The Dudley Group NHS Foundation Trust

Paper for submission to the Executive Team on 22nd April and Quality and People Committees on 29th April 2025

Report title:	Nursing Safer Staffing Review. Including – Emergency Departments, Adult Acute Assessment Units, Adult inpatient wards, Children and Young People inpatient ward, Operating Theatres, Neonatal Unit and Critical Care Unit.
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Summary of key issues

This report outlines the approach taken by the Trust to undertake the safer staffing review during January – February 2025, in line with national guidance, and provides the outcome and recommendations for individual clinical areas from an establishment and skill mix perspective.

Safer Nursing Care Tools (SNCTs) – summary of the review:

- Overall, the safer staffing establishments within the assessed areas are in a positive position to maintain the provision and delivery of safe, effective, high-quality care.
- No serious concerns pertaining to quality and safety have been identified by the Divisional Chief Nurses based on the current establishments. However, based on professional judgement and triangulation of quality metrics and acuity, some clinical areas feel additional staffing or change of skill mix may enhance care and experience in these areas. The Nurse Sensitive Indicators reviewed as part of the review, indicate that ongoing improvement work is required for example, with regards to patient observations, medicine management, pressure ulcers and falls amongst others.
- Inconsistent approach in how the 22% headroom/relief is applied and how this is utilised where in place has been noted, negatively contributing to the bank usage. A discussion was held with the Chief People Officer (interim), Chief Nurse (CN) and Divisional CNs, and agreement reached to standardise the approach across the Trust by recruiting into the 10% headroom/relief and using the rest for contingency cover which should see a positive impact on bank use.
- It is evident from the quantitative data that there is a disconnect between the recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues, which we continue to work on. Professional judgement has been a key guiding factor with decision making and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow and patient experience.

The following table provides a summary of the recommendations, including where changes have been requested. Should these changes be approved, they would be subject to the Divisions identifying solutions in line with their financial envelope, annual plan requirements, underpinned by Quality Impact Assessments:

Jan 25	Requests suggested by ward leadership.	Changes supported by Division	Jan 25	Requests suggested by ward leadership.	Changes supported by Division	Jan 25	Requests suggested by ward leadership.	Changes supported by Division
AMU1	No	No	B6	Yes	Yes	C7	No	No
AMU2	Yes	Yes	C1A	Yes	Yes	C8	Yes	Yes
AMU3 (A4)	Yes	Yes	C1B	No	No	CCU	Yes	Yes
AMUA	No	No	C2	Yes	Yes	DL	Yes	Yes
B1	No	No	C3	Yes	Yes	ESH	No	No
B2H	No	No	C4	No	No	MECU	Yes	No
B2T	No	No	C5A	No	No	FMU	No	No
B3	No	No	C5B	No	No	ED Adults	No	No
B4	No	No	C6	No	No	ED Paeds	Yes	Yes

Establishment change requests	
AMU 2	Increase in RN overnight 1 WTE.
AMU3	Appoint a Band 7 Lead Nurse 1 WTE (same lead nurse also responsible for AMU2).
B6	Increase nighttime CSW by 1 WTE - would reduce the overall temporary staffing use.
C3	Increase nighttime CSW by 1 WTE - would reduce the overall temporary staffing use.
C1 A	Increase nighttime CSW by 1 WTE - would reduce the overall temporary staffing use.
C8	Review parity of workload for the Lead Nurse, responsible for 3 areas, and consider how the stroke Clinical Nurse Specialists can support.
CCU	Increase nighttime CSW by 2 WTE.
DL	Work to reinstate as a Discharge Lounge.
SS	Temporary ward reliant on bank with no funded establishment. *This is no longer applicable and is no longer used for this purpose.
C2	Increase 1 WTE RN Band 5 for PAU area. *See the CN recommendation section for other steps to be considered in the first instance.
ED paeds	Change of establishment within present budget of Band 6s to a Band 7 to ensure senior cover across all shifts.

Theatre, Neonatal and Critical Care staffing review:

- The first safer staffing review was completed in these areas in September 2024, that provided a benchmark of future safer staffing reviews to be undertaken in alignment with the system.

September 24	Requests suggested by ward leadership	Changes supported by Division
Day Case Theatre Corbett Hospital	No	No
RHH Day Case Theatre & Recovery	No	No
RHH Day Case Theatre Ward	No	No
Theatres General, Urology, ENT & Plastics	No	No
Theatres Obs, Gynae, Vascular & Emergency	No	No
Theatres Recovery and Anaesthetics	No	No
Theatres T&O Dept	No	No
Critical Care (inc. CCOT)	No	No
Neonatal Unit	No	No

Following Divisional reviews, the Chief Nurse and her team have met with the Divisional Chief Nurses/deputies to review the outcome of all reviews and agreed the following:

- For the majority of clinical areas which have requested an increase or change, this cannot be supported at the present time. It is felt that as part of the focussed work to be undertaken with regards to Bank use, standardisation of how the 22% headroom/relief is applied and strengthened oversight of workforce deployment by implementing the use of Safe Care tool, this should result in benefit realisation without the need for increasing workforce establishments. No significant impact on quality has been raised by the Divisions regarding the current establishments in these areas, including concerns that they are not safely staffed. QIAs will be completed by the Divisions to outline any risks and mitigations associated with this decision.
- Review of parity of workload for the Lead Nurse on C8 to be completed.
- Closure of all additional capacity areas, including reinstatement of the Discharge lounge, which will positively impact on bank use.
- The Neonatal Unit has had a business case approved in January 2025 to meet the BAPM staffing requirement, which means that the budget is now in place to meet it. Separate to this, a business case for AHP service provision in critical care and neonates is being developed as this has continually been raised as a gap as part of the Neonatal Network reviews.
- There are two areas, which the Chief Nurse recommends that changes are approved. These would be managed within the existing financial envelopes:
    - **Paediatric ED** – skill mix change from Band 6 to 7 to ensure that there is 24/7 senior nursing presence in this area across all shifts and to enable attraction of a stronger calibre of workforce.
        - There are currently 2.73 WTE Band 6 twilight shifts which despite extensive efforts have not been recruited into. It is proposed that these posts are converted into Band 7 posts and the change managed within the existing financial envelope. It is felt that if offered as a Band 7, this would attract more suitable individuals and ensure senior nursing cover across all shifts.
        - PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered.
    - **C2/PAU** – staffing has been particularly challenged during times of extreme pressures, resulting in very high allocation of patients to one nurse. The ward already has a model of reviewing and redistributing staff across the whole area as required, but this has been challenging during times of high activity. Associated risks are being mitigated and the Chief Nurse has agreed a temporary solution with the Divisional Chief Nurse to maintain safety on the ward and unit. It is therefore recommended to increase staffing establishment by 1 WTE Band 5 RN. However, prior to this establishment change being enacted, if approved, the following steps should be taken in the order indicated:

- The ward will shortly be trialling different work patterns to increase support into PAU.
- A clinical Band 7 post is being considered (funding is already available), to strengthen flow and coordination on the ward.
- PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered. This may also mean that an increase of 1 WTE Band 5 RN may not be required.
- In early April 2025, the Division completed a review of whether a more flexible workforce model would be appropriate to respond to the seasonal variation in activity. This review did not recommend any establishment changes, and this will be revisited following the co-location.

2. Alignment to our Vision	
Deliver right care every time	x

Be a brilliant place to work and thrive	x
Drive sustainability (financial and environmental)	x
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	x

3. Report journey
Executive team on 22nd April 2025 Quality Committee on 29th April 2025 People Committee on 29th April 2025

4. Recommendation(s)
The Public Trust Board is asked to:
a. Receive this report for assurance and evidence of the Trust's compliance with reviewing safer staffing (nursing) in line with national requirements.
b. Debate and provide a view on the proposed skills-mix and establishment changes.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	x	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	x	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	x	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	x	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0		Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0		Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	x	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	x	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date: Y TBC		
Is Equality Impact Assessment required if so, add date: N		

The Dudley Group
NHS Foundation Trust

Safer Staffing Review

January - February 2025

1. EXECUTIVE SUMMARY

The purpose of this report is to inform the Executive team, Quality Committee, People Committee and subsequently Trust Board, of the outcomes of the January - February 2025 assessment of safe staffing levels using the Safer Nursing Care Tools (SNCTs - Shelford Group 2023) and professional judgement. The Developing Workforce Safeguards, published by NHS improvement in 2018 builds on various publications by the National Quality Board (2018) and Lord Carter of Coles review (February 2016) providing guidance and recommendations in relation to the reporting of safe staffing to Trust Boards.

The Developing Workforce Safeguards (NHSI 2018) reinforces the requirement for Trusts to adopt a triangulated approach for the use of evidence-based tools, professional judgement, and patient outcomes to provide assurance of safer, sustainable, and effective staffing. Compliance with the principles outlined in the document is to be assessed annually.

In relation to workforce planning, the guidance recommends that establishment setting must be undertaken bi-annually and this process should consider the following:

- Patient acuity and dependency using the latest validated Shelford Safer Nursing Care Tool
- Activity levels
- Professional Judgement
- Seasonal variation in demand
- Service developments/changes and commissioning.
- Staff supply and experience including e-rostering data
- The use of temporary staffing above the set establishment
- Patient and staff outcome measures

Additionally, comprehensive quality impact assessments must be completed when new roles are introduced, there is workforce redesign or a change in skill mix is considered.

This review will make comparisons between this information and the Authorised Funded Establishment (AFE) for each ward which is adjusted to reflect the number of nursing staff (registered and non-registered) who provide direct care to patients. Housekeepers, cleanliness support and ward clerks are not included in the calculation as they do not provide direct nursing care to patients. In addition, when planning the staffing, there is a need for an allowance to be made for periods of leave to ensure that there are sufficient nurses available to provide the planned level of nurse staffing.

This report fulfils expectations of the Nursing Quality Board's requirements for Trusts in relation to safer nurse staffing and fulfils several of the requirements outlined in the NHS Improvement Developing Workforce Safeguards guidance which sets out how to support providers to deliver hight quality care through safe and effective staffing. This review also meets standards outlined in the RCN Nursing Workforce Standards (May 2021). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both 'safe' and 'well led' domains.

At The Dudley Group NHS Foundation Trust, the level of cover (headroom/relief) built into ward establishments is 22% (429 hours) per Whole Time Equivalent (WTE) staff member. This includes:

- 17.5% Annual leave and Bank Holiday
- 3.5% Short term sickness
- 1% Mandatory Training time

It is recognised that the allocated 1% (15 hours) time for mandatory training is not sufficient. The undertaking of Priority 1 training, priority 2 and 3 training, appraisal support and preparation, professional registration reflections, Practice Supervisor and Assessor requirements and any additional champion/link roles requires on average 143 hours for a nurse, midwife or Allied Health Professionals (AHP). Priority one training is being reviewed nationally as from beginning of April we should have an update of what this consists of for priority 1 training. Other areas to be reviewed is the disparity with AHP staff protected time for CPD, that is not part of the Nurses allocated time just mandatory training. A discussion was held with the Chief People Officer (interim), Chief Nurse (CN) and Divisional CNs, and agreement reached to standardise the approach across the Trust by recruiting into the 10% headroom/relief and using the rest for contingency cover which should see a positive impact on bank use.

