The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 June 2023

Agenda item	062/23				
Report Title	Bi-annual Staffing Report				
Executive Lead	Hayley Flavell, Executive Director of Nursing				
Report Author	Stephanie Young, Lead Nurse for Workforce				
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe	√	Our patients and community	√	BAF1, BAF4, BAF 8	
Effective	√	Our people	√		
Caring	√	Our service delivery	√	**Trust Risk Register id:**	
Responsive	√	Our governance	√	327, 247, 220, 192, 1547, 130, 129, 128, 111, 581, 549	
Well Led	√	Our partners			
Consultation Communication	Nursing, Midwifery, AHP & Faciliites Workshop Steering Group. 12.04.23 People and OD Committee. 11.05.23				
Executive summary:	The purpose of this report is to provide the Board of Directors with an overview of bi-annual Nurse staffing review. • The report is a summary of the data collects in January 2023 consensus period using the SCNT for ED, CYP, Adult in patient and Adult acute • Workforce Safeguards gap analysis action plan is in progress • Plans in place to roll out Safe Care, the module that supports daily deployment bases on acuity • The consensus data is triangulated with % fill rates and red flags • Further data collection will take place in June and October 23, to enable a review of the agreed 2022 Nursing templates				
Recommendations for the Board:	The Board of Directors is asked to: • Take assurance from the report				
Appendices: (*In Supplementary Information Pack)	Appendix 1: Bi-Annual Staffing Report Appendix 1a: SCNT data collection table* Appendix 2: Workforce Safeguards Gap Analysis action plan*				

Bi-Annual Staffing Review Summary

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.

A systematic approach must be employed in determining the number staff and range of skills required to meet the needs patients and maintain their safety. The following three components should be used in safe staffing process:

- Evidenced based tools (where they exist)
- Professional judgement
- Outcomes

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.

Following a review of safe staffing processes by NHSE completed in November 2022, actions have been taken ahead of January census period to ensure staff are appropriately trained and assessed in the application of the tool and records of training maintained. Process for data collection and validation updated and has moved to an electronic system, which proves daily oversite of completion and quality assurance that data collection processes correctly applied. Ongoing training and competency assessments will ensure there is a yearly re-fresh of skills and training and competency assessments available for new assessors.

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 2023 Medicine Division (including Acute Medicine) were at 1:6 and Surgical Division (including SAU) 1:6.6 thus meeting this national guidance.

When reviewing skill mix establishment planning should ensure Registered Nurse (RN) staffing levels is at least 65% RN compared to unregistered posts. This is known to reduce mortality and increase quality and safety, wards with higher dependency benefit from staffing ratios below the 65%. Decisions on ratios are made on a ward-by-ward basis and applying professional judgement as well as evidence-based practice. The data indicates that most wards do not meet this threshold with the average overall being at 54%. Establishment reviews will continue to review skill mix and consider ratios to maintain safety.

Nursing/Midwifery overall fill rate position has improved and following operationalisation of updated template agreed in 2022 establishment review and staffing fill rates overall have shown some improvements over last 6 months. Considering registrants as a whole (Nurses/Midwifes/Nurse Associate) the daytime average fill rate was 87% and night-time 94%. The Safer Care Nursing Tool methodology and associated calculations will identify a recommended Full-Time equivalent (FTE) based on acuity/dependency but does not provide recommendations on registered to unregistered staffing based on the FTE. As the nursing workforce will include registered nurses, midwives, and nurse associate roles a review of registrants as a total will reflective the overall position of fill rate. Following the establishment review in 2022 there was an increase in planned nurse associate numbers on templates and decrease in RN’s. The planned NA workforce will take time to realise, as the current pathway for NA development and training will take time to provide trained staff to cover vacancies. In view of this, an agreement to overrecruit Band 5 nurses to off set NA vacancies until a time where qualifying NA will replace RN’s will continue. From a fill rate perspective this will reflect

in a higher percentage fill rate in RN's and a low fill rate for NA, thus the percentage fill rate for registrants will be utilised to understand overall fill rates. It should be noted fill rates do not account for skill mix and experience, and that low fill rates do not always mean that staffing levels were unsafe. For the purpose of SCNT recommendations, NA workforce has been included as a registrant when comparing FTE values of trained/untrained staff.

HCA fill rate average over the last 6 months for daytime is 95% and night-time 117%. Night-time fill rates reflect enhanced care support for 1:1. Both day and night rates show variation month on month, but overall daytime fill rate is consistently above 90% and night-time over 100%.

Triangulation of staffing with quality and safety data and red flag events should be made on a ward-by-ward basis. Fill rates are better at PRH in comparison to RSH likely as vacancy gap is less and staff working through temporary staffing on bank or agency have a preference for PRH. Since the last census in July 2022, safe staffing data is triangulated monthly at Metrics meetings where corporate and divisional teams consider events were staffing levels were below or above thresholds and the impact on patients, staff and safety by triangulation of workforce and quality data. Further work is required to develop process for timely review of red flags, capturing of mitigations and validation at divisional level to provide assurances at the time of the event, if there was any impacts on quality of care

Care Hours per Patient Day (CHPPD) is a measure of workforce deployment that can be used a ward level, service level and aggregated at Trust level and benchmarked against other Trusts. When comparing Trust data and specifically peers on Model Hospital, it suggests the Trust is above majority of peers and national average. It has been identified that new ward set up processes on e-rostering have not always included the correct staff and will have increased the Trust overall CHPPD figure. Work has been started to review template and work to exclude shifts that do not provide staffing for the overall bed base.

Following a recent review with support from NHSE, additional areas for development have been identified in line with national policy and developing workforce Safeguards, and updates to ongoing monitoring of action plan made. The oversight of and compliance with workforce safeguards is monitored via the Quality and Safety Assurance Committee and reviewed monthly at the Nursing Midwifery AHP and Facilities meeting for progress against targets. Following the review additional actions have been added follow a gap analysis process completed. Workforce Safeguards action plan and gap analysis can be found in Appendix 2.

SCNT data does not reflect staffing requirements for patients needing enhanced care 1:1 or mental health support 1:1. This data was collected alongside census and will continue to be collected with census periods to ensure it is taken into consideration with SCNT recommendations and the overall staffing needs of inpatient wards is taken into consideration. Enhanced patient support has been provided mostly by temporary staffing (bank and agency) and a plan was made to introduce an Enhance Care Support Team, lead by a Band 7 Nurse to support patients identified as needed. Additional training and support are been given to the Band 2 staff over and above current Healthcare workforce with particular enhanced skills in de-escalation techniques, dementia/delirium support. An initial plan for recruitment of 40 WTE has been slowed by lack of interest in the role, however there is now 14 Enhance Care support staff starting in Trust in the first 3 months of 2023. The aim is to improve the quality of care to patients with complex needs, provide continuity with workforce and reduce reliance on temporary staffing and thus reduce costs.

The Emergency Department SCNT and Children and Young persons SCNT have been use in both ED departments and Children's Ward 19 for the first time. ED data collection period is over 12 days, rather than 20 days minimum recommended for adult assessment units, adult

inpatient wards and paediatric wards, and ED SCNT recommendations reflect the 24 hour operation of ED departments.

As there were issues with use of SCNT tool and its application in previous census periods a minimum of two data sets are required before changes to templates are agreed. The census completed in January 2023 is first set of data and further census in June and October this year will help in understanding baseline of wards. No changes to templates are planned from this data set, however where ward functions or escalation beds have been opened and templates have been adjusted to reflect these changes. The emergency department has been particularly pressured and has regularly been caring for patients in corridors. This has created challenge for the departments and an escalation template for additional areas of care was required over and above the ED template.

There were 494 incidents over the six-month period up to and including January 2023 for staffing issues, which is slightly lower than previous 6 months. An increase in reporting of incidents (52) have been identified as potential red flags against NICE safer staffing guidance however this should be interpreted as a positive action as work was done previously to ensure staff were aware of the need to monitor and report ‘red flag’ events. All the incidents were categorised as no or low harm.

The main risks identified within this review relate to the need to reduce vacancy gaps for Register Nurses and Nurse Associates. Register Nurse recruitment is largely reliant on Internationally Educated Nurse Recruitment whereas Nurse Associate recruitment will some through a ‘a grow your own approach’. Both options have associate finance costs however there are limited alternative pathways at this time to address vacancy gaps. Due to high unavailability levels, particularly sickness and parenting and including vacancies the numbers of temporary staff are being utilised to increase fill rates in areas. Plus, additional escalation areas have been opened without substantive staffing plans by the nature of operational need to keep patients safe and improve patient flow. Reliance on wards providing substantive cover means there is regular movement of staff to cover gaps which helps skill mix of escalation but may reduce the skills and experience of staff across all ward areas as well as impact morale. Registered Nurses vacancies have increased but overall fill rates have shown improvement despite high level of attrition for nurse staffing and agency/temporary staffing use.

