The Shrewsbury and Telford Hospital NHS Trust

Board of Directors
14 July 2022

Agenda item	136/22			
Report	Bi-Annual Staffing Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1, BAF 4, BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		807, 1571, 2058, 1768, 817	
	For noting			
	For information			
	For consent			
Presented to:	Quality & Safety Assurance Committee Nursing, Midwifery, AHP & Facilities Workforce Group			
Dependent upon (if applicable)**:**	NA			
Executive summary:	The purpose of this report is to provide the Board of Directors with an overview of bi-annual Nurse staffing review. A paper in full has been presented to the Nursing, Midwifery & AHP Workforce Group in June 2022 where a summary of the data collected in January 2022, substantive availability and Red Flags were triangulated and discussed The Quality & Safety Assurance Committee is asked to: • Receive this information • Decide if any further information, action and/or assurance is required			
Appendices:	Appendix 1: Bi-Annual Staffing Report Appendix 2: Workforce Safeguards Gap Analysis action plan - in Supplementary Information Pack			
Lead Executive:				

Bi-Annual Staffing Review

NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing that will support safe, effective, caring, responsive and well-led care

Nationally it is agreed that Nurse to patient ratios in the day should be no more than a ratio of 1:8 in adult inpatient ward settings. For January 2022 Medicine Division were at 1:5 and Surgical Division 1:6 thus meeting this national guidance.

A further measure to demonstrate adequate Registered Nurse (RN) staffing levels is to ensure a mix of at least 65% RN compared to unregistered posts. This is known to reduce mortality and increase quality and safety. The data indicates that most wards do not meet this threshold with the average overall being at 53%. However, it is to be noted that with the template review all wards will have ratio of 1:6 days and 1:9 at night giving assurance that quality and safety can be maintained.

Staffing fill rates overall were below 90% for RN and above 90% for Healthcare Assistants (HCAs). It should be noted that the fill rate does not account for skill mix and experience and that low fill rate does not always mean that staffing levels were unsafe as bed occupancy may have been low.

Care Hours per Patient Day (CHPPD) when reviewed on Model Hospital and benchmarked suggests the Trust is above peer and national average.

The Trust utilises a validated tool to measure staffing twice a year (Safer Nursing Care Tool – SNCT) alongside professional judgement and triangulation of quality data. This is in line with national policy.

For increased assurance regarding the data received from SNCT, training and assessment has been rolled out to senior RNs so that data captured is as accurate as possible. This will be an ongoing process to ensure new staff are trained and assessed.

The Trust is partially compliant with national policy (Developing Workforce Safeguards), a gap analysis is complete and an improvement plan in place, monitored via the Quality and Safety Assurance Committee quarterly and reviewed monthly at the Nursing Midwifery AHP and Facilities meeting for progress against targets.

The data from SNCT continues to suggest the numbers of RNs currently budgeted is not enough and the numbers of HCAs is too high. This should be taken with caution as although improvements have been made regarding data capture more work is needed with staff training currently and we have continued not to be able to utilise 2 consistent data captures due to ward areas continuing to flex and change to meet the operational demands of COVID 19 and non-elective emergency activity.

There were 89 incidents in January 2022 for staffing issues, which is lower than the previous 6 months. 19 of these incidents have been identified as potential red flags against NICE safer staffing guidance. All of these were however categorised as no or low harm.

The main risks identified within this review relate to the identified lack of RNs and the numbers of temporary staff being utilised to increase fill rates in areas. The RN ratio has remained the same last review in July 2021 and unavailability across the inpatient adult areas has

increased. Increased sickness due to covid isolation has pushed the figures up and it would be expected that the July data collection see a drop in this area.

The national team have released a SNCT for Emergency Departments (ED) and the licence has been received. Training has commenced and the ED team will take part in the July acuity data collection

Paediatrics will be included in July 2022 data collected as they are now on Safecare.

The Trust employed a fixed term AHP Workforce lead in February 2022 that reports corporately and will have Data on the AHP workforce which will be captured in the July staffing paper.

The Trust has increased the Trainee Associate placement to 30 per year to provide more Nursing associates across our Trust to increase our Nursing Associates across our organisation to increase skill mix in vulnerable areas.

A business is being written to provide training for up to 10 Nursing Associates to complete their top up training to become Registered Nurses, this allows the Trust to grow their own nurses and provides a career pathway for our Nursing Associates and helps with retention.

A workforce review continues assessing the utilisation of support roles within inpatient areas so as to release clinical time for clinical tasks.

The Trust is looking at ways of more flexible working patterns and will look at the possibility of introducing shorter shifts to wards areas that require this. This will form part of the next staffing review due the need for additional funding required to introduce shorter shifts.

The Trust took the decision to review 32 inpatient ward templates, due to many wards changes the template did not reflect the need of the wards. Many of the recommendation from previous reports reflect the changes that have been made. The template review has been agreed at board but aware sign off at system level. The changes made reflect the GPICS standards, ED expansion of RN and HCA workforce, creation of an EPS team, Band7 supervisory status and band 6 cover Monday to Sunday days and Saturday and Sunday nights.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Bi Annual Safer Staffing Report – June 2022

1.0 Introduction

1.1 Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) in particular sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

1.2 It is well documented that ensuring adequate Registered Nurse (RN) staffing levels on acute medical and surgical wards in line with national recommendations has many benefits including improved recruitment and retention, reduction in staff stress and thus sickness levels, improved patient outcomes including mortality and improved levels of patient care (Royal College of Nursing, 2021; Rafferty et al 2007).

1.3 The Developing Workforce Safeguards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and builds on the National Quality Board (2016) guidance. It identifies that Trusts must ensure the below three components are used in their safe staffing processes:

- Evidence based tools and data
- Professional judgement
- Outcomes

1.4 This report provides an overview of the above bullet points for all inpatient ward areas in January 2022.

2.0 Nurse to Patient ratios – overview

2.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for.

2.2 It should be noted that this method may not always accurately reflect the needs of the individual patient as their dependency on nursing input may differ at various points. Nevertheless, the Royal College of Nursing (RCN) ‘Mandatory Nurse Staffing Levels’ (2012) and NICE ‘Safe Staffing for nursing in adult inpatient wards in acute hospitals’ (2014) suggest acute wards must have a planned Registered Nurse (RN) to patient ratio of **no more than 1: 8** during the day. There is no current guidance for nights.

2.3 Table1 shows the average RN: Patient ratio at Shrewsbury and Telford Hospital (SaTH) during the month of January 2022. You will see in appendix 1 that NA sit in their own establishment line, and as registrants are counted into the RN ratio.

Table 1: Actual Average RN: Patient ratio during January 2022

Division	RN : Patient Ratio
Medicine & Emergency	1:5
Surgery, Anaesthetics & Cancer	1:6

2.4 This shows that during January 2022 the 2 main adult divisions met the national requirement overall of a ratio of 1:8 maximum with Surgery having the best ratios overall.