Authorised funded establishments should also afford staff in leadership roles the time to assume supervisory status which is evidenced to improve staff engagement and improve patient outcomes. The SNCT includes an allowance for ward leaders to undertake their leadership roles in a supervisory capacity for 40% of their time.

As a Trust we have committed to supporting our Lead Nurses to have 80% of their time in a supervisory capacity. This was flexed during times of operational extremis and decreased to 60% and has had a negative impact on their supervisory roles. The Tool provides clear guidance of expectations to follow called Red Rules. Our compliance with these rules is detailed in Appendix 1.

The report also includes the staffing review undertaken in September 2024 in Operating Theatres, Neonates and Critical Care Unit which was based on the Theatre Association of per-operative practitioners' guidelines, British Association of perinatal care (BAPM) and British Association of critical care nurses (BACCN)/ Royal college of Nursing RCN Critical Care Forum and Intensive Care Society ICS guidelines. This was the first staffing review undertaken in the Trust for Operating Theatres and Critical Care Unit and will be used as a benchmark for future reviews as only a verbal professional judgement was undertaken so the report has no written narrative to clarify findings. The next safer staffing review for these areas will be in April 2025, aligned to the system workforce approach. This data collection will follow the same process as the inpatient ward areas, which includes data collection and professional judgement, then the divisional challenge and confirm meetings and finally professional conversation with the Chief Nurse. However, no quality and safety concerns were raised, and the service leads agreed to no changes in the establishments.

2. PROCESSES

The safer staffing review has been undertaken using the latest validated Safer Nursing Care Tools (SNCTs). This is a NICE-endorsed evidence-based tool currently used in the NHS. The overall data collection output when using the tool can be viewed at Appendix 2.

The SNCT includes a suite of tools for different settings:

Used by the Trust:

- Adult inpatient wards in acute hospitals (updated 2023 – all previous versions of the tool are no longer valid).
- Adult acute assessment units (updated 2023 – all previous versions of the tool are no longer valid).
- Children and young people's inpatient wards in acute hospitals.
- Emergency Departments.

Not applicable to the Trust:

- Mental health inpatient wards.

The SNCT has been developed to help NHS Hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. Each tool has their own decision matrix (Appendix 3/4) to support the measurements. The tool, when aligned to Nurse Sensitive Indicators (NSIs), offers nurse leaders a reliable method against which to deliver evidence-based workforce plans to support existing service or the development of new services.

Acuity and dependency measurements should take place twice yearly as a minimum with data collection timeframes locally agreed. Trusts should collect data across the wards on the same months/timeframe to enable benchmarking. An average of the combined data sets is used to support nurse establishment setting/resetting (Appendix 5). Ultimately this evidence base should support workforce plans for nursing that should accurately predict and enable resources to be identified to support nursing establishments that meet patient and service needs.

During data collection periods it is strongly recommended that external validation of acuity and dependency measurements is undertaken weekly in partnership with the designated ward nurse. This validation must be undertaken by a senior professional who has been appropriately trained. The Trust identified key senior professionals who were allocated areas to quality assure and validate data collection.

Quality control is seen as fundamental to ensure a robust approach to the data collection. This process ensures accuracy and consistency of scoring whilst providing greater assurance to the Trust board in relation to the tool's recommendations.

Patient Flow The tool considers patient flow, such as admissions, discharges transfers/escorts. There for the addition of resources for these elements may result in double counting and lead to inaccurate recommendations.

Enhanced therapeutic observations (present in previous versions of the tool) of the additional staffing requirement to support patient needs for safety reasons and/or reducing risk of harm, was not included and needed to be collected separately. The new version of the tool, used in the review has new levels of acuity to meet this progressing need.

Nurse Sensitive Indicators are quality outcomes linked to nursing care. They inform nurses of good and poor patient outcomes enabling sharing of good practice and review of potential reasons for poor quality. Nurse sensitive indicators when aligned to acuity and dependency data and supported with professional judgement will enable agreement of nursing establishment appropriate to meet the needs of each ward/department. These indicators or outcomes can vary between speciality and therefore should be locally agreed for each clinical area.

The main NSIs reviewed as part of this review are unplanned omissions in providing patient medication and patient observation's (Early Warning Scores EWS) not assessed or recorded as outlined in the plan of care. It is recommended that a delay of 30 minutes in providing pain relief is also reviewed, however this data is challenging to obtain due to the lack of preset family groupings of the medications on the system.

It is widely accepted that these NSIs can be linked to nurse staffing challenges, including leadership, establishment levels, skill-mix and training and development of staff.

Critical Care Unit and Neonatal Unit process

In critical care, the patient acuity and staffing levels are recorded twice a day 6am and 6pm and as part of the safer staffing review, this will be recorded as part of the tool for 28 days. For the next data collection, the Nurse care indicators as part professional judgement will be taken into consideration as part of the data collection. BAPM standards apply and have been utilised for the Neonatal Unit.

Operating Theatres process

Operating theatres collect daily actual throughput data for each individual theatre along with the number of cases booked which would also show number cancelled by each theatre. The staffing is templated by day so they can also be cross-referenced showing number of staff to case ratio for example. Anaesthetic type can also be added to provide an overview of acuity along with the ASA grade for patients seen by anaesthetists. This data is collected over the 28 periods of the safer staffing to be analysed and reviewed to ensure safe staffing. For the next data collection, the Nurse care indicators as part professional judgement will be taken into consideration as part of the data collection

3. SKILL MIX

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of 65/35 Registered Nurses/Care Support Workers. The Trust agreed aspirational skill mix is 70/30 ratio. However, this is often not achieved with an average ratio of 60/40.

Jan 25	RN/CSW%		Jan 25	RN/CSW%		Jan 25	RN/CSW%
AMU1	60/40		B6	55/45		C7	50/50
AMU2	55/45		C1A	50/50		C8	55/45
AMU3 (A4)	50/50		C1B	50/50		CCU	80/20
AMUA	55/45		C2	80/20		DL	60/40
B1	60/40		C3	55/45		ESH	70/30
B2H	40/60		C4	70/30		MECU	75/25
B2T	50/50		C5A	60/40		FMU	30/70
B3	55/45		C5B	55/45		ED Adults	60/40
B4	50/50		C6	50/50		ED Paeds	50/50

The RCN recommendations do not currently include Nursing Associates (RNA) in their Registered Nurse category. As a Trust we have understood the benefits of and therefore supported numerous RNAs into our workforce. Currently the Trust has 59 RNAs with a further 9 undertaking the conversion programmed to Level 1 Registered Nurse, which is in line with the plan agreed in 2024.

Within the areas where there is clear derogation from the RCN skill mix recommendation, assurances have been provided by the ward leadership teams that dynamic risk assessments were in place at the point of derogation, and it was often felt that having knowledgeable Nursing Associates and Care Support Workers, was safer for the patients than having Registered Nurses who were not familiar with the ward/clinical area.

Skill-mix continues to evolve due to the development and introduction of new roles within the Nursing and Midwifery workforce. In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision. Focus is required to continue reviewing the overall registered to unregistered ratios to ensure any derogation is linked to planned model of care changes.

The ratio of Registered Nurses to Care Support Workers may be lower in some less acute areas such as areas where care needs are greater than nursing skill needs, or where other staff are involved in delivering care, for example, Assistant Practitioners and Allied Health Professionals (registered professionals) contribute significantly towards meeting patient needs.

Whilst the Safer Nursing Care Tool focuses on the clinical acuity and dependency of the patient, when triangulating the national standards, it is necessary to have a mixed economy in terminology. The RCN standard of 1 nurse to 8 patients during the day equates to each patient receiving nursing focus for 7.5 minutes of every hour. In many areas the ration of RN/CSW falls short of the national standard. Whilst we are moving away from the ratio's many of the national documents still refer to the ratios. Below provides an indication of what this means:

Nurse: Patient Ratio	Nurse time per hour (In minutes)	Nurse time per 12-hour shift
1:4	15	180 minutes or 3 hours
1:6	10	120 minutes or 2 hours
1:8	7.5	90 minutes or 11/2 hours
1:10	6	72 minutes
1:12	5	60 minutes or 1 hour

It should be noted that on average, a routine set of observations/vital signs should take 5 minutes to complete with the average patient medicine round taking over 20 minutes to complete, providing no intravenous (IV) medication is required. If a patient is on IV fluids, a nurse must review the cannula site (VIP Score) hourly and record how much fluid has been infused. If undertaken efficiently this action takes just under 6 minutes to complete. If a patient is not mobile or has an increase in risk of pressure area damage, review, and regular skin assessments to support intervention will take between 10 – 25 minutes dependant on the mobility and care needs of the patient. It must also be noted that when safeguarding thresholds are met and additional needs are required, a referral often takes over 60 minutes to complete with additional unaccounted for time from the ward-based teams when supporting the ongoing process once referrals have been made. To note there were 126 safeguarding referrals.

Theatres skill mix: Association of per-operative practitioners' guidelines (AfPP Safe staffing Guidelines V.4)

Minimum staffing for single cavity theatre cases		
Team members	Role	Number
Registered practitioner	Anaesthetic Practitioner	1
Registered Practitioner, Nursing Associate or Assistant Practitioner	Scrub Role	2
Registered Practitioner, Nursing Associate Assistant Practitioner or CSW	Circulator	1
Registered practitioner	Recovery Practitioner	1
Minimum staffing for dual cavity theatre cases		
Team members		Number
Registered practitioner	Anaesthetic Practitioner	1
Registered Practitioner, Nursing Associate or Assistant Practitioner	Scrub Role	3
Registered Practitioner, Nursing Associate Assistant Practitioner or CSW	Circulator	2
Registered practitioner	Recovery Practitioner	1
Minimum staffing for treatment rooms with planned operating lists		
Team members		Number
Registered practitioner	Anaesthetic Practitioner	1
Registered Practitioner, Nursing Associate or Assistant Practitioner	Scrub Role	1
Registered Practitioner, Nursing Associate Assistant Practitioner or CSW	Circulator	1

Neonatal skill mix: British Association of Perinatal Medicine (BAPM) standards are:

Department	Nurse ratio
ITU	**1:1 Registered Nurse**
HDU	**2:1 Registered Nurse**
Special care and transitional care	**1:4 Registered Nurse / Midwife**

Neonatal ITU/HDUs, should ensure that either or both, registered nurses or midwives care for the babies. Staff looking after transitional care babies should be at least 1 staff: 4 babies. Non-registered clinical staff may care for these babies under the direct supervision and responsibility of a registered nurse or midwife. Staffing in this area must be sufficient to ensure support for parents with all care for their baby including enteral tube feeding, low flow oxygen administration and any other additional needs. Other staff the standard recommend are outreach Nurses and Practice educators.

Critical care skill mix: The GPICs v2.1 dictates nursing ratios as below:

Patient Acuity level	Nurse ratio
Level 3 patient	**1:1 Registered Nurse**
Level 2 patient	**2:1 Registered Nurse**

A part of the critical care skill mix it is expected that each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service. There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7. Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to enable the delivery of safe care.

Critical Care Unit must have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD (Continuing Professional Development) framework for intensive care nursing staff and pre-registration student allocation. This should equate to a minimum of 1.0 WTE per 75 nursing staff. 7. All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to enable achievement of basic specialist competence. Then a minimum of 50% of registered nursing staff must be in possession of a post-registration academic programme in Critical Care Nursing.