Work is also focused on agency reduction with first priority to remove ‘off framework’ agency use. The impact on staffing will continue to be monitored across all areas and with planned work to utilise ‘safecare’ as a deployment tool to support decision making in relation to ward safety based on acuity and staffing levels a clear oversight of all wards utilising a standard approach will help identification of risks.

A workforce review continues assessing the utilisation of support roles within inpatient areas and how this can help align appropriate duties to non-clinical staff.

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. Future establishment reviews will consider all wards area planning some shorter shifts, so staff have more choice.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Biannual Safer Staffing Report – January 2023

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 In ensuring the safe, effective delivery of emergency care the Royal College of Nursing makes a number of recommendations on Emergency Department Nurse staffing levels. The key standards include an uplift of 27% to take account of education and training requirements, supernumerary time for foundation nurses, practice education team, a co-ordinator for each shift, nursing cover for breaks and the safe staffing of audio-visually separate areas, staffing to meet triage time of 15 minutes. Skills and training and experience of staff should be taken into consideration when reviewing skill mix alongside agency staffing levels as percentage of workforce. In addition, the recommended standards for children in emergency care settings advocate Emergency Departments must always have a minimum of two Registered Children's Nurses on duty, and assessment of paediatrics on arrival in the department must occur within 15 minutes. (Royal College of Nursing, 2022; The Royal College of Paediatrics and Childs Health, 2018)

1.4 Definition of staffing levels for children and young person's services is clearly articulated in Royal College of Nursing Guidance and provides an indicative baseline day and night for nurse-to-patient ratios as follows:

- Level 3 critical care = 1:1
- Level 2 critical care = 1:2
- Level 1 critical care = 1:3
- Ward care = 1:4 if the children are over 2 years old
- Ward care = 1:3 if the child is under 2 years old.

In addition, RCN guidance recommends an uplift of 25%. National Quality Board Guidance (NQB) further recommends uplifts may require adjustment as paediatric wards tend to attract a younger workforce and have a higher level of parenting leave. The average percentage leave required should be reflected in uplift and workforce plans. Guidance also advocates for establishments setting to include time for interhospital transfers of paediatric patients, support outreach of registered children's nurses into areas, such as emergency departments, and consider the impact nursing children and adolescents in a ward area with mental health has on staffing. (Royal College Nursing, 2013; National Quality Board, 2018)

1.5 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 there is a systematic approach to determining staffing numbers and skills required to maintain safety of patients in their care. The best practice principles of safe staffing that are to be used in are listed below and must be used in the Trusts safe staffing processes:

- Evidence based tools and data
- Professional judgement
- Outcomes

1.6 This report provides an overview of the evidence based tool and data of the above bullet points for 25 adult inpatient wards or acute assessment units, paediatric wards and emergency departments in January 2023 (Appendix 1a). Analysis is limited at this time as the application of the SCNT requires a minimum of two data sets and where there is variation in data, further census before recommendation proposed utilising professional judgement and outcomes. Previous applications of tool have not been applied correctly so previous data has to be considered with caution.

1.7 Areas excluded in this review include escalation wards or wards with bed base function change in relation to escalation, inpatient and day case function. Due to the variability in function the evidenced based tools would not apply or provide reliable data.

1.8 There are four different Safer Care Nursing Tools (SCNT) utilised for assessment of wards including ED SCNT, Adult Acute SCNT, Adult Inpatient SCNT and Children and Young Persons (CYP) SCNT. ED SCNT was utilised in Emergency departments at PRH and RSH, Adult Acute SCNT was utilised in both Acute Medical Units and Surgical Assessment Unit, CYP SNCT was utilised on Paediatric Ward at PRH.

2.0 Nurse to Patient ratios

2.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for, but do not accurately reflect the needs of the individual patients, as acuity and dependency needs may vary at different points and as such nurse-to-patient ratios must account for these factors. 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.

2.2 Table 1 shows the average RN: Patient ratio at Shrewsbury and Telford Hospital (SaTH) during the month of January 2023. Nurse associates have been included in ratio calculations as a registrant, as the role will contribute to most aspects of care. Nurse

associate roles have developed since NICE guidance was published and are part of the nursing team.

Table 1: Actual Average RN: Patient ratio during January 2023

Division	RN: Patient Ratio (daytime average)	RN: Patient Ratio (average)
Medicine & Emergency	1:6	1:6.7
Surgery, Anaesthetics & Cancer	1:6.6	1:7.2

2.3 Table 1 shows that during January 2023 the 2 main adult divisions met the national requirement overall of a ratio of 1:8 maximum daytime with Medicine and Acute Medicine having the best ratios overall. The average ratio has increased for both divisions since last census period in July 2022 where they both had a daytime average of 1:5.

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 for whether actual hours match required hours.

3.2 The Adult Inpatient, Acute Assessment Units and Children and Young Persons tools are designed to be used daily for a minimum, 20-day period twice per year, collecting individual patient acuity and for ED the period is 12 day with acuity data 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 also not designed to indicate required skill mix. The tool must be used in conjunction with application of professional judgement and patient outcomes when determining staffing establishments and skill mix.

3.4 SNCT guidance requires a review of data from a minimum of two census periods before making changes to establishments/budgets. Where data is significant different further census may be required. With multiple changes in ward function, and a number of wards moves the SCNT will have limitations if subsequent census periods do not analyse the same ward functions/locations.

3.5 When applying methodology for safer staffing reviews, the evidence-based tools, outcomes and professional judgement should be considered. To ensure the alignment of template reviews with operation planning in 2023, an increase in census periods to three in total is planned. Baseline data available by the end of 2023 will provide a level of assurance around current establishment and templates that have been implemented in 2022.

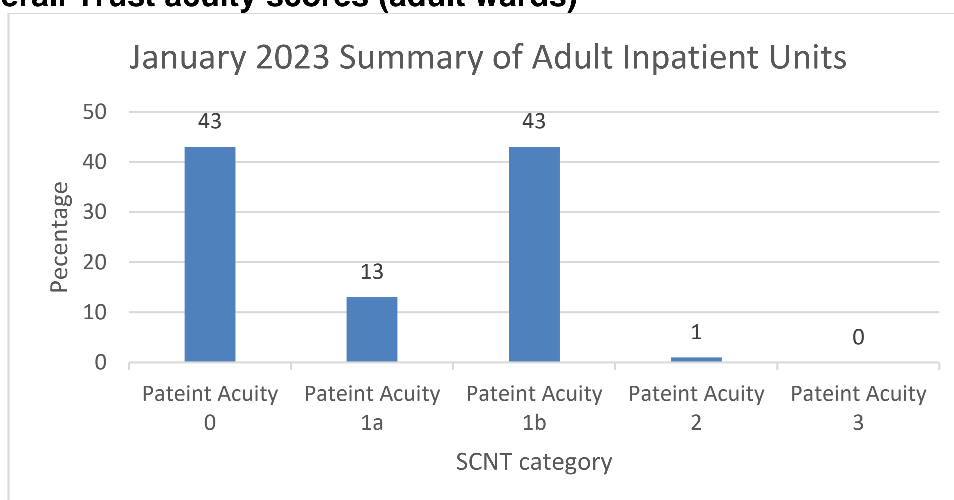
3.6 A change in data collection process was applied in January 2023 to ensure reliability of the tool. In previous census in 2022 it was also noted that whilst using a deployment tool no calculation for bed occupancy occurred, which could lead to an underestimate of acuity scoring, this issue was addressed with current census. The main ward affected with closed beds was ward 19 Children’s. Adjustments to establishments have taken into consideration when calculating Full Time Equivalent (FTE) staffing levels to open all beds.

3.7 A focused period of training and assessment of staff was completed ahead of January census 2023 as having a few core key personnel per ward with an appropriate level of training and competence will reduce variation in scoring and maintain inter-rater reliability. All staff undertaking audit or validation have completed training programme

and assessment of competence. Up to a level of 10% variation expected with the use of SCNT in scores ensuring training and competency is maintained over time will offer greater assurance regarding data reliability.

3.8 The overall average percentage data for all adult wards acuity for January 2023 is shown in Chart 1, where the main acuity of patients is Stable and requiring ward care (level 0) or stable and dependent (level 1b), with 43% of patients respectively for both categories. The number of acutely ill patients (level 1a) has dropped by half from previous census with PRH AMU the most notable of acute areas recording a variance from national average with a higher number of stable patients and lower numbers of acutely unwell. Consideration of the impact of patient flow from the emergency departments and associated delays has seen an extended length of stay in ED. Delays in transfer of patients to acute assessment unit could have impacted as time delays allowed for treatment and subsequent stabilisation. Other comparisons of July 2022 and January 2023 data is limited as previous application of the tool had reliability issues and changes in category could be attributed to previous reliability issues. January 2023 data collection has a high rate of reliability due to recent training of staff in use of the tool.

Chart 1 – overall Trust acuity scores (adult wards)



3.9 Charts 2, 3 show the acuity for January 2023 broken down by Division and charts 4 & 5 by specific areas assessed in Women and Children's and Chart 6 by Emergency Departments.