3.0 Safer Nursing Care Tool (SNCT)

3.1 The SNCT is an evidence based tool that is recommended by NICE to measure individual patient acuity and dependency. It is proposed that using SNCT offers greater understanding in regards to if actual hours match required hours.

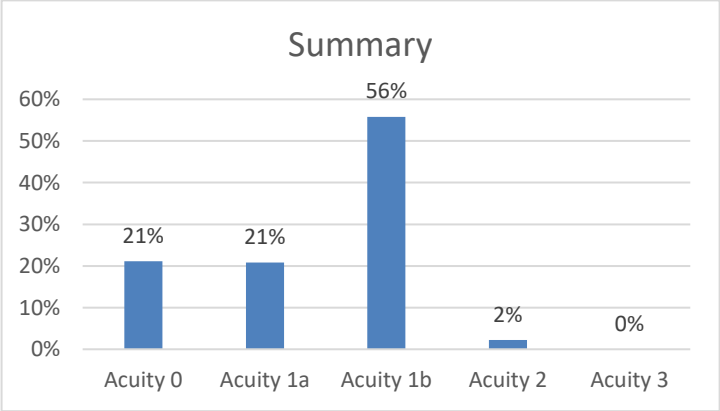
3.2 The tool is designed to be used daily for a minimum, 20-day period twice per year (January & July) collecting individual patient acuity and for ED the period is 12 day and acuity collected twice a day.

3.3 The SNCT allows clinical staff to assess the needs of every individual patient. It is worth noting that as a generic tool, subjective application of SNCT has an expected 10% variation from ward to ward and is not designed to indicate required skill mix. It should be used as part of professional judgement and patient outcomes also as has been the case with this review.

3.4 The Corporate Team have been working with the national safer staffing team to roll out SNCT training to aid increased compliance and accuracy in patient scoring and also reducing the number of staff per ward allowed to submit the acuity and dependency scores; this will help to reduce the expected variation and offer greater assurance in regards to submitted data.

3.5 The analysis for all wards acuity in January 2022 is shown in Graph 1, where circa 56% percent of patients are a level 1b.

Chart 1 – overall Trust acuity scores



3.6 This shows a similar result to the previous staffing reviews.

3.7 Graphs 2, 3, 4 and 5 show the acuity for January 2022 broken down by Division.

3.8 It shows that for Surgery and Medicine, the highest proportion of patients fall into the 1b category. For Gynaecology, the majority were classed as a 1a. This is similar to the data collected in July 2021.