4. FILL RATES

Acute trusts are required to collate and report staffing fill rates for external data submission to NHSE/I monthly. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and CSW. The summary position for the last three months to the data collection is shown in table below. A more detailed position for January – February 25 is in Appendix 6.

% Fill Rate	Nov 24	Dec 24	Jan 25
Registrant Day	87	88	88
Registrant Night	93	94	94
Non-Registered Day	84	88	84
Non-Registered Night	94	96	94

It should be noted that there were still some wards where shifts were below expected levels and that the fill rates are based on current expected levels and may not reflect the required numbers from SNCT and professional judgement results. It should also be noted that a low fill rate does not always mean that staffing levels were unsafe as bed occupancy may have been lower and the anticipated acuity of the patients may have been different. Throughout January - February 2025, the demand on services would not have allowed for a lower bed occupancy.

Fill rates also do not consider the skill-mix within an area including what percentage of this fill was temporary staff; all of which are contributing factors to quality and safety within the clinical environment. Following the RCN standards advice, the Trust makes every effort to not have more than 50% of the clinical team as temporary staff.

5. NICE RED FLAGS & NURSE SENSITIVE INDICATORS (Appendix 7 for full data set)

Nursing Red Flags are specified in Safer Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals overview (NICE 2021). 2 key red flags have been examined through this review, patient vital signs not assessed or recorded as outlined in the care plan, and unplanned omissions is providing patient medications.

Patient vital signs not assessed or recorded as outlined in care plan

Patient Vital Signs	Sets to be completed	Number over the required time	% Observations on time
30 min observations	1533	1212	21
Hourly observations	3905	2643	33.2
4 hourly observations	123,811	60,127	52.5

The observation interval '30 minutes' has an additional requirement of a Medical Emergency call being placed and an emergency team response being activated. Throughout the month of January there were 166 Medical Emergency Team calls

Area	Number of MET calls	Area	Number of MET calls	Area	Number of MET calls
AMU1	23	**B4**	6	**C5A**	10
AMU2	10	**B5**	16	**C5B**	8
AMU3	1	**B6**	1	**C6**	9
AMUA	10	**C1A**	5	**C7**	9
B1	2	**C1B**	4	**C8**	10
B2 T	1	**C3**	3	**CCU**	6
B3	11	**C4**	9	**MECU**	6
SS	2	**B2 H**	3	**FMNU**	0

Unplanned omission in providing patient medications

There were over 64 thousand late or missed medications throughout this data collection, compared to 96 thousand in June 2024 data collection. 22058 were late (30 minutes or more after the directed time on the prescription) and 44979 which were not performed. Due to the significant number of given medications, it is currently too challenging to create a stable report to provide data on those which were administered on time. As part of the quality priorities for 25/26, time critical medication is being reviewed so this will hopefully contribute to the improvement of late medication.

Nurse Sensitive Indicators

Nurse sensitive indicators (NSIs) refer to quality outcomes that can be linked to nurse staffing issues, including leadership, establishment levels, skill-mix and training and development of staff. This information can be further used to support ward staffing requirements identified through acuity and dependency measurement. Medication errors, slips, trips & falls and pressure ulcers are all NSIs which have been identified as key indicators of quality of care with specific sensitivity to nursing intervention and lack of.

These are regularly scrutinised across the divisions and within the clinical areas, with a significant amount of work being undertaken to support their reduction.

Pressure Ulcer Damage and Falls

Throughout January 2025 there were 95 falls across the areas and 129 Pressure Ulcers reported through the DATIX system (to note the data extract at the end of January 25 and used by the Divisions would have been unvalidated data and all incidents would not have gone through the Trust internal validation frameworks e.g. Pressure ulcer scrutiny Group or Falls Group). Since the data collection in June 2024, we have reduced the falls, but the pressure ulcers have increased that was recorded on Datix.

PRESSURE ULCER DAMAGE					
Jan-25	**No PU**	**Jan 25**	**No PU**	**Jan 25**	**No PU**
AMU1	5	**B6**	2	**C7**	3
AMU2	5	**C1A**	4	**C8**	10
AMU3 (A4)	3	**C1B**	2	**CCU**	4
AMUA	0	**C2**	0	**DL**	5
B1	2	**C3**	6	**ESH**	1
B2H	6	**C4**	2	**MECU**	2
B2T	10	**C5A**	7	**FMU**	2
B3	5	**C5B**	1	**ED Adults**	0
B4	9	**C6**	2	**ED Paeds**	0
				Super surge	0

FALLS								
Jan 25	**No Falls**		**Jan 25**	**No Falls**		**Jan 25**	**No Falls**
AMU1	2		**B6**	2		**C7**	3
AMU2	8		**C1A**	4		**C8**	10
AMU3 (A4)	3		**C1B**	2		**CCU**	4
AMUA	0		**C2**	0		**DL**	5
B1	1		**C3**	6		**ESH**	1
B2H	4		**C4**	2		**MECU**	2
B2T	9		**C5A**	7		**FMU**	3
B3	10		**C5B**	1		**ED Adults**	0
B4	5		**C6**	2		**ED Paeds**	0
SS	1						

INFECTION PREVENTION CONTROL ESCALATIONS					
Jan 25		**Jan 25**		**Jan 25**	
AMU1	2 Norovirus	**B6**	14 Norovirus	**C7**	
AMU2	2 CDI 1 Norovirus	**C1A**	1 CDI	**C8**	
AMU3 (A4)	2 Norovirus	**C1B**	1 E-coli	**CCU**	
AMUA	2 CDI 1 Covid 19	**C2**	1 - MSSA	**DL**	1 cdi
B1		**C3**	1 CDI 1 Norovirus	**ESH**	2 E-Coli
B2H	1 E-coli	**C4**		**MECU**	
B2T		**C5A**		**FMU**	

B3	1 - MSSA		**C5B**	1 CDI 1 Norovirus		**ED Adults**	19 E-coli 3 CDI
B4B	1 - MSSA		**C6**			**ED Paeds**	
Surge	1 CDI						

In addition to the above indicators, the number of complaints which are received is also a strong indicator of nursing care and levels of staffing. Throughout January 2025, there were 28 complaints. Safeguarding the nature and complexity of the referrals is not to be underestimated and the workload this creates is substantial for both the teams undertaking the initial referrals and subsequently the teams who support with the inpatient care of these patients. Throughout the review period there were 126 safeguarding referrals.

Jan 25	NO complaints				Jan 25	No complaints
AMU1	3		**B6**		**C7**	
AMU2			**C1A**		**C8**	2
AMU3 (A4)			**C1B**		**CCU**	
AMUA	2		**C2**	2	**DL**	1
B1			**C3**		**ESH**	2
B2H			**C4**		**MECU**	
B2T			**C5A**		**FMNU**	1
B3	1		**C5B**	1	**ED Adults**	11
B4	1		**C6**	1	**ED Paeds**	
SS						

Jan 25	No safeguarding				Jan 25	No safeguarding
AMU1	1		**B6**	0	**C7**	1
AMU2	0		**C1A**	0	**C8**	0
AMU3 (A4)	0		**C1B**	0	**CCU**	0
AMUA	0		**C2**	2	**DL**	0
B1	0		**C3**	0	**ESH**	1
B2H	0		**C4**	0	**MECU**	0
B2T	1		**C5A**	1	**FMU**	0
B3	1		**C5B**	0	**ED Adults**	57
B4	1		**C6**	1	**ED Paeds**	135
SS	1					

A breakdown of the nurse sensitive indicators per clinical area can be reviewed in Appendix 8.

As part of the Operating Theatres, Critical Care Unit and Neonatal Unit's safer staffing review, this data was not captured as part of the data collection in September but for the next data collection it will align to the other inpatient ward areas.

6. CHPPD

Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. CHPPD is calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available for each patient on the ward or unit. A detailed individual ward position is available in appendix 6.

CHPPD	November 25	December 24	January 25
Registered	5.24	5.2	5.15
Care Staff	3.57	3.45	3.45
Total	8.81	8.65	8.6

7. PROFESSIONAL JUDGEMENT

Professional judgement can be described as the use of accumulated knowledge and experience, as well as critical reasoning to make an informed professional decision – often to help solve a problem, or in relation to a patient; or policies and procedure affecting patients. Staffing decisions based solely on professional judgement are considered subjective and may not be transparent.

However, professional judgement remains an essential element of safer staffing decisions. For this reason, the Trust uses a triangulated approach, with safer staffing data, clinical quality indicators and professional judgement. Details of the data sources, in addition to the below can be found in Appendix 8.

As part of the safer staffing reviews professional judgement must include consideration of the following:

- **Ward layout/facilities:** The configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, ward layouts, might make adequate surveillance of vulnerable patients more difficult. Some ward layouts are associated with significantly more walking between patients than others. Some wards have essential functions (dirty utility) out of the main ward environment.

- **Escort duties:** This is not captured by the Safer Nursing Care tool. Consideration needs to be given if this role is likely to affect the numbers of staff required, a local data collection and analysis exercise must be undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care need. This data has been captured using the Safecare (Allocate) system and the data has been made available for review.

- **Shift pattern:** The type of shifts (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These should be monitored to understand the impact and effect on staff and patients.

- **Multi-professional working:** Consider the make-up of the care team for the ward. Would specific AHPs or support roles meet the needs of patient groups at particular periods of the day more appropriately? Conversely the absence of administrative support staff such as ward clerks may increase nurses' workload at particular times.

The following questions have been considered throughout this review:

- What is the care/treatment to be provided?
- What competencies are required to deliver that care/treatment?
- Which staff member (taking into consideration the wider multidisciplinary team) is competent and best placed to deliver that care/treatment?
- Can aspects of the care/treatment be safely delegated with appropriate education and training (if so, to whom)?

- What are all members of the team responsible for?

Another key item which has been factored into the review is the time commitments required when undertaking our safeguarding processes. Anecdotally each referral takes 45-60 minutes with additional work following for case conferences, preparation of reports and ensuring the additional safety requirements of the patients are met.

It is clear from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments. Throughout the reviews gaps have been scrutinised as best as possible and all the available data has been triangulated. However, it is recognised that some data has not been collected in the desired way. Professional Judgement has been a key guiding influence with this and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, and experience.

8. TRAINING

The initial safer staffing all individuals involved in the data collection and data assurance had to undertake training re knowledgeable and competent to assess acuity and use the Safer Nursing Care Staffing Tool. Prior to this data collection training sessions were advertised for virtual sessions for staff new to the data collection or staff who required refreshers. Following completion of training, individuals who were undertaking the reviews or quality assuring the reviews completed an assessment to verify competence. This training is required two yearly or if staff require a refresher, this then gives data integrity can be assured by ensuring staff have relevant training and are competent.

9. WHAT DOES THE DATA TELL US

Overall, the safer staffing establishments are in a positive position to ensure the provision of safe, effective, high-quality care. The data was collected at 15:00 each day within the inpatient and assessment unit areas for 30 days. Within the Emergency Department, the data was collected over a period of 2 weeks, twice a day with the times staggered to capture every hour in the day and night (Appendix 10). To reduce the risk of transcription errors a bespoke Microsoft form was created for each ward area along with a bespoke quality assurance/validation document. The approach this time ensured that Divisional Chief Nurses/Matrons were able to independent have oversight of data collection to ensure this was completed daily. Quality assurance/validation was more challenging to ensure on this occasion due to the operational pressures across the Trust and as a result, some colleagues have had to review additional areas per week to ensure all areas were subject to quality assurance weekly.