3.10 Data collected for Surgical area show the highest proportion of patients fall into the 1b category (stable dependent patients), whereas Medicine and Acute Medicine the highest category is Level 0 (stable patients requiring hospital care) closely followed by 1b category. For Gynaecology ward and Paediatrics, the majority were classed as a Level 0 - stable patients.

Chart 2 – Surgery, Anaesthetics and Cancer Divisional acuity scores

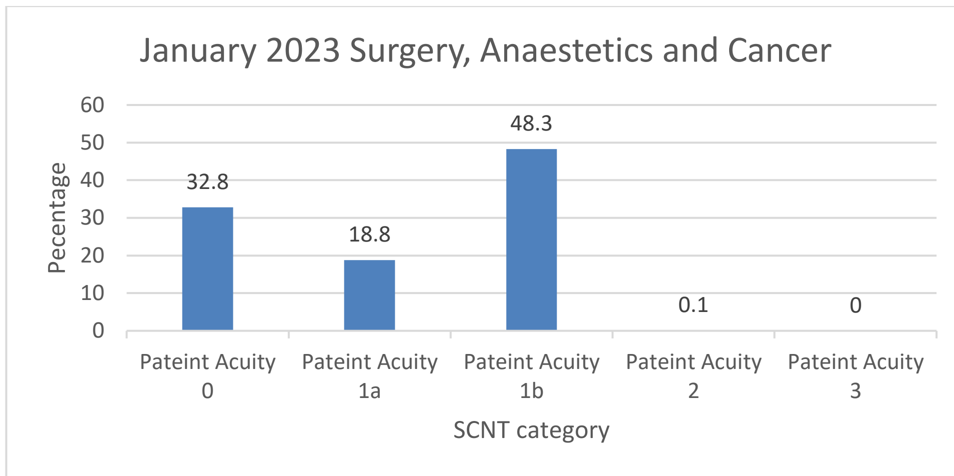


Chart 3 – Medicine and Emergency Divisional acuity scores

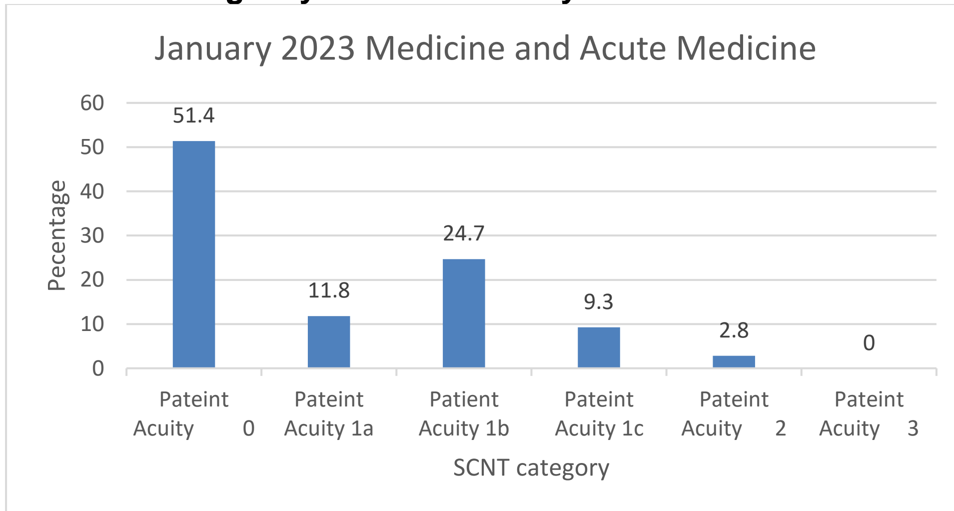


Chart 4 – Ward 14 (Gynaecology) acuity scores

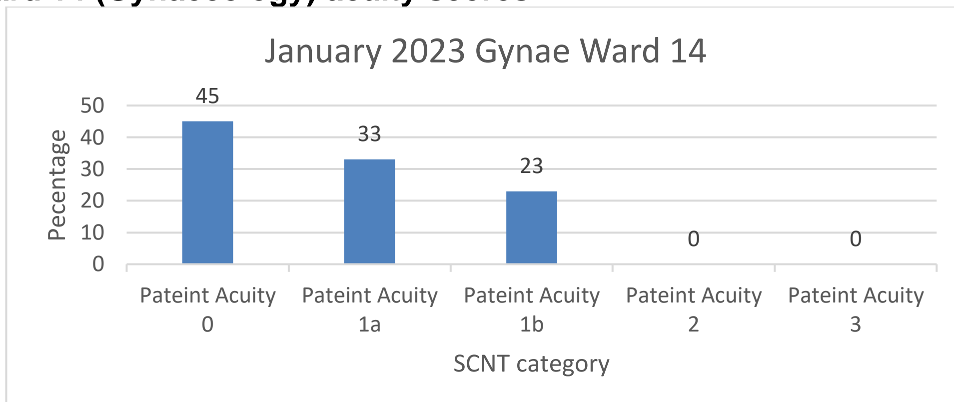


Chart 5 – Ward 19 Paediatrics acuity scores

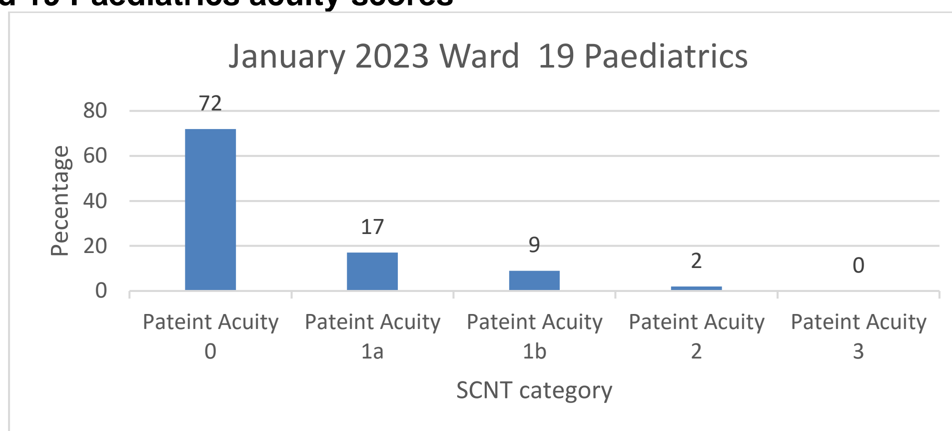
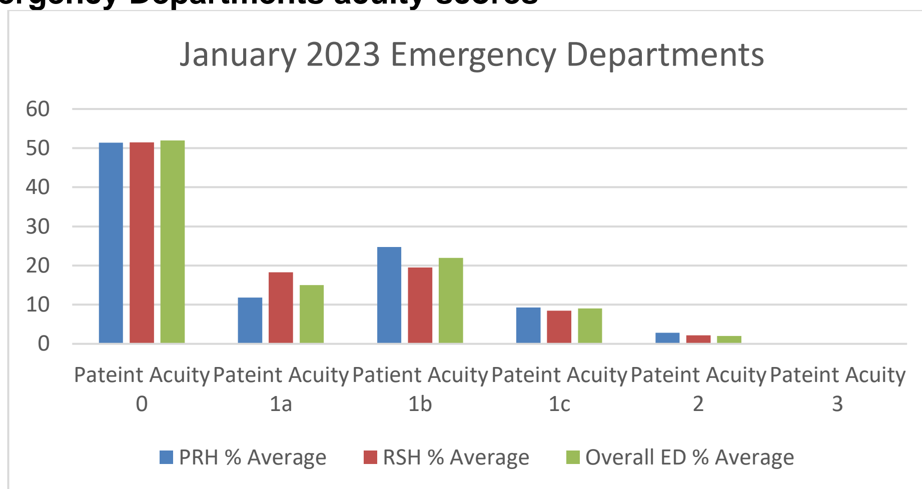


Chart 6 – Emergency Departments acuity scores



3.11 The emergency department SCNT census has been collated for the first time in January 2023 and data is similar across both departments with majority of patients in the Level 0 (stable but requiring hospital care). During the census period scores are only given to patients who have been in the emergency departments <12 hours. Calculations for SCNT utilise the annual attendance rate in working out daily averages. It was known during the census period there were issues with delays from ED, opening of additional escalation areas for patient awaiting ward beds and these patients are included in calculations however on an hour-by-hour basis escalation capacity is not fully reflected in the number of patients in the department as collected by the tool as additional patients (patients > 12 hours) are not counted. As such, where escalation areas continue to open to accommodate additional patients this must be reflected in the total numbers of staff required to care for patients as staffing for escalation in the ED may be over and above planned establishment. To better capture opening of escalation the ED rosters have been adjusted from February 2023 to record planned staffing based on baseline establishment and separate escalation staffing.