Chart 2 – Surgery, Anaesthetics and Cancer Division scores

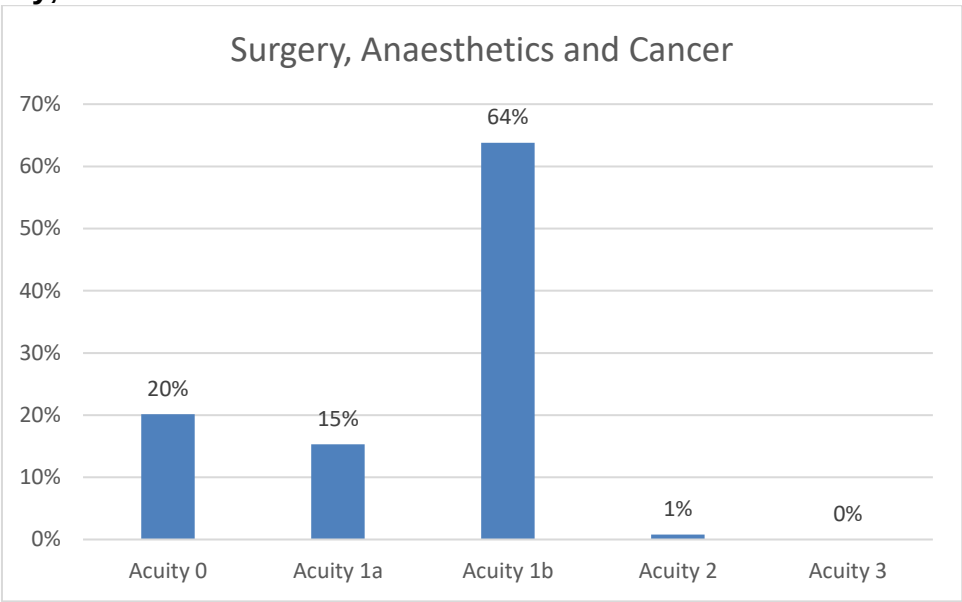


Chart 3 Surgical, Oncology and Haematology

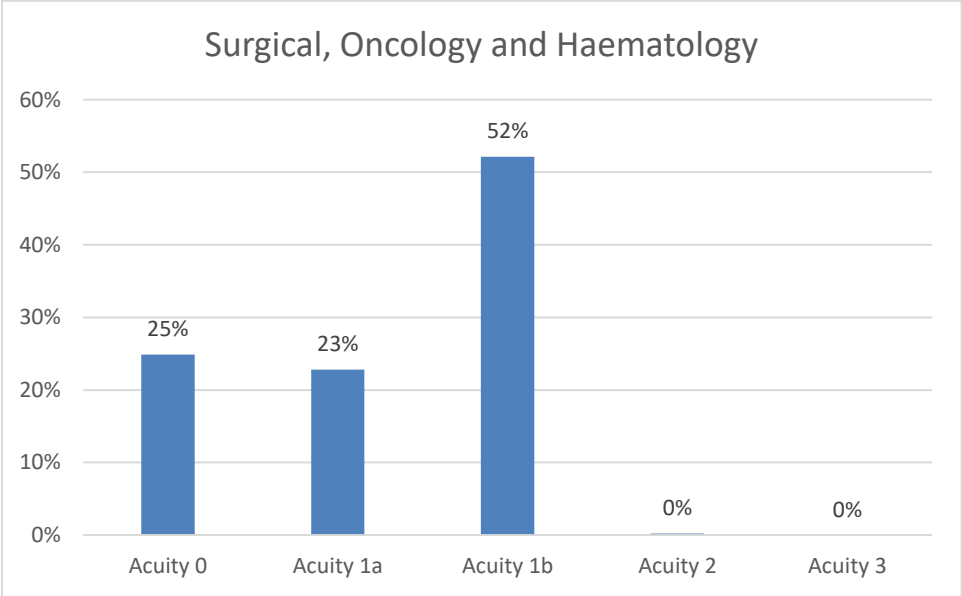


Chart 4 – Medical Division acuity scores

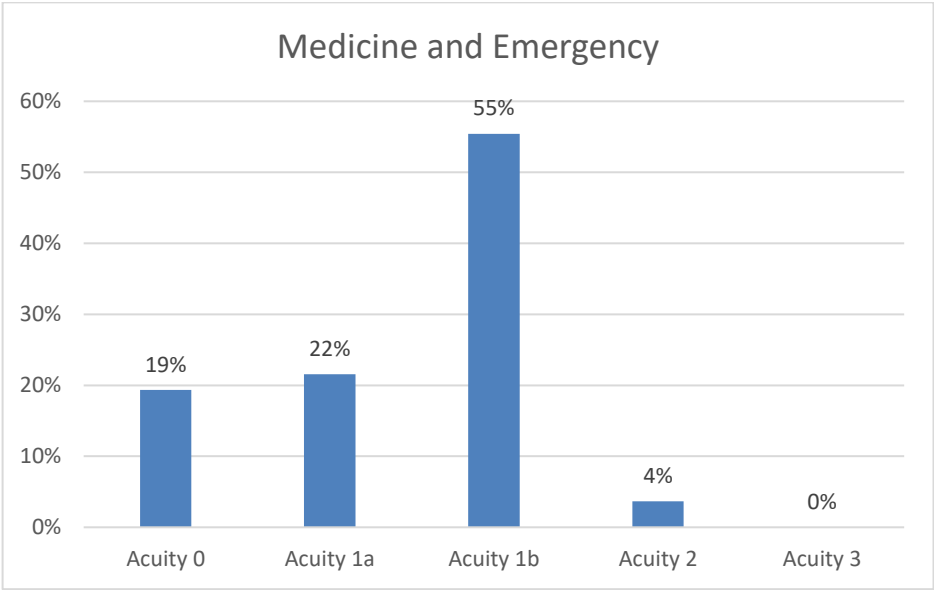
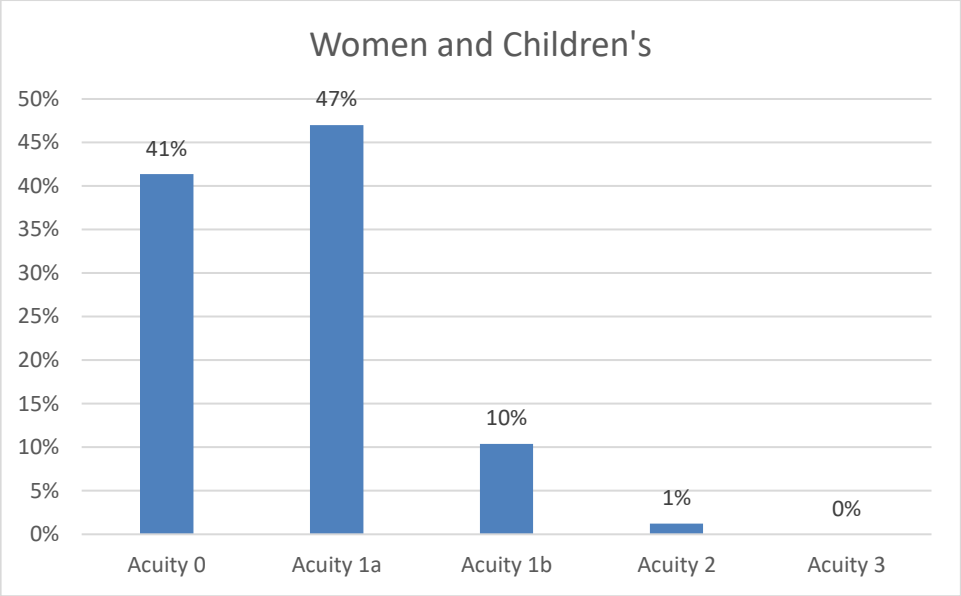


Chart 5 – Ward 14 (Gynaecology) acuity scores



3.9 For the purpose of the bi-annual staffing reviews, a RN: HCA ratio of 65:35 has been utilised within the SNCT in line with national guidance.

3.10 It should be noted that the Gold standard would be a mix of 70% RN to 30% HCA linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths et al 2016, RCN 2021).

3.11 The full analysis of the data collection in January 2022 is shown in **Appendix 1**. To aid triangulation the data supplied includes, by ward; the acuity of patients; current budgeted establishments and expected establishments based on acuity (SNCT), CHPPD, RN: HCA ratios and fill rates.

3.12 Further work continues to enable a disaggregation of the workforce if the ward budget covers more than an in-patient area such as Gynaecology and Paediatrics for example.

3.13 It should also be acknowledged that again there have been several ward changes since this data was collected to cope with the rising demand in non-elective emergency admissions and further ward changes are planned for the coming months.

3.14 The area with the highest Nonregistered ratio was Ward 6 Cardiology Ward at 78%; this is likely to be due to the increased RN numbers required for the CCU

3.15 The inpatient ward with the lowest Nonregistered patient ratio was Ward 11 (Nephrology) at 39%. In January Ward 11 had 4 datix forms submitted regarding staffing, 1 medication error, 1 patient fall with harm and 2 official complaints.

4.0 Fill rates

4.1 Acute Trusts are required to collate and report staffing fill rates for external data submission to NHSE/I every month. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and HCA.

4.2 The summary position for January 2022 Source; (Census period January 10 – February 4, 2022) is shown in table 2.

4.3 Registered nurses include the NA within the Trust although at the establishment for NA is 45.45 WTE against an RN WTE of 508.75. The template proposes increase in the establishment for NA to WTE 100.91.

Table 2 – Fill rates

	Registered Nurses		HCA	
	Day	Night	Day	Night
January 2022	85%	95%	82%	115%

SOURCE: Census period January 10 – February 4, 2022

4.4 The data from January suggests that fill rates overall on both hospital sites for RNs and HCAs day was below 90% and therefore of come concern, however other contributing factors need to be considered as discussed.

4.5 HCA night shifts were higher than planned which is likely to be due to EPS requirements where there tends to be greater clinical risk.

4.6 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.

4.7 Fill rates also do not take into account 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.

4.8 The Ward with the lowest day RN fill rate was identified as Ward 21 (45% fill). Between the 7 -17 January 2022 the ward had an outbreak and was underoccupied for January 2022. Staff were moved from other wards to ensure safety. This ward also had a vacancy rate RN WTE 8.77 in January 2022 and 7.77 WTE in February. Bed occupancy was 93.51%. Ward 21 had 5 falls with no harm, and 6 datix due to lack of staff in January 2022. There were no other patient outcome concerns during this time.

4.9 The Ward with the highest RN Day fill rate was Ward 36 Elective Orthopaedics at 118% with a bed occupancy of 92.53%.

4.10 Ward 22 Orthopaedics had the highest Night RN fill rate at 131% with a bed occupancy of 92.20%.

4.11 Ward 32 Cohort (RSH) had the lowest RN fill rate on Nights at 79%, bed occupancy however was only at 55.61%. There were no major quality and safety concerns with the area only reporting 2 medication error and 2 fall with no harm.

