidence about the delivery and quality of their services. Effective governance:

- gives timely insight into the issues that need to be addressed and escalated
- provides positive assurance that statutory functions in relation to the quality of care are being delivered
- ensures that potential risks and issues have been addressed effectively and escalated where necessary.

In the context of workforce, governance processes should already be in place to ensure that the requirements set out in Developing workforce safeguards are complied with in full. This includes regular reporting to the board and the requirement for bi-annual staffing assessments. Although these requirements remain, we anticipate the paediatric clinical workforce will be impacted by increased demand, for which providers need to plan and act. Boards need to be assured that plans to expand the paediatric workforce are sufficiently robust and that risks associated with increased demand are mitigated as far as possible. Boards should also review their risk appetite in relation to quality and workforce when demand for paediatric care increases as a result of RSV and other respiratory illnesses in children, and communicate the level of risk they are prepared to tolerate.

We recognise that providers have been operating under significant pressure as a result of the Covid-19 pandemic for some time and there is a risk that difficult and exceptional decisions around staffing could become normalised. Through existing safer staffing systems and processes, boards should continue to seek assurance that all wards and departments, including paediatric wards and clinical areas, have sufficient staff with the right qualifications, skills and training to safely care for patients and that any shortfalls and risks are escalated so that timely action can be taken.

Reporting should be triangulated and include quality metrics, including incident data and complaints along with NICE red flags,[4] so that the consequence of staffing decisions can be understood, and learning maximised. Boards should also gain assurance that effective leadership at a local level is supporting staff wellbeing.

A safe staffing assurance framework template is attached at Appendix 4. This can be used to support leadership decisions and prompt consistent discussion around staffing assurance during challenging times. Key questions raised by the framework can help the board maintain a spotlight on staffing risks and their associated potential impact on patient care.

We also reiterate the importance of decisions being made at the right level being clearly documented. This includes decisions taken at hospital cell/situation report

[4] These are indicators that action needs to be taken to ensure that the fundamental needs of patients are being met.

(SitRep) meetings, local system resilience meetings and regional EPRR calls where mutual aid is agreed and system challenges are discussed.

Useful tools

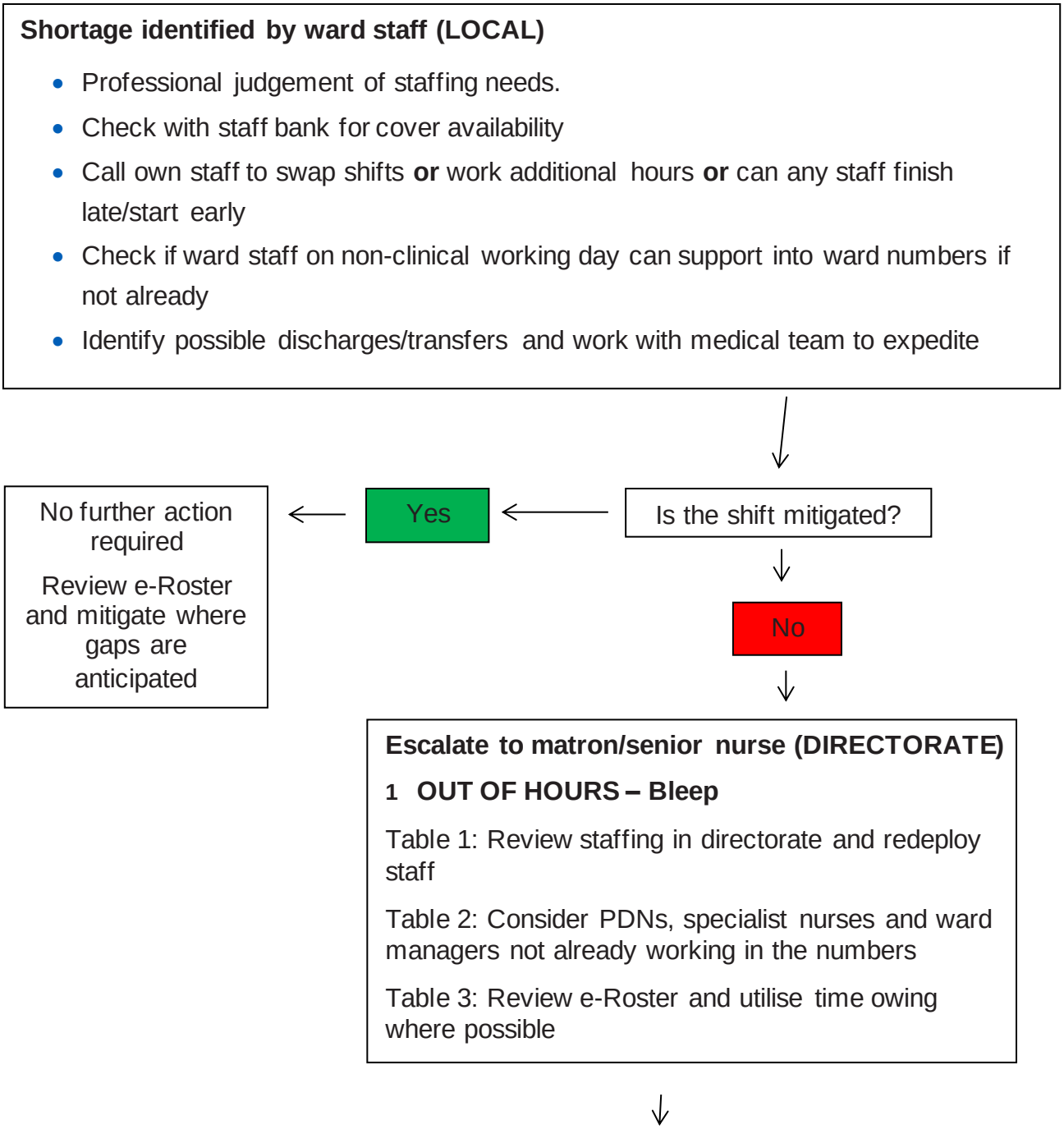
We expect providers already have embedded tools, templates and meetings to support and evidence decision-making and risk mitigation, but we include examples in the appendices, covering point of care to board approach, and ranging from the daily discussions and decision-making around filling shifts, the assessment and quality impact of changing the function and staffing of a ward, right up to the assurance that boards need to seek to ensure that decisions are robust, evidence-based and that any risks are mitigated as far as possible.