Following the period of data collection the data was collated and analysed, it was made available for the Divisional Chief Nurses to undertake their confirm and challenge conversations. A list of what this included is available in Appendices 7/8/10.

Divisional Chief Nurses at ward level undertook their confirm and challenge conversations with their Lead Nurses, Matrons, HR and Finance Business partners. All the available data was scrutinised and triangulated to understand what the ward and service need. As part of this, the professional judgement framework was used as a template for the conversations and guidance to ensure all items were given due consideration. Appendix 12 provides an overview of each area of their professional judgement and key data sources.

At these conversations, some ward areas approached their divisional review with requests for changes to their establishments. These requests have been scrutinised by the Divisional Chief Nurses and the viability and other options have been reviewed.

Below is the collated detail ward level requests, Divisional Chief Nurse level ask and whether supported by the Trust's Chief Nurse.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
AMU 1	If extra beds are permanent will need to meet SAM guidance and need to address lead nurse covering two areas as non-compliant with RCN guidance.	Lead nurse is also responsible for AMU assessment (Breach of RCN guidance) this accounts for 55 patient spaces including 8 level 1 and over 140 staff. Monitored beds – high demand this winter period patients in bed base who should have been in monitored beds. 187 transfers into monitored beds. 35 patients went to a level 2 or 3 facility (increase from 15 last census). High volume of admissions 483 Direct admissions from ED Ward rounds are continuous throughout the day hours. Ligature free rooms x 2 with reduced visibility Bays are covid compliant with expanse of gaps horizontally between bays, unable to observe to patients unless physically in the bay Increased number of escorts internal and external. **Recommend – no change if beds are temporary and mitigate increase by bank Consider the Lead Nurse position of covering two wards**	For the majority of clinical areas which have requested an increase or change, this cannot be supported at the present time. It is felt that as part of the focussed work to be undertaken with regards to Bank use, standardisation of how the 22% headroom/relief is applied and strengthened oversight of workforce deployment by implementing the use of Safe Care tool, this should result in benefit realisation without the need for increasing workforce establishments. No significant impact on quality has been raised by the Divisions regarding the current establishments in these

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
			areas, including concerns that they are not safely staffed. QIAs will be completed by the Divisions to outline any risks and mitigations associated with this decision.
AMU2	Current staffing establishment does not support the national SAM guidance for the night shift staffing. Request 1 RN overnight.	Lead nurse is also responsible for AMU 3 (Breach of RCN guidance) Need to scope if extra beds are long term. Lead nurse covering 2 areas in breach of RCN guidance. High volume of admissions 462 up from (392) last census, 153 discharges down from 157 discharges last census and 268. Transfers to wards and 32 to SDEC/surge up from 206 patient transfers out last census. Direct admissions from ED 32 patient shad a news of 5-7 11 news over 7 I patient went to MECU and one to ITU during census period. **Recommend – increase RN 1 WTE at night to meet SAM guidance**	Same outcome applies as stated for AMU 1.
AMU 3	Lead Nurse required	Census data suggested an increase of 2WTE team disagree and suggest the need is for a band 7 Lead nurse is also responsible for AMU 2 (Breach of RCN guidance). 114 admissions this census month and 35 discharges improved picture from last census when data illustrates: 40 admissions and 20 discharges Improved once band 7 moved from AA to support census data suggested 1d activity that was correct mental health guidance and security guidance. **Recommend – Band 7 WTE to be considered**	Same outcome applies as stated for AMU 1.
AMU A	none	Lead nurse is also responsible for AMU 1 (Breach of RCN guidance) this accounts for 55 patient spaces including 8 level 1 and 140 staff.	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		PDN 1.0 WTE for all AMU areas 16 single cubicles and 1 x 4 bedded bay not visible in main dept and one side room. No formal additional patients due to layout but patients regularly que on entry to department. Admissions 777 an increase from 735 last census discharged 148 as opposed to 114 last census and transferred 629 an increase from 621 last census out to bed base. This does not include transfers on top Activity consistent for 12-month period high acuity patients: 4 patients moved to level 2 facility during census period. **Recommend – no changes**	
B1	none	Even though the data states 1.57 over establishment the ward has a higher turner over of patient's elective patients compared to the non-elective wards from the admission, post operative care and discharge. What the data didn't capture 50 ward attenders that required staff to review wounds and some required removal of clips. **Recommend – no changes**	Agreed with no change.
B2 H	none	The data collection indicated 8 WTE less than the present establishments, upon review the DCN and matron feel the data collected may not be accurately categorised as most patients require additional intervention to mitigate risk and maintain safety at any one time. One suggestion was to ensure before the next data collection staff underwent refresher training. **Recommend- no changes**	Agreed with no change.
B2 T	none	The data relatively matches the present establishments. The proposed establishment includes 2 x band 7 co-ordinations who do not care for a cohort of patients. The only additional request for staffing are 1-1 care or transfers to other hospitals that cannot be managed by the budget. **Recommend- no changes**	Agreed with no change.
B3	none	The proposed staffing establishment increases by 1.66 WTE. While the team does not believe that additional staffing is necessary, there are times when	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		extra staff are requested to accommodate the needs of 1-1 patient care or to manage an increase in VASCU activity. **Recommend- no changes**	
B4	none	The proposed staffing establishment increases by 6.94 WTE once non-clinical staff are excluded from the figures. While the team does not believe that additional staffing is necessary, there are times when extra staff are requested to accommodate the needs of 1-to-1 patient care or to manage an increase in POCU activity. **Recommend- no changes**	Agreed with no change.
B5 (ESH)	none	The proposed staffing establishment has been assessed and compared using a template which identified 36 inpatient beds, triage trollies and treatment chairs within ESH. The staffing proposals do not include Surgical Same Day Emergency Care (SSDEC) or Gynaecology Assessment Unit (GAU) waiting areas and does not capture all activity within the Emergency Surgical Hub. **Recommend- no changes**	Agreed with no change.
B6	Request for an additional 1.0 WTE CSW from 2 to 3 on day and night shifts	The geographical layout can hinder the care due to the sluice not on the main ward and the 4 bays not visible by the nursing station. Complex discharges **Recommend – an increase in CSW 2 WTE, day and night shift would reduce the requirement for additional staff.**	Same outcome applies as stated for AMU 1. Proposed ward re-location associated with B6 to be presented to the Executive team and then enacted.
C1A	Band 2 – 1.0 WTE – nights	Increased numbers of patients with learning disabilities, and patients who do not fit into the normal specialities. 39 extra additional support requested only 22 filled, just outside census this ward had to have Prometheus to support a complex mental health patient. **Recommend – An additional CSW 1 WTE, would mitigate some Bank spend overnight**	Same outcome applies as stated for AMU 1.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
C1B	none	To improve patient experience patients are starting to be dialysed on the unit. Need a PDSA model to be costed and reviewed for this expansion of service provision. **Recommend – no change. But complete PDSA work and cost up appropriately**	Agreed with no change and recommended review.
C2		The staffing proposal does not capture the full activity and staffing ratios as the decision was made not to remove PAU from the main census data collection which would have allowed a true, and accurate picture of PAU and the activity, demand and acuity. PAU (11 patients). Although capacity is dedicated to 11 in PAU, they will very often flex over this due to capacity demands. Compared to the previous years (23/24) there is an increase of patient admissions to PAU by 23%. July to January 2023/24 saw 3384 total admissions, whereas July to January 2024/25 saw an increase to 4170 admissions. Staffing establishment has not been increased to manage the increased number of patients attending C2/ PAU. **Completed PAU and Paeds ED co-location.** **Recommend – 1 additional WTE Band 5 RN for the PAU area.** **It is proposed that from a funding available to the Divisional CN (8a level), a Band 7 clinical lead post would be created that would ensure that there is improved management of capacity and flow and strengthened oversight of the ward area.**	**C2 – PAU** staffing has been particularly challenged during times of extreme pressures, resulting in very high allocation of patients to one nurse. The ward already has a model of reviewing and redistributing staff across the whole area as required, but this has been challenging during times of high activity. Associated risks are being mitigated and the Chief Nurse has agreed a temporary solution with the Divisional Chief Nurse to maintain safety on the ward and unit. It is therefore recommended to increase staffing establishment by 1 WTE Band 5 RN. However, prior to this establishment change being enacted, if approved, the following steps should be taken in the order indicated: -The ward will shortly be trialling different work patterns to increase support into PAU.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
			-A clinical Band 7 post is being considered (funding is already available), to strengthen flow and coordination on the ward. -PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered. This may also mean that an increase of 1 WTE Band 5 RN may not be required. -In early April 2025, the Division completed a review of whether a more flexible workforce model would be appropriate to respond to the seasonal variation in activity. This review did not recommend any establishment changes, and this will be revisited following the co-location.
C3	Increase of CSW 1.0 WTE	Due to complexity of pathway 3 waits on FMN, this means c3 take that extended group of more complex patients with difficult social needs. Only 5 CSW's on day shift and night shift. We need to do a specific piece of work like C7 regarding high number of additional requests. **Recommend – an increase in CSW WTE on day and night shift which would reduce the requirement for additional staff.**	Same outcome applies as stated for AMU 1.
C4	No changes	No national standard but 1:3 ratio required to support patients in isolation facility.	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		High demand for escorts to New Cross and QE, intense psychological support for patient cohort. Out of hours isolation pick up the out of hours line activity varies on this line. **Recommend – no changes**	
C5a	No changes	Unit supports the NIV bleep service for ED, this is shared between MECU C5a and C5b. CCOT level one competencies required for these staff on the Respiratory enhanced unit. **Recommend - no changes**	Agreed with no change.
C5b	No changes	Unit supports the NIV bleep service for ED, this is shared between MECU C5a and C5b. Additional patient every day on c5a during census period (treatment room away from station). Multiple escorts required from this area due to oxygen demand and need for physiological investigations off site at CITY/QE, and transfers for cardiothoracic intervention at New cross for the pneumothorax patients. High number of Bariatric patients. CCOT level one competencies required for these staff on the Respiratory enhanced unit. **Recommend - no changes**	Agreed with no change.
C6	No changes	The January data suggests that C6 required less CSWs then are currently established; there is currently no CSW rostered for Prostate Biopsy clinic which has been recommended due to monitoring patients post procedure. This is in line with NICE guidelines. A business case to address this is being written at present, therefore cannot support the reduction in CSW workforce. C6 are currently supporting 1 registered nurse in a seconded role (gynae CNS). There are no current vacancies at present but remain over established due to	Agreed with no change. Proposed ward re-location associated with B6 to be presented to the Executive team and then enacted.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		IEN recruitment drive and the Band 3 TNA programme which were never funded by the ward and a cleanliness support worker not employed for patient care. Also, the layout of the ward is not conducive for patient care so the possibility of a ward swap to B6. **Recommend- no changes and review the possibility of a ward move with B6**	
C7	No changes	C7 transfers patients to level 2/3 facility, they also receive step downs from level 2/3. Patients require isolation/barrier nursing due to gastroenterology pathology. **Recommend – no changes to establishment**	Agreed with no change.
C8	Fill vacancies and consider the using of CNS to bridge gap in ratio	2 extra patients for the full census period day and night 5.46 WTE are stroke bleep holders Stroke referral is usually 344 for month of January averaging approx. 11 a day, CNS accompanies patient to scanning Stroke coordinator/SNAp coordinator Band 7 2x CNS in budget but not on daily rota. **Recommend – CSW vacancies to be approved through exec VAR, 8 x CSW vacancies but holding 4 for novices CSWs on an apprenticeship programme presently**	CSW vacancies approved – not related to this specific review. Review parity of workload for the Lead Nurse, currently responsible for 3 areas, and consider how the stroke Clinical Nurse Specialists can support. No other changes agreed.
CCU	Increase of CSW on both PCCU & CCU, night shift	The initial data captured cath lab and cardiac day case unit this equivalent to 2 WTE RN band 5/CSW 1 WTE. Demand and capacity modelling required for the cath lab and day case, this will form part of the biosense proposal. Matron will review rota for weekend mitigation **Recommend – CSW 2 WTE on both PCCU/CCU at night**	Same outcome applies as stated for AMU 1.
MECU	Team would like to have a Nurse in charge	Funded for 8 beds (6 and 2 side rooms), increase to 9 at times commence treatment pathways prior to transfer to C5 Poor visibility of side rooms RCN recommended guidance for level 1 facility1:4 plus NIC NCEpod guidance 1:2 for patients on acute NIV	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		Recommend – Team would like their nurse in charge restored but Division feels in this climate no changes recommended	
FMNU	none	Working with admiral nurse to help with clinical supervision and reflective practise and building relationships with Holyrood at Bushey fields to help staff understand complexity of MH disease in this patient group Standalone unit with makes it difficult to benchmark staffing Dementia UK recommends there should be stimulation activities, matron is happy that current staffing levels can provide this. **Recommend – no changes**	Agreed with no change.
DL	Increase RN to 3 when operating as a discharge lounge/ Plans have to be made to push establishment up to B6 equivalent during winte pressure bedding	Currently funded as a discharge lounge: 1RN 1CSW Sat/Sunday 2RN 2CSW Monday to Friday However, it has been an inpatient ward since November 2023 Lead nurse supports c8, DL and surge that is 96 beds (not compliant with RCN guidance) **Recommendation: Need to have a staffing establishment in place as reliance on Bank is not feasible** **Plan to restore DL to original state, only one RN on weekend shifts so makes checking drugs difficult**	Reinstatement as a Discharge Lounge to be achieved.
ED	Consider the impact of the resus build	The data showed a decrease of staff, but the geographical location hinders the best of resources. Patients in the waiting room requiring treatment and at busy times patients can be exceed 12 hrs waits during which time in care and treatment from nursing care is given. Complex safeguarding referrals. **Recommendation – no changes no, however the need to consider the resus redesign and increase in triage and sepsis targets**	Agreed with no change.
ED paeds	Change to template to provide 24/7 Band 7 cover	Need to consider seasonal adjustments. Paediatrics and reflect this in staffing data in the winter months attendances will be higher due to respiratory illnesses. During the summer months we will see more minor injuries. The turnover and throughput in Paediatric ED vary depending on the time of day, tend to get busy after school times. 135 SG referrals in Jan Datix trends assault at school, mental health overdose, minor injuries.	Paediatric ED – skill mix change from Band 6 to 7 to ensure that there is 24/7 senior nursing presence in this area across all shifts and to enable attraction of a stronger calibre of workforce:

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		Recommendation - amend the template from Band 6 to 7 due to difficulties with recruiting into Band 6 posts. **Band 6 vacant posts (2.73 WTE) to Band 7. This means that the number of nursing hours would reduce by 14.5 hours per week, but that would be covered by the lead nurse. In effect, it is the lead nurse supervisory role that would reduce from the current 37.5 down to 23 hours per week. This change is supported by the Divisional Chief Nurse (interim) and the deputy matron would provide additional support with supervisory duties.**	-There are currently 2.73 WTE Band 6 twilight shifts which despite extensive efforts have not been recruited into. It is proposed that these posts would be converted into Band 7 posts and the change managed within the existing financial envelope. It is felt that if offered as a Band 7, this would attract more suitable individuals and ensure senior nursing cover across all shifts. -PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered.
SS		Open to 26 patients, 28-day census with predominately bank staff. Redeployed to surge: Band 4 from c7 Band 4 from c5 Band 5 from c3, Band 2 from FMN No budget for this temporary ward area. **Recommend - establishment is completely reliant on bank – area needs to close**	Area now closed as super surge.

All, apart from two (C2/PAU and Paediatrics ED) recommended establishment changes, would require a business case to support them. The review has also highlighted there is wider work which is ongoing looking at the location of current specialities, in particular B6 and C6 relocation and Paediatric ED and PAU co-location. As this would be cross divisional, a collaborative approach is being taken to progress this work further.

	Ward/department request, /amendments	Divisional Chief Nurse (DCN) Outcome of divisional confirm and challenge	Chief Nurse Outcome of confirm and challenge
Operating Theatres	As a whole theatres are not over established as these are not accounted in the financial templates. Double cavity cases difficult to predict frequency as cancer cases majority and list planning does not account for this. Podiatry now take place at RHH and is not part of the established Theatre template (3hrs Tuesday & Thursday. Full theatre team required). Ophthalmology Wednesday as above (all evening lists). Vascular Tuesday evening list booth surgeon & anaesthetist are templated theatre are not. Frequent all day elective obs lists all day list increased to 9hrs from templated 4.5hrs every Wednesday and ad hoc according to need. High C-section rate in area 44%. Bi-weekly major cases involving two or three teams, depending on points of surgery these often continue to 23:00hrs. Example week beginning 17/03/2025 surgeon predicting a 23:00 finish. All Weekend operating outside of emergencies are currently WLI due to not being templated as are majority of evening sessions. (please see theatre planner for extra detail). Robot theatre staffing requires a 5-member team along with Monday, Thursday Friday for complex urology cases finance aware but advised continue at cost pressure. Opthalmic list require with high throughput Over 5 cataracts require extra staff member for productivity and safety. Day case RHH Recovery and anaesthetics merged with RHH Main A&R finance aware. Duel skilled staff are used to flex into different areas and skill requirements including scrub. Band 7 workforce includes a number of staff with reduced hours due to retire rehire and hrs not backfilled.	Discussion was held between the Matron and Deputy Chief Nurse.	Agreed with no change.

	Starred ODP not templated but acknowledged as best practice and requirement for ACSA accreditation. Paediatric MRI list requiring ODP, CSW & Recovery. GI propofol list requiring ODP & Recovery. Future GA in endoscopy requiring ODP and Recovery. Band 7 staff complete at least 1 clinical shift per week. Matron & deputy Matron both complete clinical shifts as part standard duties. Rostering Team both complete clinical shifts as part standard duties. AfPP guidelines dictate safer staffing numbers required for any given list or situation. **Recommendation - no changes to the establishments**		
Neonates	Since the data collection, NNU are now- 90% equates BAPM, which equates to 9 x RNs/shift which has now been approved by execs. Band 6 line includes NCOT team and 1 x Band 6 educator as well as clinical Band 6 and Band 7 line includes Band 7 NCOT lead and Band 7 Educator **Recommendation - no changes to the establishments**		Business case approved to ensure BAPM compliance.
ICU	Due to footprint we struggle to cohort wardable patients and often care for them on 1:4 ratios. Based on our level 3 equivalent commissioned capacity at 15, level 3 and footprint. We also have 3 SN in charges (as per GPICS V2.1) so establishment is to 18 X RNs/shift. The budget also includes the CCOT service (1 RN 24/7) and 1 X WTE rehab nurse. **Recommendation - no changes to the establishments**		Agreed with no change.

11. RISKS

Data quality

The tool asks for data to be collected for 30 days at the prescribed time and by a maximum of 3 collectors each day. Throughout our review there has been significant improvement of the data captured in this period. The only exception was Paediatric ED as the data did not provide a full 24 hrs overall sample of the department, so this data collection was repeated to ensure an accurate reflection of the department. Where we need to improve the tool as it states that a maximum 3 of the most senior ward staff, including the ward manager should identify the patient acuity, this wasn't the case in some wards and a variety of staff completed the data collection.

Jan 25	Data days collected (?/30)	Weekly QA numbers (?/4)		Jan 25	Data days collected (?/30)	Weekly QA numbers (?/4)		Jan 25	Data days collected (?/30)	Weekly QA numbers (?/4)
AMU1	30	3		**B6**	29	4		**C7**	30	3
AMU2	29	4		**C1A**	29	4		**C8**	27	4
AMU3 (A4)	30	4		**C1B**	29	4		**CCU**	29	4
AMUA	30	3		**C2**	30	3		**DL**	27	3
B1	30	4		**C3**	30	4		**ESH**	29	3
B2H	30	4		**C4**	30	3		**MECU**	30	2
B2T	30	4		**C5A**	30	4		**FMU**	39	4
B3	30	4		**C5B**	30	3		**ED Adults**	23/24	1/2
B4	29	4		**C6**	29	3		**ED Paeds**	24/24	1/2
SS	28	4								

The quality assurance process was followed with most areas being reviewed over 50% of the required ask.

Jan 25	Beds	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget	Diff FB is to Rec Over	Ward Profile Document WTE
AMU1	**34**	51.66	20.09	69.59	79.45	9.86	-2.54
AMU2	**30**	52.3	22.45	74.72	59	-15.72	-0.83
AMU3 (A4)	**12**	19.94	8.54	28.48	24.57	-3.91	-1.46

AMUA	**22**	25.61	10.94	36.58	61.06	24.48	-2.17
B1	**26**	19.91	8.53	28.45	30.58	2.13	1.16
B2H	**24**	30.7	11.94	42.64	50.86	8.22	-3.82
B2T	**24**	28.54	12.23	40.77	44.06	3.29	0.75
B3	**36**	47.47	20.35	67.82	66.16	-1.66	-3.05
B4	**48**	63.22	26.67	88.85	81.91	-6.94	-5.97
B6	**16**	21.15	9.06	30.22	25.57	-4.65	-1.49
C1A	**24**	33.48	14.35	47.83	38.9	-8.93	-0.54
C1B	**24**	36.3	14.12	50.41	38.9	-11.51	-0.54
C2	**47**	37.9	19.6	57.2	59.31	2.11	-1.7
C3	**36**	68.1	29.19	97.29	60.29	-37	-0.47
C4	**24**	18.98	8.48	27.11	40.48	13.37	-1.35
C5A	**24**	34.04	14.59	48.63	42.3	-6.33	2.19
C5B	**24**	37.34	14.52	51.87	50.49	-1.38	-1.54
C6	**19**	16.58	7.1	23.68	33.68	10	-3.31
C7	**36**	46.45	19.91	66.36	67.33	0.97	-0.19
C8	**44**	48.68	20.86	69.54	87.04	17.5	-2.59
CCU	**24**	27.81	11.92	39.72	56.85	17.13	0
DL	**16**	20.77	8.9	29.68	10.85	-18.83	-13.84
ESH	**26**	44.42	19.04	63.45	73.92	10.47	-5.25
MECU	**8**	11.3	4.84	16.15	22.52	6.37	-0.54
FMU	**16**	45.81	19.63	65.44	47.09	-18.35	-0.54
SS	**24**	29.29	12.55	41.84		-41.84	
ED Adults	**-------**	115.8	18.5	133.8	149.74	15.94	-0.8
ED Paeds	**-------**	20	8.6	28.6	35.43	6.83	-3.93

The use of professional judgements remains subjective, however has been extremely important with the understanding as to the differences in recommendations between the tools and the actual of the current establishments. The interpretation of the data available is also subjective however it is felt that the scrutiny and wider understanding of the information by the Chief Nurse, Deputy Chief Nurse and Associate Deputy Chief Nurse has been able to support the Divisional Chief Nurses interpretation.