5.0 Care Hours per Patient Day (CHPPD) – Model Hospital Comparison

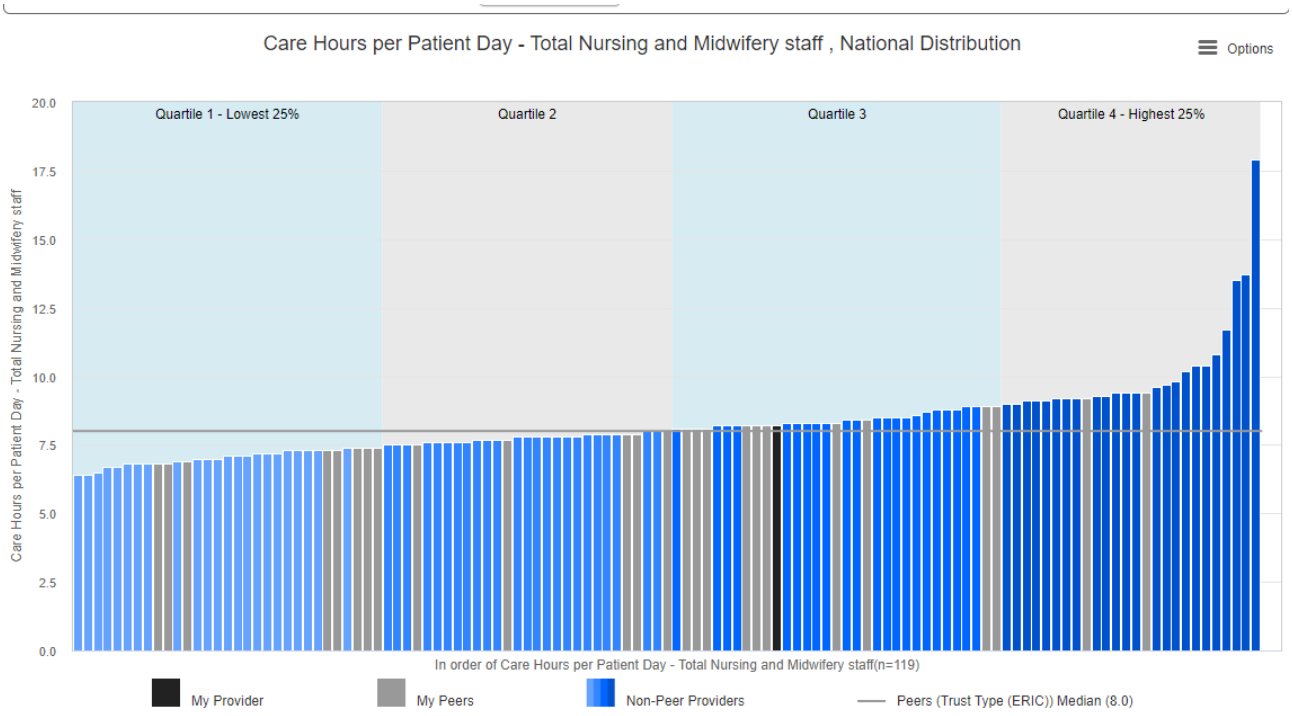
5.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. CHPPD is calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the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

5.2 The inpatient ward area identified with the highest CHPPD (Source; Census period January 10 – February 4, 2022) was Ward 23 (7.53 CHPPD) which is slightly over their actual CHPPD of 7.03; this is likely to be due to this area requiring a rich resource in terms of staffing numbers for the group of patients on the ward during this census period. The bed occupancy at the time was 93.88%.

5.3 The lowest Ward area for CHPPD excluding Women and Children Division was Ward 22 SS. Ward 22 SS had a required actual CHPPD of 7.06 and only achieved 5.76. The bed occupancy at the time was 91.42%. Ward 22 SS had 2 patient complaint, 2 SI, 6 patient falls (0 with harm), and 0 datix submissions in relation to staffing.

5.4 Chart 5 shows the most up to date position for SaTH on Model Hospital (February 2022 – Full calendar month) and indicates that for CHPPD nationally, SaTH are towards the middle in quartile 3 at 8.2 and higher than both the peer median (8.0) and the national median of 8.0. (Accessed May 9, 2022).

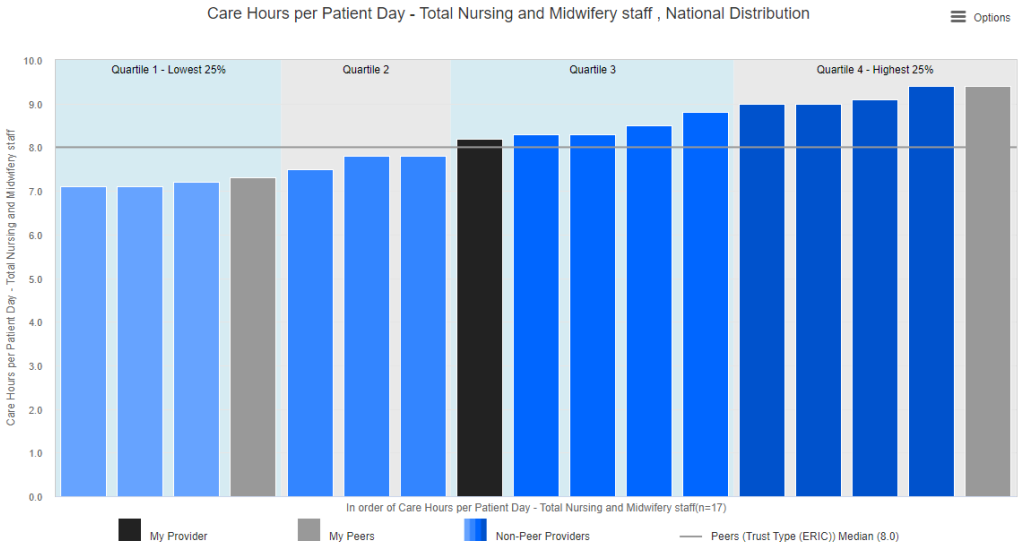
Chart 5 – CHPPD February 2022



Source: Model Hospital, February 2022 (Full calendar month)

5.5 When compared to Trusts within the Midlands, it highlights that SaTH are bottom in quartile 3 as identified in chart 6 below. One peer is in Quartile 1 Royal Wolverhampton NHS Trust (7.3), and Worcestershire Acute Hospitals NHS Trust (9.4) is in Quartile 4.

Chart 6



Source: Model Hospital, February 2022 (Full calendar month)

6.0 Substantive Unavailability

6.1 Substantive unavailability was high in January 2022 at 38%, in comparison to 32% July 2021 this has remained static although the reasons for unavailability has shifted with an increase in both sickness (11%), annual leave (15%) and parenting (5%) noted for January 2021.