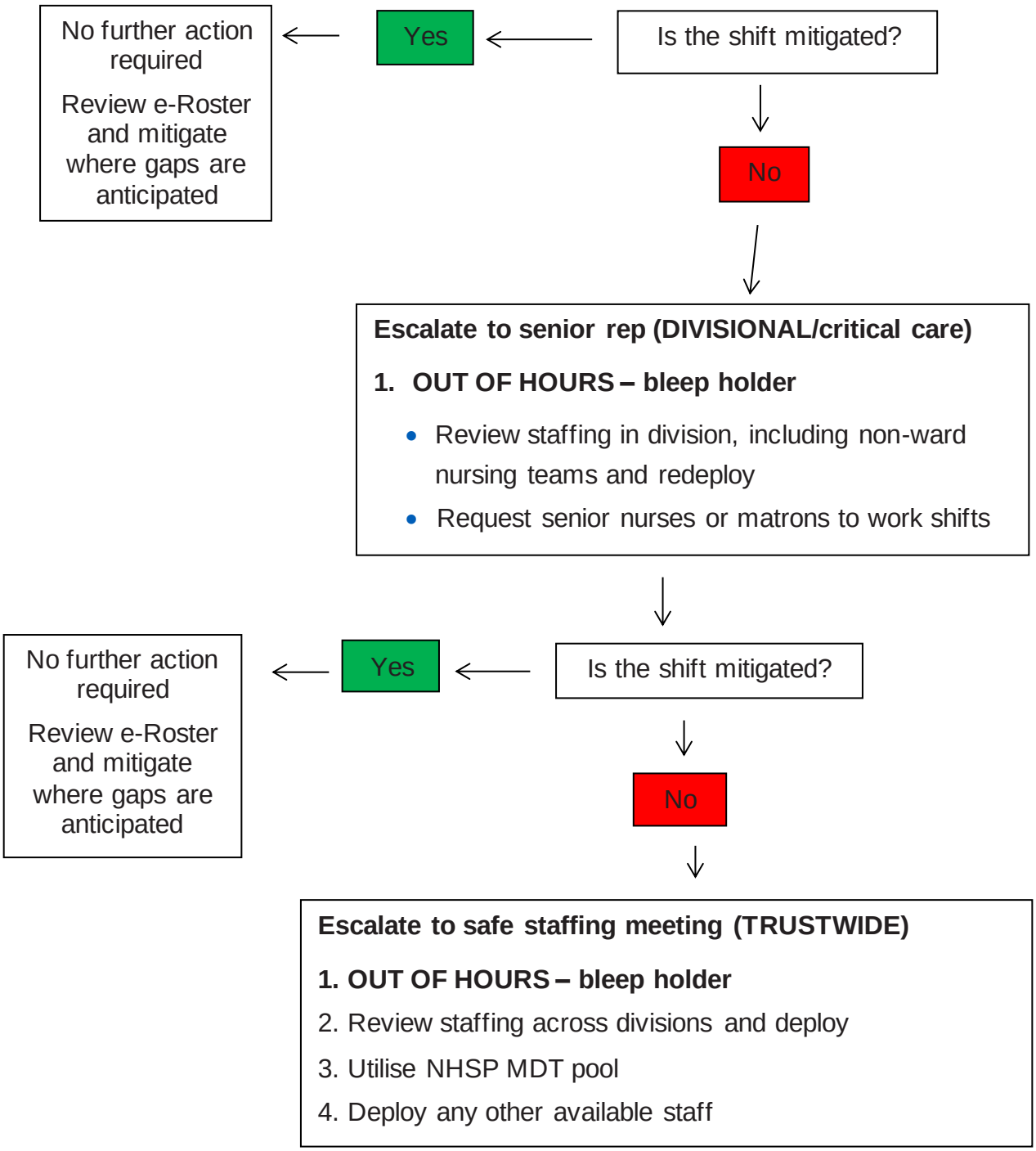
The tools are:

- decision and escalation framework tool, used to support nurse in charge and matrons on a shift-by-shift basis (Appendix 1)
- quality impact assessment, for clinical and service leads to plan changes in ward or staffing configuration (Appendix 2)
- staffing communication tool using SBAR (Situation, Background, Assessment, Recommendation) principles to ensure critical staffing issues are received, reviewed and actioned (Appendix 3)
- assurance framework for boards to use to support discussion around the staffing challenges faced and the potential impact they may have on patients (Appendix 4).

Appendix 1: Decision and escalation framework tool

Flowchart for resolution of staff shortages (Oxford University Hospitals NHS Foundation Trust)




Is the shift mitigated?
Yes
No further action required
Review e-Roster and mitigate where gaps are anticipated
No
Escalate to senior rep (DIVISIONAL/critical care)
1. OUT OF HOURS – bleep holder
• Review staffing in division, including non-ward nursing teams and redeploy
• Request senior nurses or matrons to work shifts
Is the shift mitigated?
Yes
No further action required
Review e-Roster and mitigate where gaps are anticipated
No
Escalate to safe staffing meeting (TRUSTWIDE)
1. OUT OF HOURS – bleep holder
2. Review staffing across divisions and deploy
3. Utilise NHSP MDT pool
4. Deploy any other available staff

Appendix 2: Quality impact assessment

Ward/Clinical Area	
Sister/Charge Nurse	
Matron	
Divisional Nurse sign off	

Consequence	Likelihood 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Extreme risk	0
High risk	0
Moderate risk	0
Low risk	0

	Brief description of potential impact	Risk rating: Consequence score	Likelihood score	Total risk score	Possible mitigation	Mitigated consequence score	Mitigated likelihood score	Mitigated risk score	Quality indicators	Actions taken when negative impact on quality
		On a scale of 1 to 5 - what is is the impact of the risk occurring?	*On a scale of 1 to 5 - what is is the likelihood of the risk occurring?*	***Corresponding total rating on the matrix above.***	*Detail what action will be taken to reduce any negative impact.*	*What is your adjusted consequence score post mitigation?*	*What is your adjusted likelihood score post mitigation?*	***Corresponding total rating on the matrix above.***	*How will you measure the impact on quality? What can indicate a change in the quality?*	
Patient safety										
Clinical effectiveness										
Patient experience										
Staff Experience										
Equality & diversity										

Maximum risk score (overall)	

	Date	Comments
Approval and comments -		
Chief Nurse		

Example quality indicators
Infection rate e.g MRSA
Medication errors
Slips, trips and falls
Adverse events e.g SUIs
Readmission rate
Mortality rate
Average length of stay
Patient satisfaction (discharge survey)
Patient complaints
Waiting times
Sickness and absence levels

Appendix 3: Staffing escalation (SBAR)

Situation

Ward:

Date, shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include safety/quality concern:

Background

Current problem:

Reason for problem on shift:

How long has the shift been out to the hospital nurse bank:

How long has the shift been out to the framework agency:

Assessment

My assessment of the situation is:

Current concern:

Describe actions that have been taken to solve current concern:

Recommendation

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Safe staffing assurance framework