3.12 Ensuring the appropriate level of staffing for caring for children and young persons in the emergency departments should be considered when applying professional judgement. Attendances for paediatric patients attending PRH and RSH respectively are 25% and 17% of all admissions (rolling 12 months aligned with census) with a daily average attendance of 50 patients at PRH and 29 patients at RSH. Guidance for ED SCNT acknowledges the need to have dedicated roles i.e. paediatric nurses, and also dedicated role can help or hinder flexibility in the department. Further analysis with census periods of staffing to meet CYP needs in ED would be helpful to ensure standards for paediatric care are met.

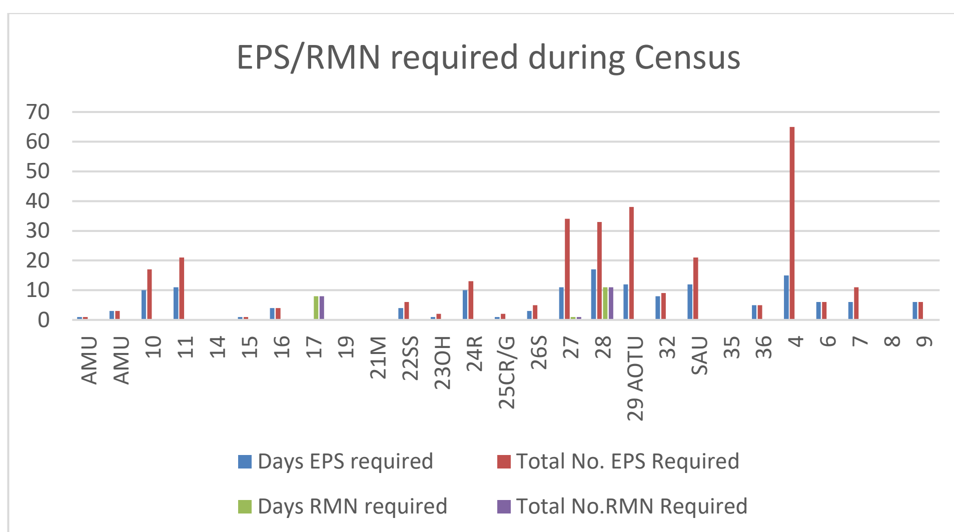
3.13 For the purpose of the bi-annual staffing reviews, a benchmark of RN: HCA ratio of 65:35 has been utilised within the SNCT for adult inpatient wards. It should be noted that the Gold standard would be a mix of 70% RN to 30% HCA. Evidence suggests that increasing RNs within a ward skill mix reduces 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). However, where a ward has a usual higher dependency rather than acuity need, it is accepted the ratio may need change. Current acuity/dependency scoring across medicine and surgery show a higher dependency of patients in January 2023 and as such templates currently reflect a ratio with higher levels of HCA. Medicine having average ratio of RN at 53%, Surgery 54%, AMU's 55%, Gynae 56% and Paediatrics 77%. Wards 6 and Ward 8 have the highest number of acutely ill patients and have a 70% and 68% RN ratio respectively. Ward 6 also has coronary care beds and as such requires a higher level of register nurses. This is also the case for Ward 8 as a Head and Neck ward it regularly has complex surgical patients and patients with tracheostomies. HCA requirements will be reviewed following next census and opportunities to consider other Healthcare Support Worker roles i.e. transfer team/ housekeepers should be considered.

3.14 The full analysis of the data collection in July 2022 is shown in **Appendix 1a**. 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. As previously mentioned, adjustments to data collection to improve reliability on acuity scoring means reasonable comparison of data sets can only occur following future census undertaken 2023. Establishment reviews will need to take account of minimum two data sets in 2023 before recommendations in establishment changes made.

3.15 Further work continues to enable a disaggregation of the workforce if the ward budget covers more than an in-patient area such as wards and assessment areas for example. SCNT tool can only be applied to inpatient beds so assessment areas although in budgets need to be clearly delineated so a reflective comparison can occur. Also ward attenders need to be captures where nurses are delivering care. Ward 35 is an example as it regularly supports line insertions and other interventions. During census period the ward can provide a narrative as part of the data submission on additional work done and time taken. Additional, Ward establishments do not normally have time for external transfers out of trust included in daily staffing plans. Wards have been able to comment on time spent by staff on external transfers during census and it is noted during the 20 days only 4 external transfers were recorded where registered nurse had to support. The areas transferring patients included Ward 16, ward 27, AMU RSH and Ward 19 Paediatrics. Current numbers of transfers do not necessarily reflect a need to adjust establishments as transfers in these numbers can likely be supported by Ward Managers who can provide cover. Transfer numbers will be monitored in future census.

3.16 Additional Staff, i.e. Enhanced Patient Support (EPS) or Mental Health Nurses, are not normally planned in establishments and data has been collected during January 2023 census on the need of both (Chart 7). The highest use of EPS for Surgery was the Trauma and Orthopaedic wards at both sites and for Medicine Ward 27/28 at RSH and Ward 10/11 at PRH. The case mix of all of these wards has a higher number of dependent patients. The need for Mental Health trained nurse was limited to a couple of wards. However, with a recently appointed Mental Health Matron in post, potential opportunities for recruitment of Mental Health Nurses should be considered as part of establishments in areas with need for this experience and skill. Opportunities to improve quality of EPS care and appropriate allocation of staff has commenced following the introduction of the Enhance Care Team lead by Band 7 Nurse. This work will continue as team is recruited to. There is also an opportunity for reduction of agency EPS as substantive staff will be allocated where available reducing agency requests.

Chart 7 – Data collected on days EPS or RMN and total numbers required in census period.



3.16 The inpatient ward with the lowest registered to nonregistered patient ratio is Ward 10 - 48%, Ward 11 - 49% and Ward 32 - 49%. Although Ward 10/11 has a high number of dependent patients there are wards with a higher dependency. Ward 32 has opened annex beds which are out of sight of main ward so staffing levels will reflect the need to observe patients. As patients in this area are only bedded if meeting strict criteria it is felt staffing ratio and skill mix will provide observation needed. In Jan only 1 Datix was submitted for staffing issues on ward 32 which was due to giving last minute emergency leave. Staffing levels were unmitigated and Datix records no harm. Quality data did not identify any significant variation over time, and there is only observations on time that is lower than expected. Ward 10 has had 2 Category 3 Pressure Ulcers. Friends and family audit has been positive though out last 6 months but again observations on time were slightly lower than standards for this area. Ward 11 has had a fall with harm (not reported as an SI) and a slightly varied friends and family but mainly positive results and a slightly lower level of observations on time. Some of these indications could be attributed to skill mix so ongoing monitoring and monthly reviews of red flag events will continue.

4.0 Vacancies

Table 2 – Vacancy position January 2023

Division	Total Vacancies	Nursing/Midwifery	NA	HCA/NSA
Trust Total	601.1	140.2	114	160
Surgery Anaesthetics and Cancer Division	182	26	26	49
Medicine and Emergency Care Division	267	75	78	98
Clinical Support Services Division	73	4	0	1
Finance	26	2	0	0
Womens & Childrens Division	59	33	11	19
Corporate Services	-37	1	-1	-7
Estates	0	-1	0	0
Other	32	0	0	0

[source: workforce reporting hub January 2023]

4.1 The number of vacancies remains high in January 2023 (Table 2) with main workforce plans including the recruitment of 175 Internationally Educated Nurses this coming financial year. Anticipated workforce recruitment will also come from Nurse Associate qualifiers, NA to RN conversations plus university qualifiers of RN/RCN and RM's. The golden ticket process has been refreshed in the last year and more students will be offered post on qualifying. The golden ticket process is also now in place for AHP's.

4.2 There is a high turnover of nursing staff and numbers recruited in the last year equal those that have left. The highest number of leavers whose length of service is less than 1 year is in the Medicine and Emergency Centre, with highest leavers across all areas by length of service is in the 2-5 year bracket. A retention strategy has been developed across the ICS and task and finish groups have been set up to deliver focused work on actions to support retention work.

4.3 Reducing and maintaining minimal HCSW vacancy rates is essential to supporting the NHS' recovery from COVID-19 and the delivery of the NHS long Term Plan. Local improvement plans include the enhanced training through the Academy, to ensure staff are fully prepared for ward work, supporting staff without previous care experience to complete the care certificate, enhancing opportunities for career pathways in the NHS as a whole but also into Nursing and Midwifery in particular. Local recruitment campaigns have seen a positive impact on recruitment, however, the need to reduce vacancies in HCSW continues with a regional target of 'zero' vacancies set. It is important to note even though recruitment has been successful there still remains a high number of staff wanting the flexibility of bank and would prefer to work for temporary staffing and as such, despite recruitment, overall vacancy reduction does not reflect numbers appointed. Opportunities to offer flexible opportunities to staff and encourage movement into a substantive post should be maximised.