6.2 There has been an increase in unavailability since pre-Covid although it is unclear if this is related. For January 2020 as an example prior to Covid, unavailability was at 25%. The main reason for the increase since this time appears to be higher sickness levels and parenting which is likely to be linked to the pandemic. See **appendix 2** for a full breakdown.

7.0 Emergency Centre

7.1 The Trust now has the Emergency Department SNCT multiplier licence. Training has only recently begun by the National Team. The aim will be to undertake the bi – annual review in ED in July but this may need to be delayed if further training is not completed before this date due to current demands.

8.0 Paediatrics

8.1 Bed occupancy for Ward 19 (Paediatrics) was only at 64.96% in January 2022 (Source; Census period January 10 – February 4, 2022) and as such the acuity and dependency data collected was not reflective of the usual activity or demographic of patients, for this reason, Paediatrics have not been part of this bi-annual review at this point.

8.2 The Director of Nursing has asked for a peer review of Paediatrics which will include staffing compliance which will be included in the July data

9.0 Incidents

9.1 During January 2022 there were 89 staffing related incidence submitted to the datix system which is lower than in any of the previous 6 months (see **chart 7**).

9.2 19 of these incidents could be identified as potential red flags as defined by NICE (2021) due mainly to delays in patient care including rounding and medications. The Divisional Directors of Nursing continue to review these with their teams for confirmation. Whilst these incidents were categorised as no or low harm it should be noted that this will still negatively impact on patient and staff experience.

9.3 The main wards of concern 22 T&O (9 Datix), Ward 28 (8 Datix), and Ward 23 Neonatal (7 datix).

9.4 It should be noted as a caution that the datix submission detail does suggest an element of concern regarding staff understanding of safer staffing which continues to be addressed.

9.5 All datix submissions are now being reviewed monthly by the Lead Nurse for Workforce and the Divisional Directors of Nursing to review for red flags and monthly escalation.

Chart 7

10.0 NICE Red Flags

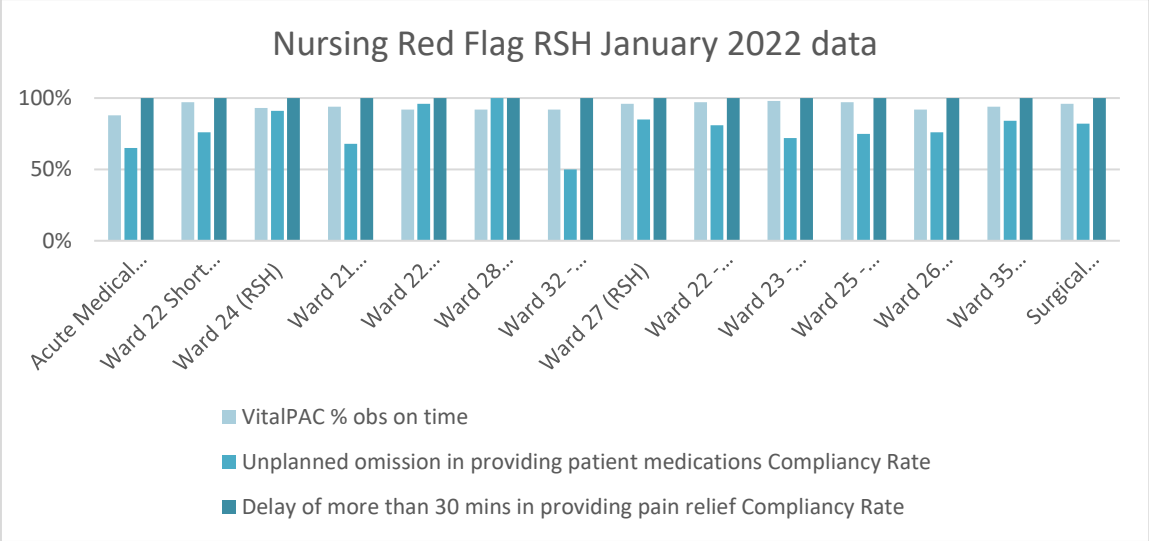
Nursing Red Flags as specified in Safe Staffing for nursing in adult inpatient wards in acute hospitals overvew (NICE 2021).

10.1 Patient vital signs not assessed or recorded as outlined in care plan**.**
ITU/HDU at RSH and PRH are not currently using VitalPac fully as alternative monitoring in place for patients. At RSH compliancy ranges between 88% (AMU RSH) and 98% (Ward 23 Oncology/ Haematology). PRH ranges between 88% (AMU) and 98% (Ward 6, Ward 8, Ward 15 and Ward 16).

10.2 Unplanned omission in providing patient medications.
Audit data is taken from the nursing quality metrics audit which reviews 10 patient notes monthly. RSH compliancy rate ranged from 50% (Ward 32) to 100% (AMU, Ward 28), and PRH from 81% (Ward 11) to 100% (Ward 16). Matrons and Ward Managers are working to improve this complinace.

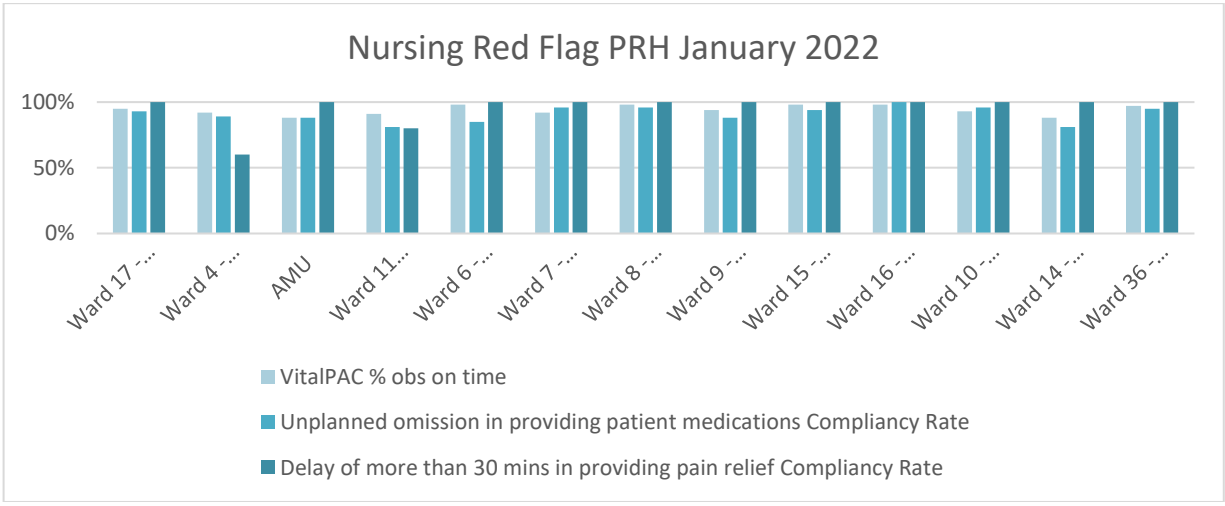
10.3 Delay of more than 30 minutes in providing pain relief.
Audit data is taken from the nursing quality metrics audit which reviews 10 patient notes monthly. RSH compliancy rate was 100% (all other Wards), and PRH from 60% (Ward 4); 80% Ward 11 to 100% (all other Wards). Matrons and Ward Managers are working to improve this complinace.