Due to how the data is made available and the need for collation, there has been a significant amount of transcription of information undertaken. This ranges from the need and necessity of the tool requirements to the manual collation of the information from the data collection. This has all had to be manually collated and inputted which increases the risk of transcription and human error. Where possible all data transcription has been double checked and any formulas used within software packages has also been reviewed. Divisional Chief Nurses have also been asked to ensure the data reflects their knowledge and wider narrative.

12. NEXT STEPS

The proposed next steps are as follows:

- Executive Team, Quality Committee and People Committee to discuss, consider and provide view on the outcome and recommendations of the review.
- Further data collection and review to be undertaken in line with national guidance and Black Country system plan.
- Further training sessions to be made available in May 2025 before the next data collection is undertaken.
- Ensure 3 named staff are identified for the next review per department to ensure a consistent approach to data collection.
- Work with colleagues in Operating Theatres, Neonates and critical care to ensure the professional judgement element is completed in the next review.

APPENDICES

Trust Compliance with Safer Nursing Care Tool Red Rules - Appendix 1

	SNCT Red Rule	January 2025 Compliance	RAG		SNCT Red Rule	January 25 Compliance	RAG
AIP AAU CYP ED	Nominate a senior registered nursing lead to quality control the data collection, process and outputs. This will include data collection timeframes, training records, external validation rotas, data analysis and dissemination of results. This should be a senior member of the corporate nursing team.	Philippa Brazier Assoicate Deputy Chief Nurse		AIP AAU CYP ED	Ensure a training and education process is in place, on how to implement the SNCT in practice encompassing and inter-rater reliability assessment and ongoing refresher training. Up to date and accessible training records must be maintained and held at trust level.	Numerous training sessions facilitated throughout the month leading up to the data collection month and throughout the data collection month. Further dates have been planned and in place for the next review. Training records are stored on a central Teams folder which is accessible the Division Chief nurses, their deputies and the corporate team.	
AIP AAU CYP	Identify no more than 3 leads per ward to complete the scoring daily for the duration of the data collection period.	Clear instructions were given to the ward teams. The collated data sets support a maximum of 3 people in ward collected data each day		AIP AAU CYP ED	The data collection should take place a minimum of twice per year to allow incorporation of variation within the year. The average combined data sets are used to support establishment setting/resetting.	Agreed across the Black Country Provider Collaborative that data collection will take place every June and January	
ED	Identify a sufficient cohort if leads/shift leaders in the department to complete the scoring twice daily for the duration of the data collection period						

AIP AAU CYP ED	The three leads must include the Ward manager. If no Ward Manager is available a nominated member of staff should be agreed with the senior nurse for the Directorate/Division	Clear instructions were given to the ward teams, that the Lead Nurse and if not available the NIC should be one of the 3 people.		AIP AAU	During data collection periods, every patient needs to have a level of care recorded daily for a minimum of 30 days using the decision matrix measuring the patient care required/received retrospectively for the previous 24 hours.	Data collected as directed at 15:00 each day. ED data collected at the prescribed hours.	
				CYP	During data collection periods, every patient needs to have a level of care recorded daily for a minimum of 20 days using the decision matrix measuring the patient care required/received retrospectively for the previous 24 hours.		
				ED	Acuity and dependency data should be collected for each patient in the department at the set twice daily intervals.		
AIP AAU	Data collection should be undertaken over 30 consecutive days and be undertaken by appropriately trained and assessed staff.	AIP, AAU and CYP areas collected data for the entire month of June. ED collected data for 14 days.		AIP AAU CYP ED	Acuity and dependency data should be collected for each patient in each bed at the same agreed time, as part of a bed ward round.	As above for all areas/	
CYP	Data should be collected for a minimum of 20 days						
ED	Data should be recorded on every patient present in the department for a total of 12 days minimum.						

AIP AAU CYP ED	External validation is conduced weekly with the designated ward nurse as part of the daily ward round by a senior nurse outside of the ward's budgetary responsibility	Rota plan created and disseminated for the QA areas.		AIP AAU CYP ED	Nurse sensitive indicators/quality outcomes data for the same timeframe are to be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system	Data collated from the central systems where possible. Datix, Allocate safecare and Sunrise being the main ones. These were collated by the Corporate team and reviewed by the leading Deputy Chief Nurse.	
AIP AAU CYP ED	Ensure the senior nurses undertaking the external validation has been appropriately trained and assessed.	All asked to undertake the training and the AIP assessment. Cross referencing this		AIP AAU CYP ED	Results should be provided to Ward Managers, Matrons, Heads of Departments Directors of nursing as soon as possible	All results were available to the Lead Nurse, Matron, Deputy Divisional Chief Nurse, Divisional Chief Nurse, HR Business Partner, Finance Business Partner, Trust Deputy Chief Nurses and Trust Chief Nurse by 14th February 25	
				AIP AAU CYP ED	These results should be reviewed within your biannual establishment setting process in line with the National Quality Board and Developing Workforce Safeguards guidance.	Challenge conversations within the divisions was undertaken in March 25	

AIP – Adult Inpatient
AAU – Adult Assessment Unit
CYP – Children & Young People
ED – Emergency Department

Data Collection Output At a Glance - Appendix 2a

Jan-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE	Data days collected (?/30)	Weekly QA numbers (?/4)	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MRSA	Observations post target			Medicines Late/Unplanned ommission		RN/CSW%	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget - June 24	Funded budget Jan 25
																				L	M	H	Late	Unplanned Ommission					
AMU 1	34	1.46	14.70	9.16	1.20	0.06	7.40	0.00	0.00	30	3	1	2	2	0	2	0	0	0	2725	219	158	182	2682	60/40	51.66	20.09	69.59	79.98	79.45
AMU2	30	1.17	16.27	12.68	3.58	0.00	1.06	0.00	0.00	29	2	0	8	5	0	1	2	0	0	3012	136	45	203	2189	55/45	52.3	22.45	74.72	59.16	59
AMU3 (A4)	12	0.33	5.66	4.96	0.23	0.66	0.00	0.00	0.73	30	3	0	3	3	0	2	0	0	0	1119	17	14	59	741	50/50	19.94	8.54	28.48	24.03	24.57
AMUA	22	5.00	7.53	6.40	0.30	0.00	0.13	0.00	0.63	30	3	0	0	0	1	0	2	0	0	1758	50	21	111	1829	55/45	25.61	10.94	36.58	63.23	61.06
B1	26	11.44	5.55	2.86	0.03	0.00	0.00	0.00	4.68	30	3	0	1	2	0	0	0	0	0	1166	3	1	546	1138	60/40	19.91	8.53	28.45	31.86	30.58
B2H	24	3.78	0.21	17.46	1.28	0.00	0.00	0.00	0.21	30	4	0	4	6	0	0	0	1	0	2080	26	10	486	2453	40/60	30.7	11.94	42.64	48.69	50.86
B2T	24	5.86	0.26	15.56	1.23	0.00	0.00	0.00	0.03	30	3	1	9	10	0	0	0	0	0	2152	24	3	437	1071	50/50	28.54	12.23	40.77	42.06	44.06
B3	36	3.46	1.80	25.66	2.06	0.00	1.90	0.00	0.10	30	4	1	10	17	0	0	0	0	0	3431	34	5	452	2823	55/45	47.47	20.35	67.82	65.82	66.16
B4	48	2.93	11.72	24.96	3.72	0.31	2.24	0.00	0.10	29	4	1	5	16	0	0	0	0	0	3330	34	4	189	3633	50/50	63.22	26.67	88.85	84.84	81.91
B6	16	5.82	1.27	5.34	2.89	0.00	0.00	0.00	0.55	29	4	0	2	4	0	14	0	0	0	1562	8	2	117	1092	55/45	21.15	9.06	30.22	25.52	25.57
C1A	24	2.34	0.58	17.93	2.44	0.00	0.00	0.00	0.68	29	3	0	4	4	0	0	1	0	0	2107	82	29	145	1237	50/50	33.48	14.35	47.83	42.24	38.9
C1B	24	2.31	2.13	18.13	0.10	0.00	0.00	0.00	0.68	29	4	0	2	1	0	0	0	1	0	2112	44	13	414	1646	50/50	36.3	14.12	50.41	42.24	38.9
C2	47	26.66	1.06	1.26			0.43	0.03	12.53	30	3	2	0	1	0	0	0	0	0	1158	299	45			80/20	37.9	19.6	57.2	53.51	59.31
C3	36	3.43	0.00	16.86	14.63	0.00	0.06	0.00	0.03	30	4	0	6	2	0	1	1	0	0	2647	27	8	154	2612	55/45	68.1	29.19	97.29	60.76	60.29
C4	24	4.33	13.13	2.93	0.40	0.00	0.03	0.00	0.16	27	4	0	2	4	1	0	0	0	0	1707	113	19	118	946	70/30	18.98	8.48	27.11	42.19	40.48
C5A	24	2.30	9.03	6.96	3.96	0.56	0.00	0.00	0.50	30	3	0	7	3	0	0	0	0	0	2439	72	51	315	1252	60/40	34.04	14.59	48.63	41.15	42.3
C5B	24	2.31	2.13	18.75	0.10	0.00	0.00	0.00	0.68	30	3	0	1	6	1	1	0	0	0	2400	130	90	282	1507	55/45	37.34	14.52	51.87	51.94	50.49
C6	19	11.24	0.20	6.48	0.00	0.00	0.00	0.00	0.06	29	3	1	2	0	0	0	0	0	0	1629	27	13	155	1823	50/50	16.58	7.1	23.68	33.01	33.68
C7	36	5.46	7.90	20.16	2.66	0.00	0.06	0.00	1.70	30	3	1	3	7	0	0	0	0	0	3482	46	24	188	2577	50/50	46.45	19.91	66.36	66.93	67.33
C8	44	8.55	5.03	27.04	1.62	0.00	1.03	0.00	0.29	27	4	0	10	7	0	0	0	0	0	4117	88	50	409	3380	55/45	48.68	20.86	69.54	91.8	87.04
CCU	24	3.37	12.31	7.13	0.41	0.00	2.06	0.00	0.48	29	3	0	4	11	0	0	0	0	0	874	12	1	384	856	80/20	27.81	11.92	39.72	52.1	56.85
DL	16	2.37	0.40	13.14	0.11	0.00	0.00	0.00	1.51	27	3	0	5	7	0	0	1	0	0	1090	5	0	125	865	60/40	20.77	8.9	29.68	25.3	10.85
ESH	26	15.24	11.48	7.79	0.37	0.00	0.13	0.00	1.96	29	4	1	1	2	0	0	0	2	0	3078	73	46	687	3013	70/30	44.42	19.04	63.45	69.58	73.92
MECU	8	0.36	1.06	2.16	0.20	0.00	2.76	0.03	2.40	30	3	0	2	1	0	0	0	0	0	296	5	3	58	517	75/25	11.3	4.84	16.15	23.18	22.52
FMU	16	0.10	0.03	4.10	10.70	1.43	0.00	0.00	0.63	30	3	0	3	5	0	0	0	0	0	1131	5	3	34	923	30/70	45.81	19.63	65.44	49.34	47.09
Surge	26	7.71	0.46	17.03	0.00	0.00	0.00	0.00	1.42	28	4	0	0	1	0	0	1	0	0				231	1354	70/30	29.29	12.55	41.84		
ED Adults	------	120.00	18.00	27.00	16.00		5.00	3.00		23/24	1	0			10	0	3	19	0	446	443	284	32	346	60/40	115.8	18.5	133.8	164.19	149.74
ED Paeds	------	5.58	2.45	0.91	0.00		0.08	0.00	13.91		1	0	0		1	0	0	0	0	21	15	8			50/50	20	8.6	28.6	35.43	35.43