4.4 The current levels of vacancies will impact staffing levels and create a need to utilise temporary staffing in bank and agency. Workforce plans should always reflective the need to substantively recruit and reduce reliance on agency in particular. The Divisions are being supported in developing trajectories which demonstrate recruitment verses agency reduction/removal which will be monitored as part of workforce efficiency in the coming financial year. Recruitment opportunities will be maximised as opportunities to grow your own workforce will be explored in addition to other recruitment planned. Nurse recruitment will continue to offset Nurse Associate vacancies, however as Nurse Associate qualify, RN's will be reduced as NA takes up posts. Without offsetting NA vacancies overall registrant staffing levels would be low and likely impact the quality and safety and delivery of care.

5.0 Fill rates

5.1 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 RN, NA and HCA.

5.2 The summary position for the last 6 months is shown in Chart 8. Nursing fill rates have seen an overall improvement for days and nights, however it is important to offset these with Nurse Associate vacancies which will not see improvements until future cohorts qualify. Two cohorts are due to this coming year.

5.3 HCA fill rates are relatively static across the last 6 months but are showing over template on night shifts. During census period in January 2023, wards were requested to provide commentary on EPS use, as this is one of the main reasons given for higher fill rates. Analysis of EPS usage will progress during the following months with the

implementation of Enhanced Care Team with an anticipated reduction in agency staff first and foremost which is currently one of the main ways of cover EPS need.

Chart 8 - % Fill rate by Month

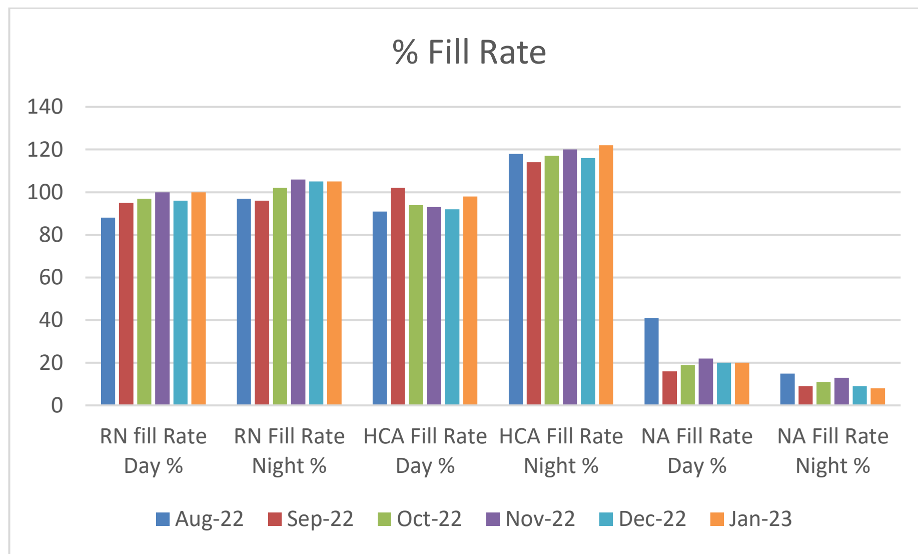
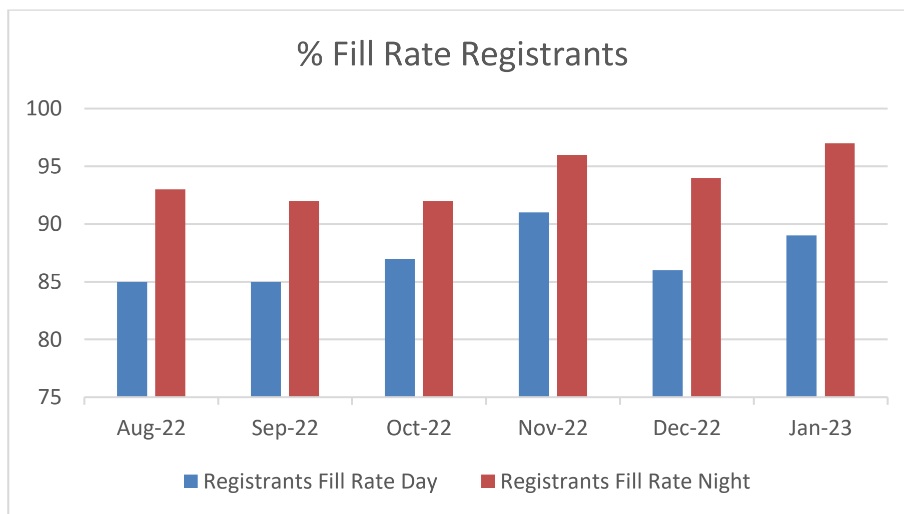


Chart 9 - % Fill rate Registrants (RN/RCN/RM/NA)



5.4 Nurse Associates current planned staffing levels are agreed at 146.36WTE. There is currently a significant number of vacancies, 114 WTE in January 2023 in this recrop as recruitment is reliant on 'grow your own' approach. With Band 5 recruitment used to offset NA vacancies, RN fill rate look healthy and it is felt an oversight of registrant fill rate would provide a more clearer picture of overall registrant staff fill rates (RN/RCN/RM/NA). The data as identified in **Chart 9** shows that fill rates for daytime has improved and is currently just below 90% in the amber range of 85-90%. Night-time fill rates also show an improving picture across the six-month period and are above 90% continually and rated 'green'. TSD cover is more forthcoming on night shifts as agency and bank are more likely to cover shifts with enhancements for unsocial hours. Despite amber day time fill rates and green night-time fill rates for registrants it is important to note there are individual wards were fill rates on daytime and night-time fall below the 75% of planned. Where this occurs, there should be a review of staffing and mitigations put in place, or escalation where no mitigations can be found and monitoring of quality metrics to ensure there is no harm occurring from significantly reduced staffing levels. Currently 'red flag' reporting relies on Datix submission, however, future plans will include the use of Safecare to monitor red flag events, record mitigations and ensure

there is oversight and validation by senior nurses in the divisions. This will enhance reporting of safe staffing and assurances in relation to staffing levels and will provide narrative on the impact staffing levels have on care where it has fallen below planned. Red flag events will also be overviewed at monthly quality metrics meetings which include safe staffing information which are chaired by the Deputy Director of Nursing and feed into the monthly safe staffing reports and Workforce Steering Group.

5.5 Collation of fill rates for registrants in January 2023 provides some assurance that there has been an overall improvement from previous census period as data from July 2022 suggests that fill rates overall on both hospital sites for Registrants has been above 85% and up to 96% on nights.

5.6 Fill rates do not take into account the skill mix within an area and only identify percentage of staff on shift. Where there are known vacancies and short term sickness the use of agency staff is higher. Agency staffing levels particularly in the Emergency departments and ITU's should not be above 20% of total registrants on duty from a safety perspective. Both ITU's have a process in place to monitor and Datix events where agency staffing levels are above national recommendations. The same process will need to be reflected in the emergency department going forward.

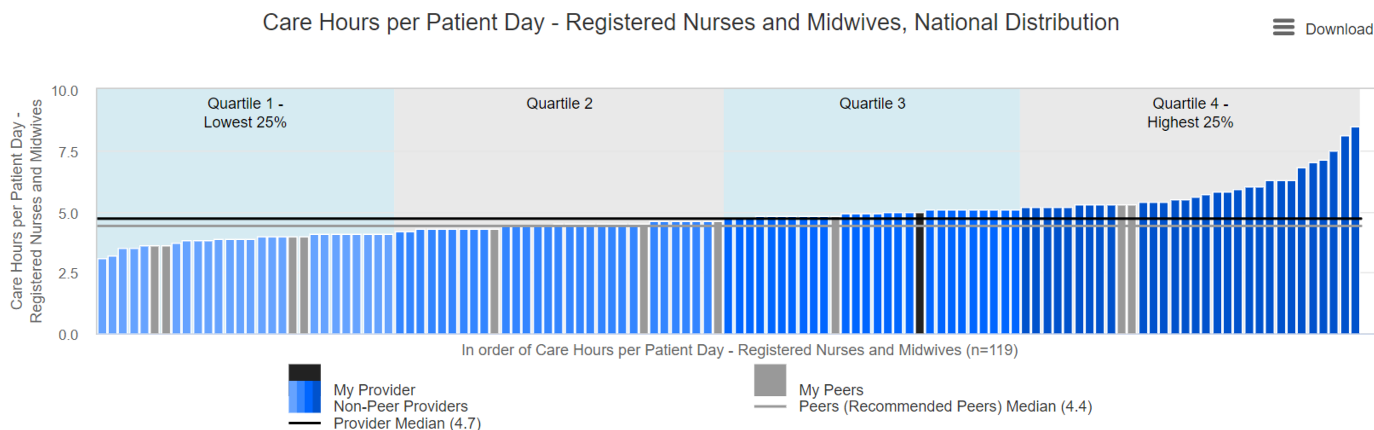
6.0 Care Hours per Patient Day (CHPPD) – Model Hospital Comparison

6.1 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.

6.2 The inpatient ward area identified with the highest CHPPD (Source; Census period 9th January 2023 to 3rd February 2023) was AMU RSH (20.8 CHPPD). This figure is in excess of what was expected and review issue with roster template set up when opening the acute floor did not clearly separate staff for assessment area and staff for the ward. CHHPD is not applicable comparator in assessment areas as patients are on trolley or in chairs. Work has commenced to separate out ward staffing for inpatient beds from assessment areas. It is anticipated that the current reported overall CHPPD may be slightly higher than actual until this work is completed.