RSH



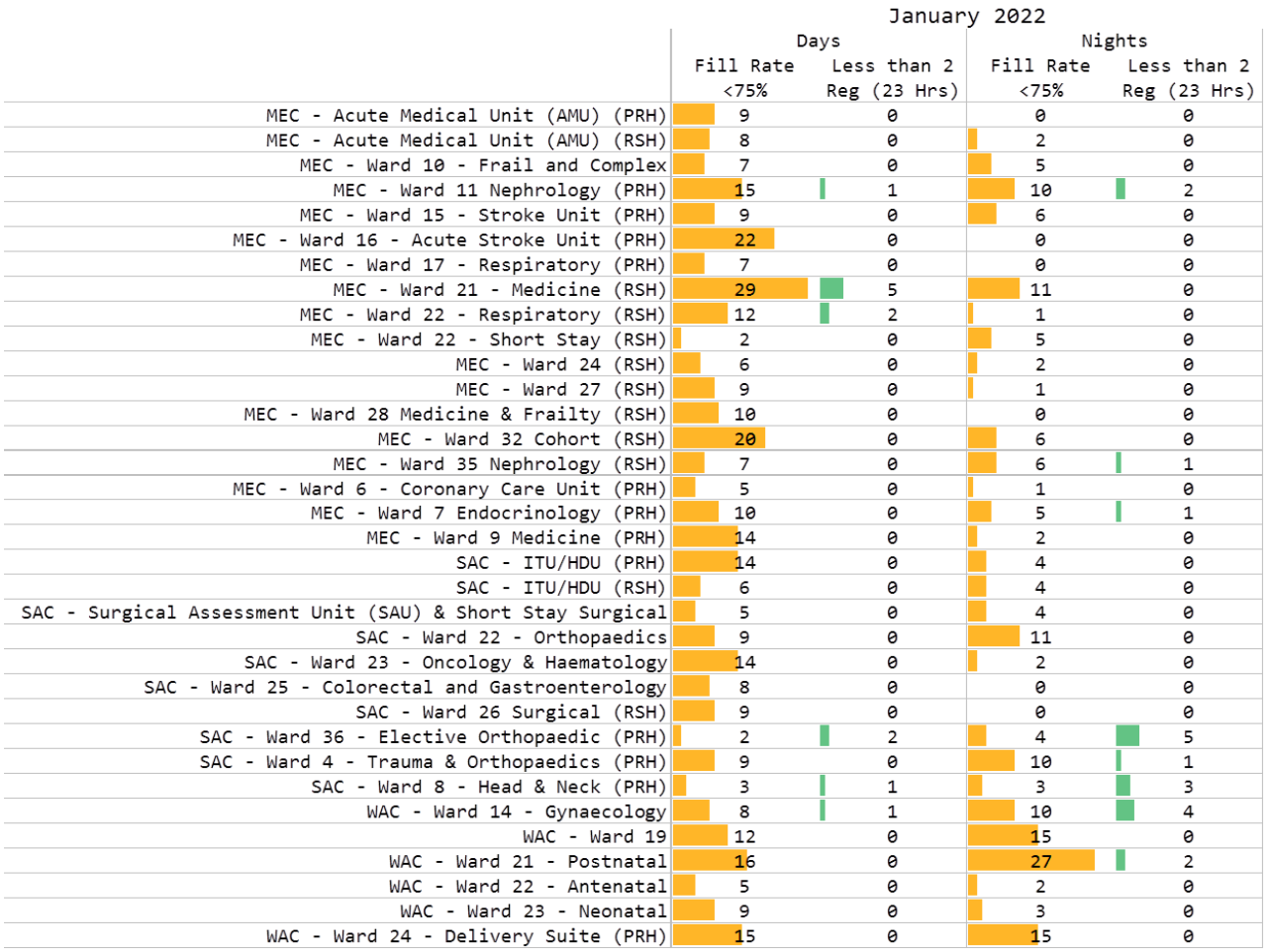
Source: Nursing Dashboard January 2022 (Full calendar month)

PRH



Source: Nursing Dashboard January 2022 (Full calendar month)

5.4 A shortfall of more than 8 hours or 25% of registered nurse time available compared with the actual requirement for the shift and fewer than 2 registered nurses present on a ward during any shift.
This data captured from E-Roster (January 2022, Full calender month) is illustrated in the graph below. There were no ward areas with less than 2RN on a shift. Assurance was gained from Matrons that this was not the case and on further exploration it was due to the movement of staff not been captured in all cases on E-roster. Work has been ongoing to get the Matrons to highlight its importance to Ward Managers.



Source: E Roster January 2022 (Full calender month)

11.0 Considerations

11.1 Ward 22 T&O continues to have an extra RN on day and nights due to concerns regarding patient safety within this area following professional judgement discussions, this is not currently budgeted for but in the recent template review this has been included and if template agreed this will then be budgeted and template can be adjusted.

11.2 The review identified continued changes to wards and specialties to meet the demands of activity and Covid within the Hospitals and this has continued to change since the January 2022 review and as mentioned in the report there are more planned move within the trust and so continues to make the biannual staffing reviews inconsistent and difficult to use to help adjust establishments.

11.3 In previous reviews the inconsistency in the Band 7 ward managers supernumerary to clinical shifts has been raised and so in the recent template review it has been recommended that the Band 7 ward manager will be completely supernumerary. We are awaiting board agreement for this template review. This recommendation falls in line with The Royal College of Nursing that the lead role should be supervisory and thus not counted in the roster numbers (RCN, 2021).

11.4 Within the recent template review it has been recommended for the 32 inpatient areas that there is a band 6 Monday to Sunday on days and Saturday and Sunday nights, this is to support the junior staff at times when there is fewer senior staff on duty.

11.5 On analysis of budgeted ward splits for RNs and HCAs; the average RN percentage is 53% which is the same as July 2021. This continues to be below national guidance (RCN being 65% registered to 35% unregistered). This is therefore a risk in terms of patient safety, mortality, and staff well-being alongside the potential impact financially on addressing this shortfall. This has been reviewed in the recent template review. The principle that has been applied to the review are:

1) A minimum ratio of 1 Registered Nurse to 6 beds during the day
2) A minimum ratio of 1 Registered Nurse to 9 beds during the night

This is a higher percentage of RN to patients bed than the Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014) that suggests acute wards must have a planned Registered Nurse (RN) to patient the Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014) suggest acute wards must have a planned Registered Nurse (RN) to patient ratio of **no more than 1: 8** during the day. There is no current guidance for nights.