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	Guidance notes	Outline the current controls (actions that mitigate risk, including policies, practice, process and technologies)	Detail the current positive and negative assurance position to give a balanced view of the current position Assurance is evidence that the control is effective – or conversely that a control is ineffective/ there are still gaps Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight Effective assurance should be a triangulated picture of the evidence (staff shortages, sickness absence, patient outcomes, complaints, harm reviews)	What is the remaining risk score (using the trust's existing risk systems and matrix)? Are these risks recorded on the risk register?	Where gaps are identified in either control or assurance, outline the additional action to take to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the local resilience forum/region/ national teams and outlined in the column immediately to the right	Provide the board with oversight of the current significant gaps are Outline the risks that are currently not fully mitigated/needing external oversight and support	Due to the likely prevailing nature of these risks, outline how these active risks are being monitored and through what operational channels (eg daily silver meetings via safe staffing heatmap)
1.0 Staffing escalation/planning for increased and exceptional demand across the system							

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
1.1	Staffing escalation plans have been defined to support increased and exceptional demand across the system. They include triggers for escalation at each phase and the corresponding redeployment approaches for staff Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (ie paediatric critical care) or as per the NQB safe staffing guidance[5]						
1.2	Staffing escalation plans have been widely consulted on and						

[5] National Quality Board guidance on safe staffing - https://www.england.nhs.uk/publication/national-quality-board-guidance-on-safe-staffing/

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	agreed with trust staff-side committee						
1.3	Quality impact assessments are undertaken where estate or ward function or staff roles (including base staffing levels) change and these are signed off by the chief nurse/medical director						
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis, including a documented risk assessment which includes a potential quality impact Local leadership is engaged and where possible mitigates the risk						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	Staffing challenges are reported at least twice daily via bronze						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver/gold discussions Activation of staffing redeployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained						
2.3	The nurse in charge who is handing over patients is clear about their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
2.4	Staff receiving the patient(s) are clear about their responsibility to raise concerns if they do not have the skills to adequately care for the patients being handed over						
2.5	There is a clear induction policy for redeployed and temporary staff There is documented evidence that redeployed and temporary staff have received a suitable and sufficient local induction to the area and patients they will be supporting						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are beyond an individual's scope of practice						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care						
2.9	The trust has robust mechanisms for understanding the current staffing levels and their potential impact on patient care						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
2.10	Staff are encouraged to report incidents in line with normal trust processes The trust considers novel mechanisms outside incident reporting for capturing potential physical or psychological harm resulting from staffing pressures (eg use of arrest or peri-arrest debriefs and outreach team feedback) and learns from this intelligence						
3.0 Daily governance via EPRR route							
3.1	Where necessary the trust has convened a multidisciplinary clinical and/or workforce/ wellbeing advisory group who inform the tactical and strategic staffing decisions via silver and bronze to						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	provide the safest and sustained care to patients. Their decision-making is clearly documented in incident logs or notes of meetings						
3.2	Immediate and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold)						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary The trust uses local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	ensure patients are provided with safe care						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and, where possible, mitigate staffing risks to prevent harm to patients						
4.0 Board oversight and assurance (business as usual (BAU) structures)							
4.1	The quality committee (or other relevant designated board committee) receives a regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks						
4.2	Information from the staffing report is considered and triangulated alongside						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	the trust's Serious Incident (SI) reports, patient outcomes, patient/carer feedback and clinical harms process						
4.3	The trust's integrated performance dashboard has been updated to include paediatric focused metrics Staffing challenges related to the care of children and young people are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges						
4.4	The board (via reports to the quality committee) is sighted on the key staffing issues being discussed and actively managed via the incident management						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	structures and is assured that high quality care is at the centre of decision-making						
4.5	The quality committee is assured that the decision-making via the incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm that may occur when staffing in extremis						
4.6	The quality committee receives regular information on the system-wide solutions in place to mitigate risks to patients due to staffing challenges						
4.7	The trust board is fully sighted on the workforce challenges and any potential impact on patient care via the						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	reports from the quality committee The board is further assured that active operational risks are recorded and managed via the trust's risk register process						
4.8	The trust has considered and, where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the potential increase in activity related to RSV and paediatric respiratory illnesses The risk appetite is embedded and lived by local leaders and the trust board (ie risks outside the desired tolerance are not accepted without clear discussion and rationale						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on its ability to deliver on the strategic objectives and these risks are adequately documented on the board assurance framework						
4.10	Any active significant workforce risks on the board assurance framework inform the board agenda and focus						
4.11	The board is assured that where necessary Care Quality Commission (CQC) and the regional NHS England and NHS Improvement team are made aware of any fundamental concerns arising from significant						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	and sustained staffing challenges						

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

© NHS England and NHS Improvement 2021