Data Collection Output At a Glance - Appendix 2b

Jan-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE	Data days collected (?/30)	Weekly QA numbers (?/4)	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget - June 24	Funded budget Jan 25	Diff FB is to Recc Over	Ward Profile Document WTE	Change requested WTE
AMU 1	34	1.46	14.70	9.16	1.20	0.06	7.40	0.00	0.00	30	3	51.66	20.09	69.59	79.98	79.45	9.86	-2.54	
AMU2	30	1.17	16.27	12.68	3.58	0.00	1.06	0.00	0.00	29	2	52.3	22.45	74.72	59.16	59	-15.72	-0.83	↑ RN at night
AMU3 (A4)	12	0.33	5.66	4.96	0.23	0.66	0.00	0.00	0.73	30	3	19.94	8.54	28.48	24.03	24.57	-3.91	-1.46	↑ band 7 - lead
AMUA	22	5.00	7.53	6.40	0.30	0.00	0.13	0.00	0.63	30	3	25.61	10.94	36.58	63.23	61.06	24.48	-2.17	
B1	26	11.44	5.55	2.86	0.03	0.00	0.00	0.00	4.68	30	3	19.91	8.53	28.45	31.86	30.58	2.13	1.16	
B2H	24	3.78	0.21	17.46	1.28	0.00	0.00	0.00	0.21	30	4	30.7	11.94	42.64	48.69	50.86	8.22	-3.82	
B2T	24	5.86	0.26	15.56	1.23	0.00	0.00	0.00	0.03	30	3	28.54	12.23	40.77	42.06	44.06	3.29	0.75	
B3	36	3.46	1.80	25.66	2.06	0.00	1.90	0.00	0.10	30	4	47.47	20.35	67.82	65.82	66.16	-1.66	-3.05	
B4	48	2.93	11.72	24.96	3.72	0.31	2.24	0.00	0.10	29	4	63.22	26.67	88.85	84.84	81.91	-6.94	-5.97	
B6	16	5.82	1.27	5.34	2.89	0.00	0.00	0.00	0.55	29	4	21.15	9.06	30.22	25.52	25.57	-4.65	-1.49	↑ CSW day/night
C1A	24	2.34	0.58	17.93	2.44	0.00	0.00	0.00	0.68	29	3	33.48	14.35	47.83	42.24	38.9	-8.93	-0.54	↑ CSW to reduce bank costs
C1B	24	2.31	2.13	18.13	0.10	0.00	0.00	0.00	0.68	29	4	36.3	14.12	50.41	42.24	38.9	-11.51	-0.54	complete PDSA and cost up effectively
C2	47	26.66	1.06	1.26			0.43	0.03	12.53	30	3	37.9	19.6	57.2	53.51	59.31	2.11	-1.7	
C3	36	3.43	0.00	16.86	14.63	0.00	0.06	0.00	0.03	30	4	68.1	29.19	97.29	60.76	60.29	-37	-0.47	↑ addiional CSW day/night
C4	24	4.33	13.13	2.93	0.40	0.00	0.03	0.00	0.16	27	4	18.98	8.48	27.11	42.19	40.48	13.37	-1.35	
C5A	24	2.30	9.03	6.96	3.96	0.56	0.00	0.00	0.50	30	3	34.04	14.59	48.63	41.15	42.3	-6.33	2.19	
C5B	24	2.31	2.13	18.75	0.10	0.00	0.00	0.00	0.68	30	3	37.34	14.52	51.87	51.94	50.49	-1.38	-1.54	
C6	19	11.24	0.20	6.48	0.00	0.00	0.00	0.00	0.06	29	3	16.58	7.1	23.68	33.01	33.68	10	-3.31	
C7	36	5.46	7.90	20.16	2.66	0.00	0.06	0.00	1.70	30	3	46.45	19.91	66.36	66.93	67.33	0.97	-0.19	
C8	44	8.55	5.03	27.04	1.62	0.00	1.03	0.00	0.29	27	4	48.68	20.86	69.54	91.8	87.04	17.5	-2.59	
CCU	24	3.37	12.31	7.13	0.41	0.00	2.06	0.00	0.48	29	3	27.81	11.92	39.72	52.1	56.85	17.13	0	↑ CSW on night for both PCCU/CCU
DL	16	2.37	0.40	13.14	0.11	0.00	0.00	0.00	1.51	27	3	20.77	8.9	29.68	25.3	10.85	-18.83	-13.84	↑ RN weekend, back to a discharge lounge ,
ESH	26	15.24	11.48	7.79	0.37	0.00	0.13	0.00	1.96	29	4	44.42	19.04	63.45	69.58	73.92	10.47	-5.25	
MECU	8	0.36	1.06	2.16	0.20	0.00	2.76	0.03	2.40	30	3	11.3	4.84	16.15	23.18	22.52	6.37	-0.54	
FMU	16	0.10	0.03	4.10	10.70	1.43	0.00	0.00	0.63	30	3	45.81	19.63	65.44	49.34	47.09	-18.35	-0.54	
Surge	26	7.71	0.46	17.03	0.00	0.00	0.00	0.00	1.42	28	4	29.29	12.55	41.84			-41.84		no, establishment plan to close this ward
ED Adults	-------	120.00	18.00	27.00	16.00		5.00	3.00		23/24	1	115.8	18.5	133.8	164.19	149.74	15.94	-0.8	need to consider resus redeign
ED Paeds	-------	5.58	2.45	0.91	0.00		0.08	0.00	13.91		1	20	8.6	28.6	35.43	35.43	6.83	-3.93	amend the template as planned to include the band 7 staff

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: - Patients at risk of a compromised airway - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains - Severe infection or sepsis - New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: - Greater than 50% oxygen continuously - Requiring close observation due to acute deterioration and needing advanced organ support - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium - CNS depression of airway and protective reflexes - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

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The Children's & Young People's Safer Nursing Care Tool - Decision Matrix

The Children's & Young People's Safer Nursing Care tool (C&YP SNCT) is based upon, but not aligned to, the Paediatric Intensive Care Society classifications (Paediatric Intensive care Society 2010). These classifications have been adapted to support measurement across a range of C&YP wards/specialties.

Children's & Young Peoples Safer Nursing Care Tool - Decision Matrix

Levels of Care	Descriptor
Level 0 Child/young person requires hospitalisation - needs met through normal inpatient care	**Care requirements may include the following** • Oxygen therapy less than 40% and patient stable • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care – observations recorded half hourly initially then 4-hourly. • Regular observations 2 – 4 hourly • Basic fluid Management • Intravenous Medication Regimes – (NOT requiring prolonged preparation/ administration/post-administration care) • **Early Warning Score** is within normal threshold.
Level 1a Child /young person is acutely ill requiring close supervision and monitoring, or is **unstable** with a **greater potential** to deteriorate usually available through normal inpatient care	**Care requirements may include the following** • Oxygen therapy greater than 40% +/- Chest Physiotherapy six hourly • Respiratory care requiring two hourly nebulised medicine • Stable nasopharyngeal airway • Post op care following complex trauma/surgery in acute phase • Patient within 24 hour of returning from PICU/ICU • Instability requiring increased level of observation and therapeutic intervention or continual observation • Patient on PCA/NCA/Epidural • Emergency Admissions requiring immediate therapeutic intervention. • **Early Warning Score** - trigger point reached and requiring escalation.
Level 1b Child/young person is **stable** but dependent on nursing care interventions/ intensive therapy to meet most or all their care.	**Care requirements may include the following** • Unaccompanied children • Established High Humidity, High Flow Nasal Cannula (HHHFNC) • Recurrent apnoea-self resolving • Stable patient requiring two hourly blood sampling • Post op care following complex trauma/surgery in rehab phase • Complex wound management requiring more than 1 nurse or takes more than 1 hour to complete. • Spinal Instability/Spinal Cord injury – rehab phase • Mobility or repositioning difficulties requiring two staff • Complex Intravenous Drug Regimes – (including those requiring prolonged preparation/administration/post-administration care) • Patient and/or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome or high level of emotional support • End of life care • Confused children/young people who are at risk or requiring constant supervision • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse • High level Safeguarding input • Tracheostomy – post seven-days.
Level 2 Child/young person who may require closer observation & monitoring than is usually available through normal inpatient care.	**Care requirements may include the following** • CPAP/ BiPAP • Unstable nasopharyngeal airway • Tracheotomy- initial seven days • Instability requiring a range of therapeutic interventions and invasive monitoring • Respiratory care requiring IV therapy • Unstable diabetic ketoacidosis • Single organ monitoring and support • Exchange transfusions • Chest drains • Hypovolaemic/neurogenic shock • Complex fluid +/or electrolyte management • Glasgow coma scale 8-12 • Prolonged seizures requiring intervention • Recurrent apnoea requiring intervention • Patients requiring NIV/respiratory support as a step down from level three care or acute illness phase
Level 3 Child/young person is unstable and requires advanced respiratory and therapeutic support for multiple organ problems.	**Care requirements may include the following** • Monitoring and Supportive Therapy for Compromised/Collapse of two or more Organ/Systems • Respiratory or CNS depression/compromise requires Invasive ventilation • Children requiring advanced respiratory support whilst awaiting transfer i.e. PICU admission. • CPAP/BiPAP Tracheotomy- initial seven days in a single room facility • Active resuscitation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/ haemorrhage/sepsis or neuro-protection • Child/Young person receiving 1:1 nurse 'specialing'

Safer Nursing Care Tool Acuity Data- Appendix 5

Jan-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3
AMU 1	34	1.46	14.70	9.16	1.20	0.06	7.40	0.00
AMU2	30	1.17	16.27	12.68	3.58	0.00	1.06	0.00
AMU3 (A4)	12	0.33	5.66	4.96	0.23	0.66	0.00	0.00
AMUA	22	5.00	7.53	6.40	0.30	0.00	0.13	0.00
B1	26	11.44	5.55	2.86	0.03	0.00	0.00	0.00
B2H	24	3.78	0.21	17.46	1.28	0.00	0.00	0.00
B2T	24	5.86	0.26	15.56	1.23	0.00	0.00	0.00
B3	36	3.46	1.80	25.66	2.06	0.00	1.90	0.00
B4	48	2.93	11.72	24.96	3.72	0.31	2.24	0.00
B6	16	5.82	1.27	5.34	2.89	0.00	0.00	0.00
C1A	24	2.34	0.58	17.93	2.44	0.00	0.00	0.00
C1B	24	2.31	2.13	18.13	0.10	0.00	0.00	0.00
C2	47	26.66	1.06	1.26			0.43	0.03
C3	36	3.43	0.00	16.86	14.63	0.00	0.06	0.00
C4	24	4.33	13.13	2.93	0.40	0.00	0.03	0.00
C5A	24	2.30	9.03	6.96	3.96	0.56	0.00	0.00
C5B	24	2.31	2.13	18.75	0.10	0.00	0.00	0.00
C6	19	11.24	0.20	6.48	0.00	0.00	0.00	0.00
C7	36	5.46	7.90	20.16	2.66	0.00	0.06	0.00
C8	44	8.55	5.03	27.04	1.62	0.00	1.03	0.00
CCU	24	3.37	12.31	7.13	0.41	0.00	2.06	0.00
DL	16	2.37	0.40	13.14	0.11	0.00	0.00	0.00
ESH	26	15.24	11.48	7.79	0.37	0.00	0.13	0.00
MECU	8	0.36	1.06	2.16	0.20	0.00	2.76	0.03
FMU	16	0.10	0.03	4.10	10.70	1.43	0.00	0.00
Surge	26	7.71	0.46	17.03	0.00	0.00	0.00	0.00
ED Adults	--------	120.00	18.00	27.00	16.00		5.00	3.00
ED Paeds	--------	5.58	2.45	0.91	0.00		0.08	0.00