11.6 The SNCT data would suggest that HCA numbers may be able to reduce in some areas however with current temporary staffing requests remain high and fill rates being utilised above 100% for this group of staff, an initial assumption would be that this cannot be the case. Work has been undertaken around EPS usage and as part of the template review, and the recommendation is that a team will be established with 40 WTE with a Band 7 to support this team

11.7 The SNCT data collected would suggest there is a shortage of RNs of 141.55 however we have 45.45 NA in post and so that leaves a shortage of 96.1 and an over recruitment of HCAs by 69.79 – this shows a slight increase in shortage of RN and a reduction in the HCA from the last report.

11.8 A reduction in HCA posts could be achieved by reviewing additional roles outside of the "nursing workforce" such as Ward Clerks, Ward Hostesses, Bed Cleaning Teams, and Transfer Teams. This work is being reviewed by the corporate team

11.9 As the numbers of Nursing Associates continues to successfully increase and a clear pathway for our HCA to process their careers to Nursing Associates, we have now looked to incorporate them into the templates. Where safe to do so inpatient areas that were in scope, we have increased the Nursing associate numbers and reduced the RN numbers. It is recognised that it will take several years to fill all the vacancies and so will back fill with RN until this can be achieved. To note all wards area will have minimum of 2 RN on all shifts.

11.10 Currently Ward areas are utilising 12-hour shifts. It should be noted that there is growing evidence that 12 hour shifts are unsafe and are no longer recommended (RCN, 2021). The factoring in of a percentage of 7 ½ shifts to each area should be considered in future workforce reviews. This has not been reviewed in the recent template review; however, wards are able to use there templates flexibly to meet the need of their staff and patients.

11.11 From the professional judgement meetings held as part of this review; it has been noted that HCAs are performing increased cleaning tasks due to Covid and that there is increased nursing time taken up for donning and doffing because of Covid which will be pulling time from direct patient care.

12.0 Future plans

12.1 It has recently been agreed by the Director of Nursing that the Trust should consider the appointment of an Allied Health Professional Chief Lead to support with safer staffing and

leadership for non-nursing, non-medical roles. This needs to be scoped with the Divisional leads for Clinical Support Services and presented to the Director of Nursing.

12.2 The Trust recruited an AHP workforce lead following successful bid monies from HEE and came in to post in February 2022 with a 6-month secondment, data collected will be included in the next bi-annual report.

13.0 Conclusion

13.1 The recommendation from the Director of Nursing is there is good compliance with the Developing Workforce Safeguards. There is an action plan in place to address the remaining gaps (see **Appendix 3** for the gap analysis action plan).

13.2 The Director of Nursing and Medical Director have confirmed they are satisfied with the plans in place and are moderately satisfied that staffing for Nursing is safe, effective, and sustainable.

Lead Nurse for Workforce – Corporate Nursing (TB)
May 2022

Appendix 1

Data collected – January 2022

SUMMARY of DATA COLLECTION
Period of Cover 10th January 2022 to 4th February 2022