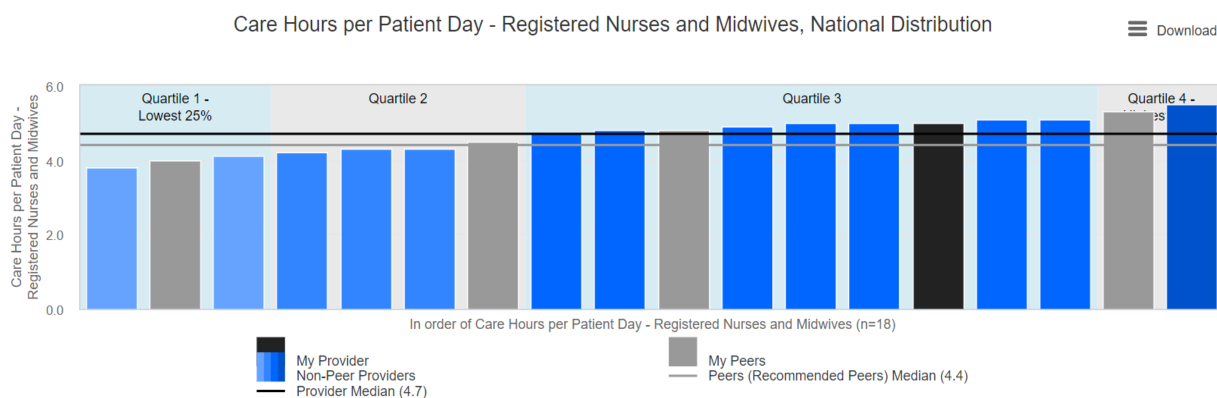
6.3 Chart 10 shows the most up to date position for SaTH on Model Hospital (December 2022 – Full calendar month) and indicates that for CHPPD nationally, SaTH are in the upper third of quartile 3 (5.0) and higher than both the peer median (4.4) and provider median (4.7). (Accessed 23 March 2023).

Chart 10 – National Distribution CHPPD RN and Midwives December 2022



[Source: Model Hospital December 2022 Data, accessed 23 March 23]

Chart 11 – Midlands Distribution CHPPD



[Source: Model Hospital, December 2022 accessed 23 March 2023]

6.4 When comparing CHPPD to Trusts within the Midlands (Chart 11), it highlights that SaTH are in the upper quartile 3 (**see chart 11&12**). One peer in quartile 4 is Worcester Acute Hospitals at (5.3), Sherwood Forest NHS Trust in Quartile 3 (4.8), Chesterfield Royal Hospital Foundation NHS Trust (4.5) in quartile 2 and Wye Valley NHS Trust (4.0) is in Quartile 1.

7.0 Substantive Unavailability

7.1 Substantive unavailability remains high at 30% [source Roster Dashboards SAC/MEC/W&C; 3 Feb 2023] a slight reduction from at 34% in July 2022. Unavailability remains above planned levels for sickness (5%), parenting (4%), Study Leave (4%), other leave (1%) and Working Day (1%). Training time likely reflects staff competing OSCE and TNA training.

7.2 There has been an increase in unavailability since pre-Covid. 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 and study leave.

8.0 Incidents

8.1 During January 2023 there were 43 staffing related incidents submitted to the datix system, a reduction across pervious months (see **chart 12**). Due to category on datix

not providing specificity it can be noted not all Datix are ward/department related and include issues with some workforce groups that are not nursing.

8.2 26 of the incidents could be identified as potential red flags, as defined by NICE (2021), positively all were recorded as low or no harm. The Divisional Directors of Nursing continue to review incidents with their teams. Whilst incidents were categorised as no or low harm it should be noted that there still could be some negative impact on patient and staff experience. A plan to review SI learning where staffing levels have directly impacted harm is required. Current oversight at Metric meeting is by previous month and a review following completion of investigation should be provided by Quality Governance Team if harm occurred in part or whole in relation to reduced nurse staffing levels.

8.3 The main wards where Datix numbers were higher in January 2023 include Birth Centre Telford (6 Datix), ITU RSH (4 Datix), Ward 25CR/G (4 Datix) and Ward 7 (3 Datix). As previously noted, incidents did not cause any significant harm.

8.4 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 through training and development of staff.

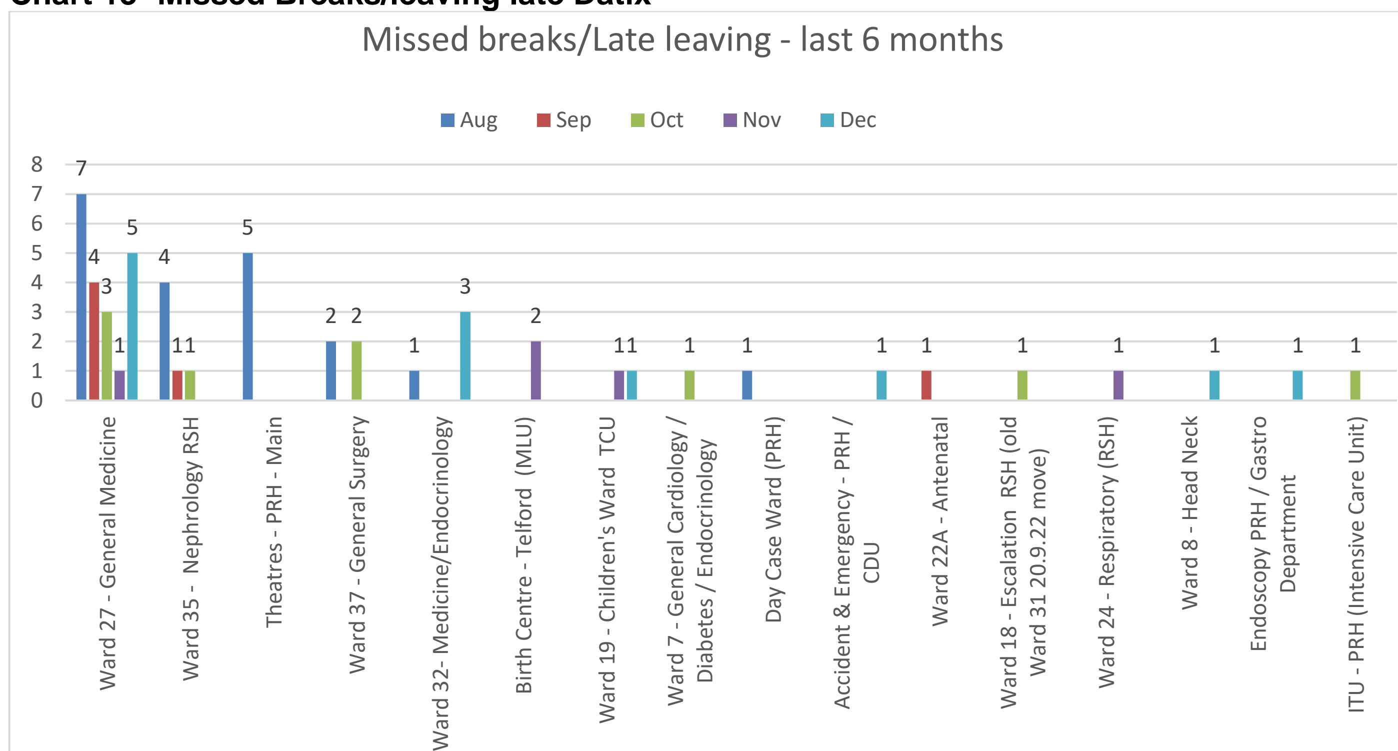
8.5 All datix submissions are now being reviewed monthly by the Lead Nurse for Workforce and the Divisional Directors of Nursing to review for red flags and monthly escalation.

8.6 Further work is planned to ensure there is daily oversite and validation of red flag incidences by Matrons/Divisions to ensure any concerning incidents are escalated at the time of the event to ensure appropriate mitigations can be put in place

8.7 Missed breaks/late off shift category was include as a separate category from July 2022. Over the last 6 months there have been 52 incidents reported all with low harm, no harm impact (Chart 13). Ward 27 has the highest number of incidences; however, it is anticipated there is under reporting on Datix. No incidents were reported in January 2023 at time of Census.