Date	January 2025

Safer Staffing Summary Jan — Days in Month 31

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Actual CHPPD Occ	Registered	Care staff	Total
B1	127	101	63	59	62	62	51	49	79%	93%	100%	96%	418	4.43	2.96	7.39
B2(H)	124	107	194	184	93	87	184	176	86%	95%	94%	96%	734	3.17	5.75	8.92
B2(T)	124	109	131	114	93	82	115	106	88%	87%	88%	92%	725	3.16	3.64	6.80
B3	194	185	205	173	186	179	173	164	95%	85%	96%	95%	1,185	3.61	3.41	7.02
B4	226	182	267	197	187	178	212	185	80%	74%	95%	87%	1,309	3.23	3.50	6.72
B5	253	215	175	143	243	222	111	102	85%	82%	91%	92%	1,136	4.71	2.53	7.24
B6	97	72	80	45	63	58	82	74	74%	57%	92%	91%	492	3.09	2.92	6.02
C1 A	126	131	147	111	93	90	118	112	104%	76%	97%	95%	736	3.51	3.63	7.14
C1 B	129	124	136	122	93	90	99	90	95%	90%	97%	91%	736	3.40	3.37	6.77
C2	283	232	64	70	249	225	63	62	82%	108%	90%	99%	556	9.65	2.79	12.43
C3	217	226	433	370	187	176	417	400	104%	85%	94%	96%	1,605	3.01	5.64	8.65
C4	209	165	74	63	125	92	68	75	79%	84%	74%	110%	675	4.45	2.35	6.80
C5 A	121	106	171	106	93	93	142	133	87%	62%	100%	94%	740	3.26	3.87	7.13
C5 B	162	151	130	102	155	150	101	93	93%	78%	97%	92%	732	4.84	3.20	8.03
C6	97	89	99	79	93	85	72	68	92%	80%	91%	94%	574	3.57	3.08	6.65
C7	218	166	194	179	156	147	189	178	76%	92%	94%	94%	1,097	3.35	3.91	7.25
C8	259	246	226	181	217	200	186	171	95%	80%	92%	92%	1,324	3.95	3.19	7.13
CCU_PCCU	256	238	70	47	218	214	40	31	93%	67%	98%	78%	768	6.91	1.21	8.13
Critical Care	525	452	124	87	527	465			86%	70%	88%		540	20.37	1.93	22.30
AMU	551	525	465	398	498	530	468	451	95%	86%	106%	96%	2,468	5.02	4.13	9.15
Maternity	852	795	262	189	527	515	156	142	93%	72%	98%	91%	1,391	9.01	2.79	11.80
MECU	93	91	34	27	93	92			98%	80%	99%		225	9.76	1.34	11.10
NNU	389	258			268	225			66%		84%		314	18.40	0.00	18.40
TOTAL	**5,630**	**4,965**	**3,743**	**3,044**	**4,519**	**4,255**	**3,047**	**2,863**	**88%**	**81%**	**94%**	**94%**	**20,480**	**5.19**	**3.43**	**8.61**

Nursing Sensitive Indicators – January 25 - Appendix 7

Jan-25	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MRSA	Observations post target			Medicines Late/Unplanned ommission	
									L	M	H	Late	Unplanned Ommissi
AMU 1	1	2	2	0	2	0	0	0	2725	219	158	182	2682
AMU2	0	8	5	0	1	2	0	0	3012	136	45	203	2189
AMU3 (A4)	0	3	3	0	2	0	0	0	1119	17	14	59	741
AMUA	0	0	0	1	0	2	0	0	1758	50	21	111	1829
B1	0	1	2	0	0	0	0	0	1166	3	1	546	1138
B2H	0	4	6	0	0	0	1	0	2080	26	10	486	2453
B2T	1	9	10	0	0	0	0	0	2152	24	3	437	1071
B3	1	10	17	0	0	0	0	0	3431	34	5	452	2823
B4	1	5	16	0	0	0	0	0	3330	34	4	189	3633
B6	0	2	4	0	14	0	0	0	1562	8	2	117	1092
C1A	0	4	4	0	0	1	0	0	2107	82	29	145	1237
C1B	0	2	1	0	0	0	1	0	2112	44	13	414	1646
C2	2	0	1	0	0	0	0	0	1158	299	45		
C3	0	6	2	0	1	1	0	0	2647	27	8	154	2612
C4	0	2	4	1	0	0	0	0	1707	113	19	118	946
C5A	0	7	3	0	0	0	0	0	2439	72	51	315	1252
C5B	0	1	6	1	1	0	0	0	2400	130	90	282	1507
C6	1	2	0	0	0	0	0	0	1629	27	13	155	1823
C7	1	3	7	0	0	0	0	0	3482	46	24	188	2577
C8	0	10	7	0	0	0	0	0	4117	88	50	409	3380
CCU	0	4	11	0	0	0	0	0	874	12	1	384	856
DL	0	5	7	0	0	1	0	0	1090	5	0	125	865
ESH	1	1	2	0	0	0	2	0	3078	73	46	687	3013
MECU	0	2	1	0	0	0	0	0	296	5	3	58	517
FMU	0	3	5	0	0	0	0	0	1131	5	3	34	923
Surge	0	0	1	0	0	1	0	0				231	1354
ED Adults	0			10	0	3	19	0	446	443	284	32	346
ED Paeds	0	0		1	0	0	0	0	21	15	8	26	26

Data Sources Supporting the Professional Judgement - Appendix 8

TOPIC	CONTENT
Complaints	All complaints received and summary of content
Falls	Number of falls per team extracted from incident management system
Medications	All late, missed or unexpected omitted medications
Safeguarding	Number of safeguarding referrals made per team
Pressure Ulcers	Number of pressure ulcers per team extracted from incident management system
Observations	Total number of observations and which were recorded early, on time or late
Red Flags	Number and reason for red flags raised in Safecare (e-rostering) per team
Professional Judgement	The records of all professional judgements recorded in Safecare per team
Ward attenders	The number of ward attenders per team
Patient Transfers / escorts	Number of patient transfers and escorts per team

Patient Acuity /Dependency Summary Sheet Schedule Emergency Department – Appendix 9

Jun-24																														
Day	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7		Day 8		Day 9		Day 10		Day 11		Day 12		Day 13		Day 14	
Time	00:00	12:00	01:00	13:00	02:00	14:00	03:00	15:00	04:00	16:00	05:00	17:00	06:00	18:00	07:00	19:00	08:00	20:00	09:00	21:00	10:00	22:00	11:00	23:00	00:00	12:00	01:00	13:00

Data Collection Theatres/NNC/Critical care – Appendix 10a

Index	
	Over established
	Correct Establishment
	Under Established

Requirement vs Actual

Unit	2	3	4	5	6	Grand Total	Comments
Day Case Theatre Corbett Hospital	0.86	0.00	0.00	-3.25	-2.77	-5.15	Shortfall in staff covered by movement of staff from other theatre areas and staff bank.
RHH Day Case Theatre & Recovery	1.59	2.00	-2.70	1.06	0.64	2.60	Excess rostered staff utilised in other theatre and ward areas to accomodate shortfalls
RHH Day Case Theatre Ward	-3.77	1.00	0.96	1.54	-5.43	-5.71	Shortfall in staff covered by movement of staff from allied theatre areas and staff bank.
Theatres General, Urology, ENT & Plastics	-1.17	0.00	-0.93	6.60	-2.29	2.20	x1 Band 5 leaving trust x1 transfering to ward
Theatres Obs, Gynae, Vascular & Emergency	1.99	0.00	0.00	-2.69	-4.26	-4.96	x3 Band 5 positions allocated to ODP's when qualified currently under A&R
Theatres Recovery and Anaesthetics	7.74	1.00	2.00	-4.26	3.57	10.05	x9.74 WTE equivalent (x6.74 Band 2, x1 Band 3 & x2 Band 4) undergoing ODP Traininmg funded by Trust
Theatres T&O Dept	1.61	0.00	-3.98	6.86	-3.21	1.28	x1 Band 2 TNA training funded by trust
Grand Total	8.85	4.00	-4.64	5.86	-13.76	0.31	Excess of 0.31 WTE in a total team of 224.4 WTE (0.14% over) 7.74WTE Unregistered staff currently undergoing ODP training

Unit	Unregistered	Registered	Grand Tota	Comments
Critical Care (inc. CCOT)	0.04	1.51	1.55	Staffing establishment based on 15 ICU beds. Significant Maternity leave ongoing and planned. Peak December 2024/January 2025 17%.
Neonatal Unit	-3.94	-6.28	-10.22	Staffing establishment based on BAPM at 90%.

Sum of WTE	Requirement vs Actua			
Unit	Unregistered	Registered	Grand Tota	Comments
Day Case Theatre Corbett Hospital	0.86	-6.01	-5.15	Shortfall in staff covered by movement of staff from other theatre areas and staff bank.
RHH Day Case Theatre & Recovery	3.59	-1.00	2.60	Excess rostered staff utilised in other theatre and ward areas to accomodate shortfalls
RHH Day Case Theatre Ward	-2.77	-2.94	-5.71	Shortfall in staff covered by movement of staff from allied theatre areas and staff bank.
Theatres General, Urology, ENT & Plastics	-1.17	3.37	2.20	x1 Band 5 leaving trust x1 transfering to ward
Theatres Obs, Gynae, Vascular & Emergency	1.99	-6.95	-4.96	x3 Band 5 positions allocated to ODP's when qualified currently under A&R
Theatres Recovery and Anaesthetics	8.74	1.31	10.05	x9.74 WTE equivalent (x6.74 Band 2, x1 Band 3 & x2 Band 4) undergoing ODP Traininmg funded by Trust
Theatres T&O Dept	1.61	-0.33	1.28	x1 Band 2 TNA training funded by trust
Grand Total	12.85	-12.54	0.31	Excess of 0.31 WTE in a total team of 224.4 WTE (0.14% over) 7.74WTE Unregistered staff currently undergoing ODP training
Critical Care (inc. CCOT)	0.04	1.51	1.55	Staffing establishment based on 15 ICU beds. Significant Maternity leave ongoing and planned. Peak December 2024/January 2025 17%.
Neonatal Unit	-3.94	-6.28	-10.22	Staffing establishment based on BAPM at 90%.