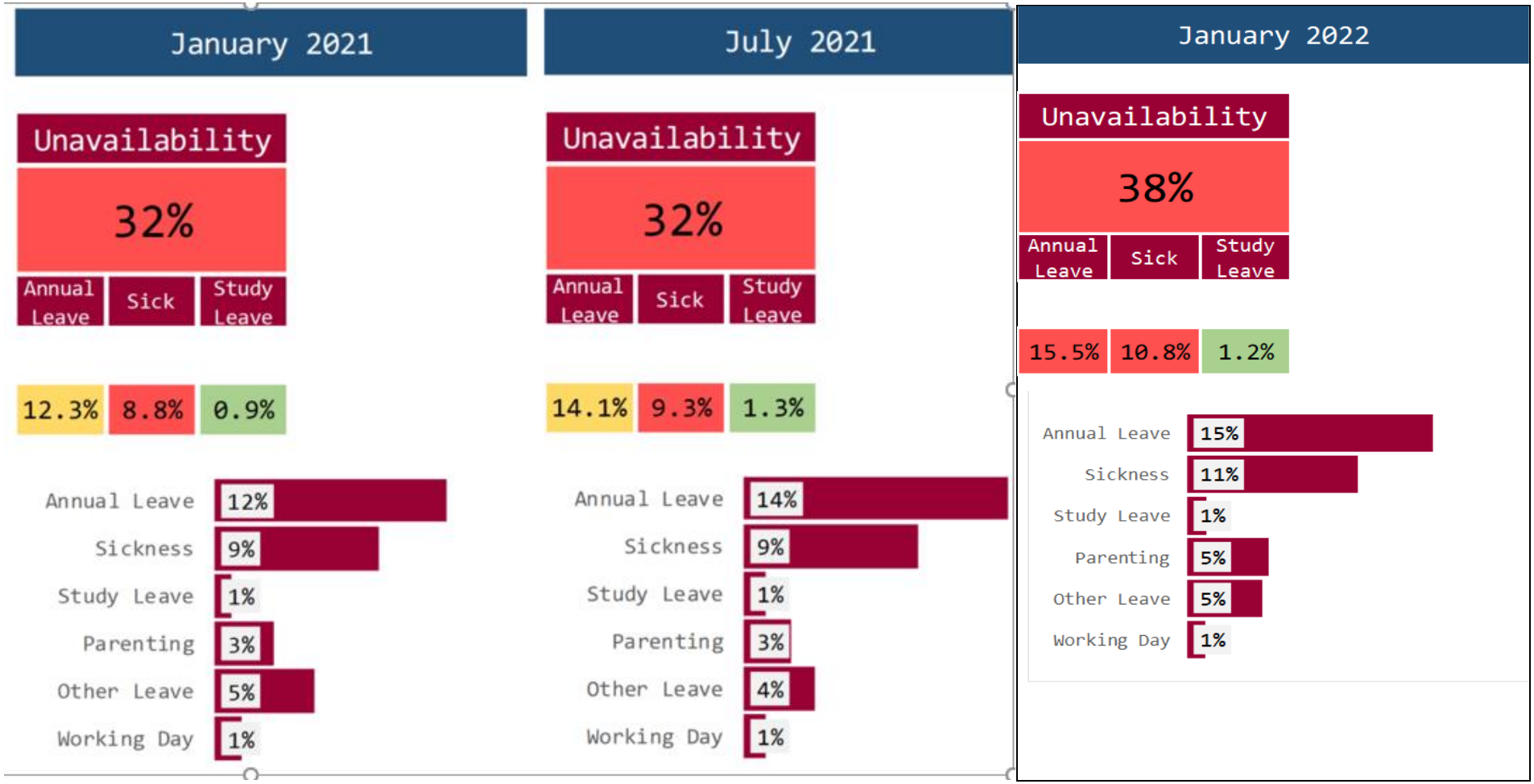
January 2022

Specialty/ Ward	SitRep Beds av daily between 10th Jan - 4th Feb 2022	SitRep Occupancy Rate	0	1a	1b	2	3	Current budgeted substantive FTE			Proposed SNCT		correct or over/under established		Ratio (percentage of RN to non RN day and night) - SNCT	Average Current Number of patients per RN (day) - SNCT	Average Current Number of patients per RN (night) - SNCT	CHPPD		Fill Rate (RN) - Day	Fill Rate (RN) - Night
		%	%	%	%	%	%	RN - B7, B6, B5	HCA - B2, B3	NA - B4	RN	HCA	RN	HCA	RN:Non Registered			Required	Actual		
			Dependency Level Summary / SNCT element																		
Emergency Care																					
AMU PRH	17	76.5	0	94	6	0	0	32.26	25	2.61	19	10.2	13.26	14.80	53%	3.7	3.3	7.35	12.71	83%	90%
AMU RSH	20	79.16	48	28	11	13	0	45.73	29.63	5	24.2	13	21.53	16.63	53%	4.2	3.6	6.55	12.67	86%	97%
SAU (W33/W34)	38	90.5	35	52	13	0	0	41.05	29.19	0	34.1	18.4	6.95	10.79	52%	7.8	5.4	6.98	7.67	83%	112%
(HASU) *(see same data for ward 15 below)*								24.28	10.93	3					51%	5.1	4.0	6.88	6.94	91%	95%
Medical																					
Ward 6 Cardiology	19	94.53	27	36	25	12	0	31.98	8.85	2	16.5	8.9	15.48	-0.05	78%	2.8	5.1	6.28	8.78	91%	93%
Ward 7 Endincrology and Nephrology (PRH)	28	93.68	7	14	79	0	0	20.96	14.53	1	27.2	14.7	-6.24	-0.17	55%	6.7	9.7	7.17	5.49	83%	93%
Ward 9 Supported Discharge	28	92.17	5	39	56	0	0	11.15	12.93	0	27.2	14.7	-16.05	-1.77	50%	7.0	9.4	6.83	6.34	87%	99%
Ward 11 Nephrology (PRH)	28	92.99	19	1	80	0	0	19.91	15.53	0	27.2	14.6	-7.29	0.93	39%	8.4	10.4	6.73	6.96	76%	91%
Ward 10 Frail and Complex Elderly (PRH) increasing by 1	28	92.72	9	2	89	0	0	20.47	18.03	4	36.7	19.8	-16.23	-1.77	57%	5.7	8.0	7.45	6.62	108%	113%
Ward 15 *Hyper Acute / Acute Stroke Unit (PRH) - also includes HASU*	25	98.77	15	19	66	0	0	24.28	10.93	3	30.6	16.5	-6.32	-5.57	51%	5.1	4.0	6.88	6.94	91%	95%
Ward 16 Rehabilitation (PRH)	17	79.41	44	1	55	1	0	23.36	20.22	2	12.5	6.7	10.86	13.52	64%	4.0	3.3	6.14	10.81	72%	95%
Ward 17 Respiratory	28	90.11	27	9	45	20	0	22.5	13.53	3	25.4	13.7	-2.90	-0.17	53%	4.8	7.2	6.76	9.02	94%	95%
Ward 21 Medicine	16	93.51	18	20	63	0	0	12.15	12.93	0	15	8.1	-2.85	4.83	50%	7.5	5.6	6.77	7.82	45%	90%
Ward 22SS	26	91.42	38	41	21	0	0	18.38	9.93	4	21.9	11.8	3.38	1.83	44%	7.3	9.3	5.76	7.06	96%	100%
Ward 22 Respiratory	20	96.92	2	35	41	21	0	16.26	14.05	3.92	20.4	11	-5.64	2.25	49%	6.7	5.4	7.2	8.81	90%	96%
Ward 24C+E Cardiology / Endincrology (RSH)	24	91.67	4	35	55	5	0	30.66	14.21	4	32.2	17.3	10.26	3.21	62%	5.7	7.0	6.98	6.4	82%	91%
Ward 27	39	97.93	32	1	67	0	0	27.14	26.17	2	36.1	19.4	-8.96	6.77	50%	8.2	8.4	6.52	5.94	79%	115%
Ward 28N medicine	34	92.76	16	9	75	0	0	30.47	18.51	0	31.6	17	-1.13	1.51	54%	6.4	6.8	6.92	7.08	83%	98%
Ward 32 Respiratory	24	55.61	18	16	48	17	0	18.9	20.06	3	13.5	7.3	5.40	12.76	50%	4.8	3.6	6.91	10.98	71%	79%
Ward 35 Renal	16	77.16	10	38	52	0	0	19.1	17.78	2.92	13	7	6.10	10.78	54%	4.3	4.5	6.66	10.82	82%	106%
Surgery																					
Ward 25G Colorectal & Gastroenterology (RSH)	38	95.75	27	16	57	0	0	27.27	21.48	0	34	18.3	-6.73	3.18	53%	7.2	11.0	6.45	5.48	91%	88%
Ward 26S General Surgery / ICA (RSH)	37	93.80	29	7	92	1	0	26.9	19.57	0	33	17.8	-6.10	1.77	54%	6.3	7.1	6.48	5.63	86%	91%
Ward 8 H&N	13	80.70	38	17	31	4	0	13.93	12.05	0	10.3	5.6	3.63	6.45	54%	5.6	6.1	5.75	8.28	90%	94%
Muscoloskeletal																					
Ward 4 Trauma and Orthopaedic	26	91.57	10	0	90	0	0	20.31	20.7	0	26.6	14.3	-6.29	6.40	46%	6.6	9.8	7.2	6.87	85%	93%
Ward 36 elective orthopaedics	17	92.50	17	13	93	0	0	11.35	5.17	0	16.6	8.9	-5.25	-3.73	52%	5.3	8.2	7	7.81	134%	106%
Ward 22 Orthopaedics	32	92.20	5	2	87	6	0	19.11	23.28	0	33.9	18.3	-14.79	4.98	47%	8.5	9.1	7.4	6.27	96%	118%
Oncology																					
Ward 23OC Oncology & Haematology	22	93.88	0	1	98	1	0	24.75	15.57	0	24.1	13	0.65	2.57	61%	5.7	5.7	7.53	7.03	78%	95%
Womens & Childrens																					
Ward 14 Gynaecology	12	74.76	39	9	52	0	0	17.46	8.26	0	7.5	4	9.96	4.26	58%	5.3	4.5	5.53	11.43	92%	93%
Total			**539**	**555**	**1547**	**101**	**0**	**508.75**	**374.27**		**650.3**	**350.3**	**-5.31**	**116.99**	**53%**			**189.06**	**224.66**		

Appendix 2

Substantive unavailability

Source January and July 2021 Full calendar month. January 2022 Census period January 10 – February 4, 2022.



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