Chart 12 – Staffing incidents as reported on Datix

Chart 13 -Missed Breaks/leaving late Datix



9.0 NICE Red Flags

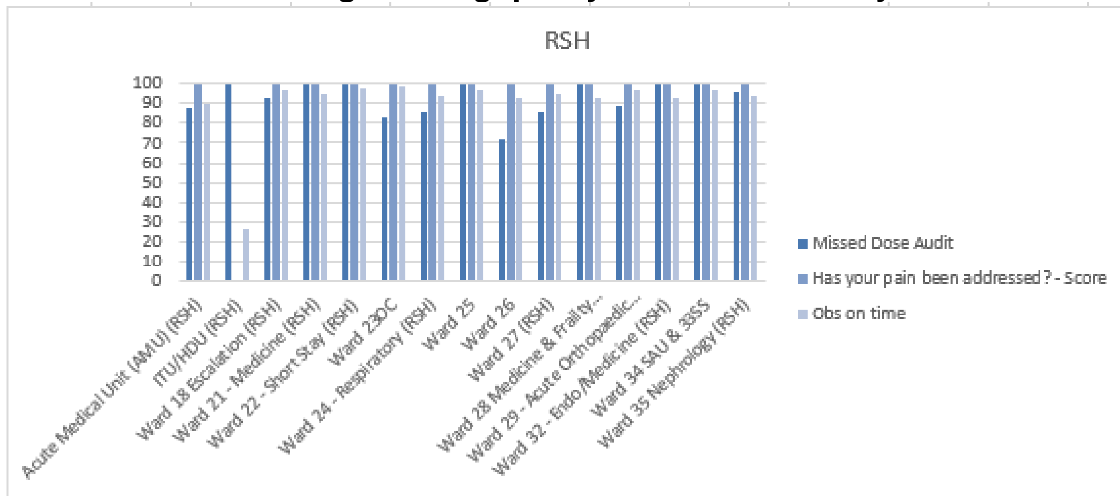
Nursing Red Flags as specified in Safe Staffing for nursing in adult inpatient wards in acute hospitals overvew (NICE 2021).

9.1 Patient vital signs not assessed or recorded as outlined in care plan (Chart 14 &15)**.**
At RSH compliancy ranges between 90.1% (AMU) and 98.8% (Ward 23OC). PRH ranges between 86.8% (AMU) and 97.1% (Ward 8). Obs on time were low for both ITU's but this is because alternative monitoring is in place on admission to ITU or HDU.

9.2 Unplanned omission in providing patient medications (Chart 14 & 15).
Audit data is taken from the nursing quality metrics audit which reviews 10 patient notes monthly. RSH compliancy ranges from 72% (Ward 26) to 100% (Ward 21, 22, 25, 28, 32, 34, ITU/HDU RSH). PRH compliancy rate ranged from 74% (Ward 10) to 100% (Ward 8, 9 and 14). Matrons and Ward Managers are working to improve this compliance.

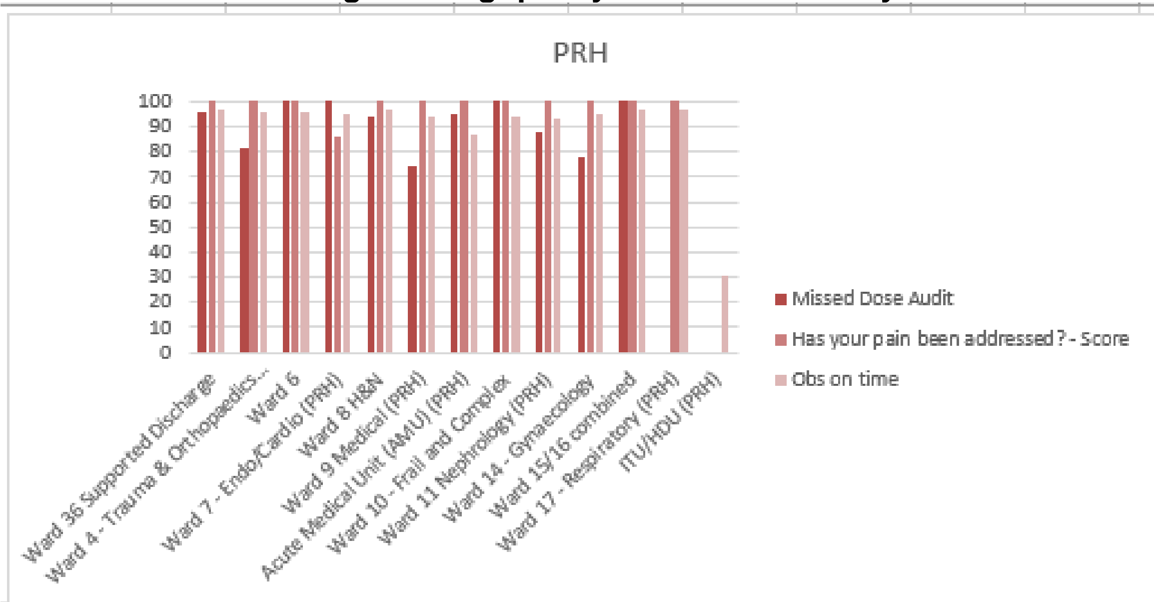
9.3 Delay of more than 30 minutes in providing pain relief (Chart 14 &15).
Audit data is taken from the nursing quality metrics audit which reviews 10 patient notes monthly. RSH compliancy rate was 100% (All Wards) and PRH ranging from 86% (Ward 7 to 100% All Wards). Matrons and Ward Managers are working to improve this compliance.

Chart 14 – RSH Nursing RedFlag quality measures January 2023



Source: Nursing Dashboard January 2023 (Full calendar month)

Chart 15 – PRH Nursing RedFlag quality measures January 2023



Source: Nursing Dashboard January 2023 (Full calendar month)

9.4 Red flags also include a shortfall of more than 8 hours or 25% of registered nurse time available, when compared with the actual requirement for the shift. Also fewer than 2 registered nurses present on a ward during any shift. The data captured from E-Roster (January 2023, Full calender month) is illustrated below (Chart 16). 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 the importance or red flags and ensure rosters reflect staff deployments. In the last 6 months all ward managers have been given access to deploy staff on safecare system so any ward moves can be updated on the roster in a live or timely manner. Ongoing monitoring at monthly quality metrics meeting where workforce data and nurse sensitive quality indicators will be reviewed and triangulated on a monthly basis, will highlight where roster does not reflect staffing plans enacted.

Chart 16 – Fill Rates data for RN/RCN/RM January 2023

	January 2023			
	Days		Nights	
	Fill Rate <75%	Less than 2 Reg (23 Hrs)	Fill Rate <75%	Less than 2 Reg (23 Hrs)
MEC - Acute Medical Unit (AMU) (PRH)	3	0	1	0
MEC - Acute Medical Unit (AMU) (RSH)	16	0	15	0
MEC - Ward 10 - Frail and Complex	3	0	0	0
MEC - Ward 11 Nephrology (PRH)	2	0	1	0
MEC - Ward 15/16 Stroke Unit (PRH)	6	0	0	0
MEC - Ward 17 - Respiratory (PRH)	2	0	0	0
MEC - Ward 18 - Escalation (RSH)	3	0	2	0
MEC - Ward 21 - Medicine (RSH)	14	2	15	0
MEC - Ward 22 - Short Stay (RSH)	3	0	0	0
MEC - Ward 24 - Respiratory (RSH)	8	0	1	0
MEC - Ward 27 (RSH)	2	0	0	0
MEC - Ward 28 Medicine & Frailty (RSH)	4	0	0	0
MEC - Ward 32 - Endo/Medicine (RSH)	5	1	2	0
MEC - Ward 35 Nephrology (RSH)	8	0	2	0
MEC - Ward 38 - Escalation (RSH)	6	5	5	2
MEC - Ward 6 - CCU/Cardio (PRH)	1	0	0	0
MEC - Ward 7 - Endo/Cardio (PRH)	5	0	1	0
MEC - Ward 9 Medicine (PRH)	2	0	1	0
SAC - Acute Orthopaedic Trauma Unit (AOTU) (RSH)	5	0	2	0
SAC - ITU/HDU (PRH)	1	0	0	0
SAC - ITU/HDU (RSH)	2	0	0	0
urgical Assessment Unit (SAU) & Short Stay Surgical	4	0	1	0
SAC - Ward 23 - Oncology & Haematology	1	0	1	0
SAC - Ward 25 - Colorectal and Gastroenterology	8	0	0	0
SAC - Ward 26 Surgical (RSH)	9	0	5	0
SAC - Ward 36 - Elective Orthopaedic (PRH)	10	0	1	0
SAC - Ward 4 - Trauma & Orthopaedics (PRH)	0	0	1	0
SAC - Ward 8 - Head & Neck (PRH)	1	0	0	0
WAC - Bridgnorth Maternity Unit	25	29	0	0
WAC - Ludlow Maternity Services	8	31	0	0
WAC - Oswestry Maternity Unit	12	11	0	0
WAC - Shrewsbury Midwifery Team	24	0	0	0
WAC - Ward 14 - Gynaecology	1	0	0	0
WAC - Ward 19	8	0	4	0
WAC - Ward 21 - Postnatal	27	0	29	0
WAC - Ward 22 - Antenatal	22	0	5	0
WAC - Ward 23 - Neonatal	5	0	1	0
WAC - Ward 24 - Delivery Suite (PRH)	5	0	2	0
WAC - Wrekin Midwife Led Unit	13	0	30	31

Source: E Roster January 2023 (Full calender month)

10.0 Considerations

10.1 As acknowledged in previous report, due to a number of changes in ward locations and functions and application of SCNT previously not correctly applied, there will be three planned census periods in 2023. Additional census data will provide data required to complete review of establishments. Establishments will be reviewed after every census period however it is recognised a minimum of two data sets is required before changes to establishments can be made.

10.2 Following previous changes to ward establishment reviews that were supported by the Trust Board, it was agreed Band 7 ward managers would be supervisory in their role. This will continue. 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).

10.3 On analysis of budgeted ward splits for RNs and HCAs; the average RN percentage has reduced slightly from to 56 to 54%. This continues to be below national guidance (RCN being 65% registered to 35% unregistered) and is therefore a risk in terms of patient safety, mortality, and staff well-being, alongside the potential impact financially on addressing this shortfall. It is important to note that overall actual daily ratio of RN to patients was satisfactory, apart from 3 areas. Ward 15/16 (1:9.1) Ward 11 Nephrology (1:8.4) and Ward 29 AOTU (1:8.5) all had a slightly higher actual percentage of RN to patients than is recommended in NICE 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). Indeed, acute wards guidance identifies a planned Registered Nurse (RN) to patient ratio of **no more than 1: 8** during the day. There is no current guidance for nights. None of the wards had planned levels of staffing that took

them below the ratio guidance and levels were only extended due to staffing gaps related to vacancy, unavailability.

10.4 The numbers of non-registered staff have increased from previous census period which has affected the Registered/non-registered ratio. The overall SNCT data would suggest that HCA numbers may in some areas could be reviewed, however further census data is required and professional judgement conversations will guide decision maker what is possible. Nurse sensitive quality indicators should be reviewed as wards with quality issues may not be suitable to adjust staffing. SCNT calculations are based on wards where there was a high level of quality so wards where quality is impacted may not be suitable for alteration in establishment if it reduces staff. Work has been undertaken around EPS usage and in previous bi-annual review it was recommended a team was established; recruitment is still ongoing and has been slow to progress, but impact of the team will be considered in future staffing reviews. It is also important to note that SCNT does not calculate for patients requiring 1:1 support and the data on requirements was captured at the time of the January census so this could be considered in future establishment reviews. The acute units and assessment areas have a higher level of HCA. During reviews following January census Ward Managers described having to support transfers and flow of patients from their own team and it was felt this was why higher levels of HCA were required. AMU at PRH notes they had previously had WTE removed from HCA budget to support transfer team in working hours, however they noted the number of transfers were happening later in day and were reliant on their own staff to ensure transferred were expedite timely to support flow from ED as transfer team was not available after 5pm. Other areas that describe using HCA workforce to facilitate moves also includes discharge lounge. Opportunities to explore additional roles outside of the “nursing workforce” such as Ward Clerks, Bed Cleaning Teams, and Transfer Teams would likely be required if reductions in HCA were to be realised. A review of housekeepers has been completed and business case developed since last bi-annual staffing review which was presented to business case group. No decisions currently made.

10.5 Following last year’s establishment reviews and changes agreed in budgets and skill mix, was an increased gap in recruitment to Nurse Associate posts rather than RN posts. Until plans for growing the NA workforce are realised, the change in skill mix has meant several areas are over recruited in Band 5 positions. This year sees a continued gaps in both as Nursing and Midwifery Vacancies currently stand at 140 and Nurse associates at 114. With current levels of attrition recruitment of 170 Internationally Educated Nurses (IEN) is essential if the staffing gap is to reduce. IEN recruitment sits alongside other recruitment activities expected to increase substantive staffing levels. Retention activities are also key if current attrition is to be addressed. Continuing recruitment without addressing retention would more likely see no impact of recruitment efforts and continued agency use.

10.6 Registered Nurses levels are showing in excess of SCNT recommendations in a number of areas. Additional work is required to ensure templates for inpatient beds are extracted from templates of wards with assessment areas (AMU’s, Ward 23, Ward 29AOTU Ward 15/16 Thrombolysis, Ward 8, Ward 6. The additional staffing may be required to enact ward some staffing functions and although ward acuity did not fully reflect utilisation of beds as level 2 i.e. NIV beds, CCU beds, standard staffing ratios are required to ensure the department can be responsive to patient need. FTE may look positive, but the need of the specialisms needs to be understood and benchmarked. The Emergency Department staffing levels also show a FTE over what SCNT recommends. It is important to note in January census escalation capacity was open and additional staff added onto ED template. Also, where escalation areas are audio and visually isolated from other areas of the department a minimum of two staff are required to ensure safety of patients is maintained. To help identify where escalation staffing is required the ED Roster has been split into Department roster and separate escalation roster. This will allow for clear analysis of staffing for department where

SCNT will apply and assessment of staffing for escalation as separate issue. Paediatric Staffing in ED should also be considered to ensure the needs of CYP is met and staffing levels support efficient and effective delivery of care. The Emergency department census does should some peaks and troughs in activity over 24-hour period of data collected. If future reviews also identify the same activity there may be some efficiencies that could be made from varying levels of staff to meet the peak of the work. Templates for days and nights are very similar, and ED would consider further twilight shifts. Consideration of headroom for Emergency departments which meet as a minimum NQB (2018) guidance and Shelford Group SCNT recommendations should be considered as staffing for training, supernumerary time should be reflected fully in any uplift applied. Trust percentage uplift which has been applied when completing SCNT calculations is 24%. However, NQB guidance recommends minimum of 25% and Shelford Group for emergency departments recommend 27% at a minimum. Numbers of staff in foundation training would normally be 10%, if high number of new starters over and above there may be room to extend uplift to support additional training and supernumerary time required.

10.7 Currently Ward and department areas included in the review 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 shorter 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. Ward Managers are being encouraged to consider flexible requests for staff, one of which is shorter shifts. Future work will consider options to increase the number of short shifts, so staff have a better choice.

10.8 Nurse Sensitive indicators of quality and red flags do highlight some issues a higher level of omissions in medications. Plus 43 datix in total were submitted for staffing issues across several ward areas where the red flag indicators would have applied and 52 datix submitted in last 6 months for missed breaks/late leaving. Not all wards' areas are robustly submitting datix in relation to incidences as indicated by fill rates and expected number of datix no. of shifts when staffing is below planned. Further work is required to ensure red flag events are escalated and reviewed by Matron and Senior Nurses and monitored in relation to safety. Monthly review of Ward Metrics by Divisions and Senior Nurses will review red flag incidences and mitigations actions taken to support safe staffing across organisation. There are also plans to utilise Safecare to record and monitor red flag events. This will support timely action, oversight and escalation where necessary.

10.9 Following recent work with NHSE, a review of approach to safe staffing and compliance with NQB standards has identified some areas for action, including the clear separation of deployment tool from SCNT. Further work is required to ensure the use of the deployment tool is embedded in daily practice, daily oversight of red flags and escalation processes is clear, actions taken for mitigation captured. Funding has been agreed for a fixed term Band 7 post to support the Lead Nurse for Workforce in ensuring the effective use and implementation of the deployment tool 'SafeCare'. Education and training is required for Ward managers and Matrons, Site Teams, On-call Managers and Executives on call regards the use of Safecare to support decision and recording and monitoring of variances in safe staffing metrics.

10.10 Off Framework agency reduction is a key priority for the Trust from a financial and quality perspective. Monitoring of the impact on fill rates on a monthly basis is essential if agency requests are continuing to be scrutinised and rationalised by the divisions. The monthly staffing report will consider agency utilisation and impact of agency reduction strategies on fill rates. Furthermore, from April 2023 a new bank incentivisation scheme will be in place across all non-medical staff groups which will support equity in pay across wards and staff groups which previous department bank enhanced rates did not. Executive support has been agreed for specialised areas to

maintain a higher rate of pay due to limits in staff available with specialist skill from bank to provide short term cover.

11.0 Future plans

11.1 The secondment of AHP workforce lead following successful bid monies from HEE has been further extended while business case for Chief AHP and Lead AHP go through governance processes. There is support for the roles in principal and potential funding streams have been identified. Divisionally these roles will sit with the Clinical Support Services as the majority of AHP's work in this division. The post holders will also support work across all divisions where AHP's are an essential part of staffing groups.

11.2 Paediatric Wards and Emergency Departments have been included for the first time in this report, Consideration of safe staffing across other wards and departments where SCNT does not apply will be included in the Safer Staffing Policy and process for review and outcomes included in subsequent staffing papers.

12.0 Conclusion

12.1 The issues in relation to the application of the SCNT have been address since the last bi-annual staffing review and data now collected is more reliable in relation to the acuity and dependency of patients. Further census period(s) are required before recommendations are made in relation to adjustments in establishments based on SCNT.

12.2 Work continues in relation to providing assurances in relation to Developing Workforce Safeguards. With action plan in place to address the remaining gaps (Appendix 2 – board paper)

12.3 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 (SY)
March 2023